MAYERS MEMORIAL HOSPITAL DISTRICT

Quality Committee Meeting
Wednesday, July 13, 2016 *(12 noon)*

Meeting called by:	Kerns	**Type of meeting:**	BOD Committee
		Board Clerk:	Valerie Lakey
Attendees:	Mike Kerns, Committee Chair, Board Member Beatriz Vasquez, Board Member Louis Ward, CEO	AJ Weinhold, MD, Chief of Staff Sherry Wilson, CNO, Quality Designee Laura Dolman-Byer, Community Member	
Please bring:	Agenda & Attachments		

----- Agenda Topics -----

Meeting Called to Order		Kerns	
Requests from audience to speak to issues/agenda items		Kerns	
Approval of Minutes – May 11, 2016 (Attachment)	A	Kerns	Action
Departmental Reports (OB, Physical Therapy, Social Services/Activities, Business Office, Hospice, Respiratory, Staff Development) • Report on quality data • Report on quality issues and/or quality projects	B	Green, Marzan, Burks. T.Lakey, Ranquist, Dendauw, Lee	Report
Quarterly Reports • CMS Core Measures • Compliance • Workers Comp		Hathaway Staff Mee	Reports
Standing Reports: Monthly— • SNF Events/Survey • Administrative Report • Quality – Performance Improvement • Infection Control		 Wilson Ward Green Lee	 Report Report Report Report
New Business: Policies and Procedures for Approval 1. Complaint (Non-Employee) with Complaint Investigation Form MMH55 and Reporting Concerns Brochure 2. Controlled Substance Medication Cart Count Procedure with MMH83 3. Disclosure of Unanticipated Outcomes 4. Fair Credit Reporting Act Policy 5. Fall Prevention Program, Acute Care with Fall Interventions, Standard & High Risk 6. Items Issued from Inventory 7. MEC-Governing Board Endorsement for Physician Reappointment and Privileges 8. MEC-Governing Board Endorsement for AHP Reappointment 9. MEC-Governing Board Endorsement for AHP Appointment and Privileges 10. MEC-Governing Board Endorsement for Additional Privileges 11. Medication Errors 12. Minimal Patient Lift Policy	C		Action

13. Parenteral Products - Quality Assurance 14. Post Fall Assessment and Documentation with Post Fall Huddle Packet MMH559 15. Quality Review Report 16. Quality Improvement and Patient Safety Plan			
Closed Session Announcement, Government Code 54962, Medical Staff: • Chief of Staff Report (Health & Safety Code §32155)		Weinhold, Wilson, Overton	Reports/Action
Reconvened to Open Session – Report Action(s)		Kerns	
Announcements: Next meeting: Wednesday, August 10, 2016 – Fall River			
Adjournment		Kerns	

Posted
06/06/16

MAYERS MEMORIAL HOSPITAL DISTRICT
QUALITY COMMITTEE MEETING
MINUTES – MAY 11, 2016

FINAL
Attachment A

QC Attendance	Other Staff Present	Absent
Mike Kerns, Board Chair	Travis Lakey	Beatriz Vasquez, PhD, Committee
Louis Ward	Adam Dendauw	
Sherry Wilson	Pam Sweet	
Theresa Overton	Chris Broadway	
Laura Dolman-Beyer, Community	Pam Sweet	
	Kay Shannon	
	Shelley Lee – by Phone	
	Valerie Lakey	

(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.)

SUBJECT	DISCUSSION	
CALL TO ORDER	The meeting was called to order at 12:04pm by Kerns in Fall River Mills	
Public Request to Speak	None	
Opening Remarks by Chairman Kerns	None	
Minutes	Minutes from the April 13, 2016 quality committee meeting were approved. **M/S/C (Lakey/Wilson).** All Approved	**Approved**
Department Reports	**Imaging, Adam Dendauw** – (Powerpoint) The department will be doing the American College of Radiology Accreditation (equipment and people). Staff is required to complete annual CEU's. Check Policies and Procedures, safety concerns, quality concerns. It will take about 6 months. Samples of adult and pediatric testing. Currently working on the intra-hospital relationship – radiology staff and peers. Two way communication, TEAM effort. Some personnel changes. Current lead is Tyson. **HIM, T. Lakey**– (Written Report) Lori Stephenson is almost done with RHIT. Candy Martin went for Birth Certificate program training. Quarterly reports are being sent out of Paragon to OSHPD **Med Staff, Pam Sweet** – (Written Report) Changing approval process for P & P's. Kerns would like a report back in about 6 months. Med Staff – learned a lot from Mock Survey. Peer Review process lacks confidentiality, we are correcting the procedure. Correcting telemedicine credentialing process. External peer reviews will be increased. Credentials	**Reports**

	criteria – working on getting reports for procedure criteria. ATLS, PALS – will be current within 6 months. Off-site radiologists need telemedicine privileges. Contracts are all going into MCN. MCN Is backed up monthly. **Outpatient Services, Kay Shannon** – (See Notes) Referenced notes from the survey. The department needs to know what the quality criteria are. Kay will contact the surveyor. HIPPA concerns – we have room for improvement with paper and department is only using partial electronic. CPOE medication orders are the biggest concerns. Need to be able to document and review charts electronically – notes, photos, etc. What they are using is great on a day to day basis, but not for over a course of time. None of the current outpatient documents migrate to papervision official record. **Patient Access, Travis Lakey** – Deposits are being done at night. Looking at up front collections training. Working through CCHAN. Use of a phone automation discussion.	
Quarterly Reports	**Patient Safety First:** Educational opportunities. Improving fall programs. **CMS Core Measures, Holly Green:** Absent	**Reports**
Standing Reports	**SNF Events/Surveys, Sherry Wilson**: **Administrative Report** – Mock Survey – hoping to do it more often. There are opportunities we are exploring. Possibly quarterly to look at specific things. Timeline in place for building project. May 17 – RFQ's are due to Porter. Building committee will meet on the 23rd to develop a short list. RFP request will be due June 20th. Contractor will be selected by end of June. Looking at a cataract surgeon – potentially starting out quarterly. Dr. Ure – Ortho will also be doing surgeries at MMHD. ACHD meeting last week. Differences between healthcare district and hospital district. Working on transparency – certified healthcare district. Kerns would like to show how (dollars/hours) invested in the staff. **Quality/Performance Improvement Holly Green**: Absent **Infection Control** – Written report. Mock survey helped a lot. Added hand hygiene was added along with a few other items. Will get some samples from other facilities. Separate some areas out. We should do 30	**Reports**

	observances per area per month. Risk assessment annually for infection control. Moving forward with antimicrobial stewardship. Keith is helping Shelley with an antibiotic log. Travis has helped Shelley with some reports for PRIME. Looking for education for staff with hand hygiene compliance, isolation rooms, education for support services. There will be some in-services scheduled. Shelley has some help now with data entry. Shelley and Suzanne will be attending a LTC – Infection Control training in Sacramento next week.	
Policies and Procedures	**Action Notice, Pharmacy Nursing MMHD940** **False Claims** **(Kerns/ Lakey) – Approved All**	**Action**
New Business	**IT Security, Chris Broadway** – Questions about Ransom-ware. We have solid anti-virus software. We back up our system regularly. Primary system is Lynex (sp) based. Threat level B+ to A- We have a solid backup and would be able to recover with minimal impact.	
Announcements;	Next meeting: Wednesday, June 8, 2016 in Fall River Mills	
Adjournment	Meeting adjourned 1:35pm	

Minutes By: Valerie Lakey

Closed Session 1:35 pm Re-Appointment Approved

B

Quality Meeting June 8, 2016

The Social Service department is dedicated to the highest quality service for patients and residents of Mayers Memorial Hospital. Several steps have been taken to improve and enhance the social service aspect of patient and resident care.

Education:

- Attendance at the Shasta County Case Manager /Care Coordinators Summit

This summit meeting was a great asset to communication and information exchange with over 25 other facilities and resources. The networking and presentations were invaluable. Mayers Memorial ended up being a featured facility.

- Community Interdisciplinary Team Meeting

This department attends once a month meeting to develop strategies for community support, agencies and needed resources. The communication between Mayers Memorial and the Sheriff department, Fire department, Adult Protective Service and multiple other agencies in the Intermountain area support a strong safe discharge for both Long Term Care and acute/swing patients.

MediCal Insurance

- A new delivery process through MediCal along with new employees has presented several challenges for this department.

These challenges are being met through collaboration, relationship building and agreed upon point person from their department. The results so far have been positive.

These and other changes to further develop this department have along with the utmost professional staff in all departments had a positive response from prospective family members placing loved ones and case managers from other entities. Receiving phone calls, drop in tours and messages have stated "You have a good reputation, I have heard a lot of good things about this place" and specific requests to be transferred to Mayers Memorial upon acute discharge.

Respectfully submitted

BJ Burks Social Services

BJ Burks MSW LSCSW

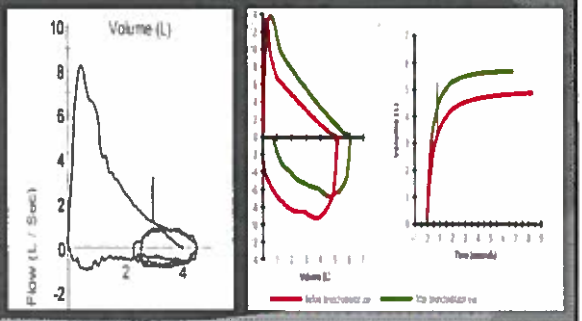
July 13th 2016

RESPIRATORY THERAPY QUALITY REPORT

PFT
Pulmonary Function Testing Machine

- New streamlined testing system cuts back on testing time from 1.5-2 hours to about 45 minutes on average
  - Patients can perform better tests with fewer efforts
  - Patient can take less time out of their lives to get test done
  - We can have more PFT appointments in a day
- Quality of testing results are greatly improved
  - Less chance of miss diagnosis
  - Proper respiratory medication prescribed post test
  - Reading physicians appreciate cleaner results
- Better patient interactions
  - Spend more time focused on patient then the machine
  - Patients are more comfortable leading to better testing results
  - The new equipment shows our investment in patient care
  - Same equipment used by many of the bigger hospitals, testing equipment is on par with them

PFT
Pulmonary Function Testing Machine



Pulmonary Rehab
Quality Care = Quality of Life Improvement for Patients

- Pulmonary rehab is a 18 week program of 36 hourly visits
  - One on one patient interaction
  - Pulmonary education
  - Daily exercising and activity
  - Provide moral, mental and emotional support
- Progress is tracked daily
  - Pulmonary function results Pre-rehab, midway and Post-rehab
  - Cardiovascular exercise time trending
  - Home medication or device usage
  - Vital signs measured

PFT Normal Values
80% Predicted
(Based on Age, Height, Sex and Race)

PT #1 60 year old Female, extensive smoking history, recent respiratory failure and congestive heart failure hospitalizations. Oxygen Dependent

	Pre	Mid	Post
FVC (Forced Vital Capacity)	25% Severe Restrictive Disease	68% Moderate Disease 270% increase	74% Mild Disease 300% increase
FEV1 (Forced Expiratory Volume)	26% Severe Obstructive Disease	71% Mild Disease 270% increase	80% Normal 310% increase
PEF (Peak Expiratory Flow)	21% Severe Obstructive Disease	61% Moderate Disease 290% increase	87% Normal 414% increase

C

MAYERS MEMORIAL HOSPITAL DISTRICT

BOARD POLICY AND PROCEDURE

COMPLAINT (NON-EMPLOYEE)

Page 1 of 3, plus the following Attachments:
Complaint Investigation Form – Non-Employee, MMH55;
Concern Grievance Log – SNF;
Reporting Concerns and/or Filing a Grievance tri-fold brochure; and
1-page "Poster"

DEFINITION:
For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in MMHD facilities, including inpatients, outpatients, residents and clients.

POLICY:
It is the policy of Mayers Memorial Hospital District (MMHD) to support each resident's, patient's or family member's right to voice grievances without discrimination or reprisal and to ensure prompt efforts by the facility to acknowledge and resolve grievances, including those with respect to the behavior of other residents/patients. Information obtained in resolving grievances will be used in departmental and hospital's performance improvement process to prevent similar concerns from arising in the future.

PROCEDURE:
When approached with a concern, staff will:

1. Attempt to immediately resolve the issue(s). Non-supervisory personnel shall refer the complaint to his/her immediate supervisor.

2. The supervisor will assist the complainant in documenting the complaint(s) using the Complaint Investigation Form.

3. Inform the complainant that he/she may lodge a grievance with the State agency directly, regardless of whether or not he/she has first used the hospital's process. Provide the complainant with the phone numbers and addresses for external agencies:

California Department of Health Services
Licensing & Certification
Chico District Office
1367 East Lassen Avenue, Suite B-1
Chico, CA 95926
Phone: (530) 895-6711 or 1-800-554-0350

Medicare
State: (805) 383-2038 (San Francisco, CA)
Federal: (410) 786-5994 (Baltimore, MD)

4. If the complaint is against a physician or healthcare provider, related to professional competence or conduct, provide the complainant with the phone numbers and addresses for external agencies:

Medical Board of California
1426 Howe Avenue, #54
Sacramento, CA 95825

California Board of Podiatric Medicine
1420 Howe Avenue, Suite #8
Sacramento, CA 95825

Central Complaint Unit for Physicians and Podiatrists: 1-800-633-2322

For CRNAs and Nurse Practitioners:

Board of Registered Nursing
1625 North Market Boulevard, Suite N217
Sacramento, CA 95834-1924

Enforcement
For information on disciplinary action or filing a complaint against an RN.
Fax: (916) 574-7693
Email: Enforcement_BRN@dca.ca.gov

For Physician Assistants

California Department of Consumer Affairs
Physician Assistant Committee
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815
Telephone: 916 561-8780
FAX: 916 263-2671
E-Mail: pacommittee@mbc.ca.gov

5. The supervisor will immediately forward all complaints to the Risk Manager.

6. The Risk Manager will investigate the complaint. Ongoing communication to the complainant will occur and be documented. Documentation will include facts, observations, conversations and quotations and will be dated, signed and indicate name, address and phone number on all documentation provided.

7. When an issue cannot be resolved at the supervisory level, administration must be notified.

8. The findings and recommended correction actions will be reported to the complainant within thirty (30) days of the grievance receipt.

9. Long Term Care: In the event that the grievance cannot be resolved by the facility to the satisfaction of the complainant, the facility will contact the Ombudsman for further assistance with the complaint. If facility resolution is still not acceptable to the complainant after Ombudsman assistance, the Ombudsman's number will be given for the complainant to contact:

   Long-Term Care Ombudsman: (530) 223-6191 or 1-800-231-4024 (Redding, CA)

10. Long Term Care maintains a *Concern/Grievance Log* and manual for centralized, on-going documentation.

11. All original grievances and investigative reports will be kept in the Risk Management office. Copies can be maintained in confidential departmental files.

12. A summary of the grievance will be submitted for CQI (Continuous Quality Improvement) trending/tracking

SPECIAL CONSIDERATIONS:

Brochures will be included in admission packets prepared by Patient Accounting (Business Office).

REFERENCES:

CMS, COP, 42CFR, §482.13
California Civil Code 43.96
BETA Risk Reporter, Volume 15, Jan.-Feb. 2003: "Complaint Management – Then & Now"

COMMITTEE APPROVALS:
QI:
GOV. BOARD:

MAYERS MEMORIAL HOSPITAL DISTRICT

Today's Date:_____

TO BE COMPLETED BY PERSON FILING COMPLAINT

Person Filing Complaint: _____

Are you a:

☐ Patient/Resident ☐ Visitor ☐ Family Member ☐ Representative ☐ Other

Mailing Address: _____

Phone Number Where You Can Be Reached: _____

Name of Patient/Resident of Concern:_____

Location of Concern:

☐ Acute Hospital ☐ SNF – Fall River Mills ☐ SNF – Burney ☐ SNF – ADCU

Room Number (if known):_____

DESCRIPTION OF PROBLEM/CONCERN:

Date & Time of Alleged Event:_____

What happened?_____

_____

_____

_____

How did it happen?_____

_____

_____

_____

Approvals: QI:

MMH55

COMPLAINT INVESTIGATION FORM (NON-EMPLOYEE)

Attached to policy Complaint (Non-Employee)

INVESTIGATIVE PROCESS: COMPLETED BY SUPERVISORY PERSONNEL
Was informal resolution sought? (If yes, describe, including date.)_____ _____ _____ _____ Complainant's Desired Resolution:_____ _____ _____ _____ _____ Other Persons With Knowledge of Incident:_____ _____ _____ _____ Recommendations for Corrective Actions:_____ _____ _____ _____ Resolution/Corrective Actions Taken:_____ _____ _____ _____
DATES/TIMES OF INVESTIGATIVE PROCESS/INFORMATION GIVEN TO PATIENT/RESIDENT/FAMILY MEMBER/VISITOR/REPRESENTATIVE/OTHER
Date:_____ Information Given By:_____ To:_____ Time:_____ Their Response:_____
Date:_____ Information Given By:_____ To:_____ Time:_____ Their Response:_____
Date:_____ Information Given By:_____ To:_____ Time:_____ Their Response:_____

THE CARING STAFF OF MAYERS MEMORIAL HOSPITAL FEEL HONORED WHEN WE RECEIVE COMPLIMENTS FROM OUR PATIENTS AND/OR THEIR FAMILY MEMBERS AND FRIENDS.

◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆

WE ALSO APPRECIATE IT WHEN SOMEONE TAKES THE TIME TO LET US KNOW HOW WE COULD HAVE IMPROVED THEIR VISIT.

◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆

IF YOU HAVE A CONCERN ABOUT THE CARE YOU RECEIVED, PLEASE BRING IT TO OUR ATTENTION BY ANY OF THE METHODS WE HAVE OUTLINED IN THIS BROCHURE.

MAYERS MEMORIAL HOSPITAL WANTS TO KNOW IF YOU ARE NOT SATISFIED WITH THE CARE/TREATMENT YOU RECEIVED.

IF WE FAILED TO MEET YOUR EXPECTATIONS, PLEASE ASK TO SPEAK WITH A NURSING SUPERVISOR OR HOSPITAL ADMINISTRATION.

A COMPLAINT IS CONSIDERED RESOLVED ONLY AFTER YOU ARE SATISFIED WITH THE ACTION(S) TAKEN ON YOUR BEHALF.

FURTHER INFORMATION IS AVAILABLE IN THIS HANDOUT.

MMH

Mayers Memorial Hospital

REPORTING CONCERNS AND/OR FILING A GRIEVANCE

Mayers Memorial Hospital
P.O. Box 459
43563 Highway 299 East
Fall River Mills, CA 96028

530-336-5511, Extension ~~1187~~
~~Performance Improvement Dept.~~

Mayers Memorial Hospital

TO: Patients, Residents, Family Members and/or Visitors

It is our desire that you be treated in a caring, respectful manner. We will make every effort to meet your expectations of care and service in a timely, reasonable and consistent manner. If we fail to meet your expectations, please take a moment to let us know.

To report your concern, ask to speak to the nursing supervisor or hospital administration. They will work to resolve the complaint or describe the actions necessary to pursue resolution. Our goal is to handle complaints quickly - within 1 business day.

If a previous complaint about care was not resolved or involved issues of abuse, neglect or noncompliance with the Centers for Medicare and Medicaid Services and/or Hospital Conditions of Participation, you may wish to file a more formal complaint. These types of complaints can take up to seven (7) days to resolve.

- Request a "Grievance Form" from Administration, the Performance Improvement Office, and/or SNF (Skilled Nursing Facility).
- Complete and deliver (or request assistance in delivering) the form to one of the above-mentioned department(s).
- To make a verbal complaint, ask to speak to the nursing supervisor or hospital administration at 336-5511, extension 1187.

If you choose, you may also voice your concern/complaint anonymously by calling the Mayers Memorial Hospital **HOTLINE at 530-336-5511, extension 1195.**

You also have the right to file a complaint with any (or all) of the following organizations:

- California Department of Health Service, Licensing & Certification
  Chico District Office
  1367 E. Lassen Avenue, #B-1
  Chico, CA 95926
  Phone: 530-895-6711 or
  800-554-0350

- Medicare
  State Number:
  805-383-2038
  San Francisco, California

  Federal Number:
  410-786-5994
  Baltimore, Maryland

- Long-Term Care Ombudsman:
  530-223-6191 or
  800-231-4024
  Redding, California

Reference: §482.13(a)(2)
Form - Reporting Concerns and/or Filing a Grievance
01/25/06

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY & PROCEDURE

CONTROLLED SUBSTANCE MEDICATION CART COUNT PROCEDURE

ORIGINATING DATE: 6/25/09
REVIEW DATE:
REVISION DATE:
MANUAL(S): SNF, PHARMACY

Page 1 of 1, plus Attachment
ITControlled Substance Cassette Tracking Form.doc

DEFINITION:
For all intents and purposes, the word "patient(s)"refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

POLICY:
To assure that all controlled substances are accounted for.

PROCEDURE:

1. Licensed nurse is to count cassettes in medication carts including narcotic liquid.
2. Check the Green Lock from the overflow is checked every shift to make sure the number correct with Tracking Form.
3. Charge Nurse and Floor nurse initials.
4. The original is sent to pharmacy and charge nurse gets a copy.
5. If cassette is discontinued or emptied, it is subtracted from controlled substance cassette tracking form with appropriate box marked, placed in Medication Room for return to pharmacy.

COMMITTEE APPROVAL(S):

P & P: 10/21/09
Quality: 11/17/09

Author Initials: SL, SF, JR
File & Path Name: \\Mmh2k01\public\Policies and Procedures\SNF (Skilled Nursing Care)\In Progress\Controlled Substance Count Procedure.doc

MAYERS MEMORIAL HOSPITAL DISTRICT
CONTROLLED SUBSTANCE CASSETTE TRACKING FORM

DRAFT

Date	Total # Cassettes in CART	Resident / Rx# / __ of __	Signature	Empty Cassette to Pharmacy	Discontinued Cassette to Pharmacy	**Added** Cassette from Pharmacy	**Added** Cassette from Overflow	New Total # Cassettes in CART

Return Completed Form to Pharmacy

APPROVALS: P&P: 4/9/08
MMH83 / ke Page 1 of 1
CONTROLLED SUBSTANCE CASSETTE TRACKING FORM

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

DISCLOSURE OF UNANTICIPATED OUTCOMES

DEFINITION:
For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

UNANTICIPATED OUTCOME: It is a result that differs significantly from what was anticipated to be the result of a treatment or procedure. Examples of unanticipated outcomes:

1. An event that resulted in the need for treatment and/or intervention and caused temporary patient harm.
2. An unexpected occurrence involving death or a serious physical or psychological injury or risk thereof.
3. Errors that result in serious, long-lasting harm.
4. Outcomes that require patients and their families to participate in current and future decisions affecting the patient's care.

POLICY:
It is the policy of Mayers Memorial Hospital District to inform patients and their families of unanticipated outcomes or serious events. This policy and procedure supports our commitment to patient safety and a nonpunitive environment that allows honest and open discussion of unanticipated outcomes.

PROCEDURE:

1. The healthcare professional will notify the patient's attending physician and the Nursing Supervisor that an unanticipated outcome has occurred.
2. The Nursing Supervisor will immediately notify the Chief Quality Officer and/or the Chief Executive Officer.
3. The attending physician or peer designee, with the direct or indirect support/advice and concurrence of appropriate staff, will inform the patient of the unanticipated outcome. Examples of "appropriate staff" are the Director of Chief Quality Officer, Chief Executive Officer, Chief Nursing Officer, Chaplain or Legal Counsel.
4. The attending physician or peer designee should determine what family members, if any, should be present.
5. The attending physician or peer designee should then disclose the unexpected outcome. This is done without assigning or admitting blame. Demonstrate compassion and sympathy, answer questions and discuss the plan of treatment.
6. The attending physician or peer designee who informed the patient should document the following in the medical record:
    a. Time, date and place of discussion.

b. Name(s) and relationship(s) of those present.
c. Discussion of unanticipated outcome.
d. Any follow-up discussions.
e. Offer of assistance and response to offer.
f. Questions posed by the patient, family members and legal representatives.
g. Consults with psychiatrist, Ethics Committee, etc.
h. Treatment plan.

7. The Nursing Supervisor/Administrative Personnel should evaluate the need for staff counseling and/or support and call appropriate resources, i.e., Chaplain or counselor.
8. The healthcare professional who identified the event should utilize the Quality Review Report (QRR) form to document and report the occurrence.
9. The Chief Quality Officer will notify liability insurance carrier, licensing board and/or FDA, as appropriate.
10. The Chief Quality Officer, in collaboration with the Medical Staff, will complete a confidential Root Cause Analysis (RCA). The findings will be forwarded to the appropriate committees, i.e., Medical Staff, Peer Review, Surgery, Obstetrics, etc.
11. The RCA results will be used to modify/amend practice to prevent a reoccurrence. Performance improvement initiatives will be implemented and monitored for desired outcomes. Monitoring process changes will be reported to the Quality Improvement Committee within 3-6 months.

SPECIAL CONSIDERATIONS:
The patient must give permission for family member(s) to be involved in discussions relating to his/her care, if able.

REFERENCE:
JCAHO Patient Safety Standards – The Patient's Rights and Organizational Ethics, Chapter RI.1.2.2., dated 2006

Title 22, §70707: "Patient's Rights"

Evidence Code §1160

Credentialing and Peer Review Legal Insider, August, 2004, "Set hospital policy covering physician's disclosure of medical errors."

Monograph prepared by the Monographs Task Force of the American Society for Healthcare Risk Management, dated May, 2003.

Disclosure of Unanticipated Events: 3-part series: Published May 2003, November 2003 and February 2004.

American Society for Healthcare Risk Management (ASHRM) of the American Hospital Association. Perspective on Disclosure of Unanticipated Outcome Information – April 2001.

COMMITTEE APPROVALS:

QI:

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

FALL PREVENTION PROGRAM, ACUTE CARE

Page 1 of 3, plus the following attachments:
Fall Interventions - Standard and High Risk (2-page handout)

DEFINITION:

For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

POLICY:

Patient falls occur as a result of the interaction of intrinsic and extrinsic factors that are unique to each individual. Preventing falls requires a multi-disciplinary approach that includes individual patient assessment, interventions appropriate to the intrinsic and extrinsic factors, and focusing on not only reducing falls, but preventing injury. Fall prevention emphasizes bedrail reduction. Bed rails contribute to patient fall risk by creating barriers to patient transfer in and out of beds. Use of bedrails must be assessed specific to individual patient needs. When possible, the use of alternative pillows and positioning devices is recommended to avoid the use of bedrails.

DEFINITIONS:

Patients: for all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

Intrinsic factors: factors within the individual such as weakness, gait/balance disorders, cognitive impairment, postural hypotension, incontinence, polypharmacy (more than 4 drugs), age, chronic disease, etc.

Extrinsic factors: factors in the environment such as time of day, lighting, clutter, lack of non-skid footwear, slippery floor surfaces, etc.

Fall: loss of upright position that results in landing on the floor, ground, or an object or furniture or a sudden, uncontrolled, unintentional, non-purposeful, downward displacement of the body to the floor/ground or hitting another object like a chair or stair.

Slip: loss of balance as a result of a slippery surface that does not result in a fall.

Stumble: loss of balance due to knees giving way or other reasons but does not result in a fall.

Trip: loss of balance due to a specific obstacle that does not result in a fall.

THE MORSE FALL SCALE (MFS) (Morse, 1997):

History of Falling	No = 0 Yes = 25	0 25
More than one Diagnosis	No = 0 Yes = 15	0 15
Ambulatory Aid	None, on bedrest, uses W/C, or nurse assists = 0 Crutches, cane(s), walker = 15 Furniture = 30	0 15 30
IV/Saline Lock	No = 0 Yes = 20	0 20
Gait/transferring	Normal, on bedrest, immobile = 0 Weak, uses touch for balance = 10 Impaired, unsteady, difficulty rising to stand = 20	0 10 20
Mental Status	Oriented to own ability = 0 Forgets limitation = 15	0 15
Risk Level	**MFS Score**	**Action**
No Risk	0-24	None
Low Risk	25-50	Standard Fall Interventions
High Risk	51 or greater	High Risk Fall Interventions

PROCEDURE:

1. All patients are assessed for fall risk on admission using the Morse scale, which is in the *Acute Care Admission Assessment* ~~*Record* (MMH155).~~ in the EMR. Based on the Morse score (see above) the patient is assigned as either "no risk," "low risk," or "high risk" for falls.

2. Risk Measures
   a. Patients who score as "no risk", usual measures are taken to ensure patient safety.
   b. Patients who score "low risk", **Standard Fall Interventions** are deployed, as appropriate to the patient.
   c. Patients who score "high risk", **High Risk Fall Interventions** are deployed, as appropriate to the patient.
   d. Standard- and high-risk fall interventions are placed on the patient's chart as an action guide for the nursing staff. (see *Fall Interventions – Standard and High Risk* handouts, attached).
   e. If patient meets standard or high risk protocol then a referral for Physical Therapy Evaluation is placed.

3. Thereafter, the nurse will re-assess the patient's fall risk each shift using the Morse scale, and document it on the ~~on the shift assessment record~~ daily assessment in EMR. ~~(*Patient Assessment Record – MMH157).*~~

4. Fall risk concerns will be discussed with the physician and other members of the interdisciplinary team, as needed. Actual falls will be discussed at the Care Delivery Team meeting for input/options from the team.
5. Patients at high risk for falls will have "Fall Risk" written on their allergy band. ~~, and a "Fall Leaf" magnet placed outside the door.~~

6. On discharge, if the patient is still a fall risk, patient education materials will be given to the patient and family.

7. If a patient does fall:
   a. Assess the patient for injury, and report to physician.
   b. Document in the nurses notes the circumstances surrounding the fall, including what treatment was provided, and what measures were taken to prevent a future fall.
   c. Complete a Quality Review Report (QRR) and turn it in to the Director of Nursing (DON) Med/Surg.
   d. The DON will complete the Acute Care Fall Quality Monitor and enter the fall in the Acute Care Fall log.

REFERENCES:

Hendrich, A., Nyhuis, A., Kippenbock, T., & Soja, M.E., 1995. Hospital Falls: Development of a predictive model of clinical practice. Applied Nursing Research, 8. 129-139.

Department of Veterans Affairs. (1996). Clinical Practice Guidelines: The prevention and management of patient falls. Tampa, Fl: Author.

Morse, J. (1997). Preventing patient falls. Thousand Oaks, CA: Sage.

Maki, B.E. (1997). Gait changes in older adults: Predictors of falls or indicators of fear? Journal of American Geriatrics Society. 45, 313-20.

National Safety Council. 1999. Reports on injuries in America. Itasca, Il.

Steven, J., &Olson, S. (1999, October). Check for Safety. A home fall prevention checklist for older adults. Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Tideisaar, R. (1997). Falling in old age. Its prevention and management. (2nd ed.). New York: Spinger Publishing.

COMMITTEE APPROVALS:

QI:

FALL INTERVENTIONS - STANDARD

Instructions: The following actions are suggestions for use in patients who meet the criteria for **Low Risk** for falls. They are provided to aid the nursing staff as potential interventions for patients who are at risk for falls. Please place this form on the patient record and refer to it as necessary. All interventions must be individualized, as appropriate, to each patient, in conjunction with the physician. To be used for patients whose **Morse scale score is 25-50.**

Bed Placement:

- Assign patient a bed that enables them to exit toward his/her stronger side whenever possible.
- Keep bed in low position, locked at all times when patient is unattended.
- Upper side rails should be used as needed. (Do not entrap patient by using both pairs of bed rails if patient is determined to get out of bed)
- Keep call bell within reach.

Activity/Ambulation:

- Assess the patient's coordination and balance before assisting with transfer and mobility activities.
- Use treaded socks/slippers for all patients.
- Use Gaitbelt.
- Approach patient towards the unaffected side to maximize participation in care.
- Transfer patient toward stronger side.
- Teach patient the use of grab bars.
- Instruct patient in all activities prior to initiating assistive devices.
- Lock all moveable equipment before transferring patients.
- Individualize equipment specific to patient needs.
- Keep assistive devices used by the patient within their reach.

Toileting:

- Offer assistance with toileting on a regular schedule.
- Keep a bedside commode/urinal available.
- Keep pathway to bathroom uncluttered, if patient has bathroom privileges.

Medications:

- Instruct patient and family in medication time/dose, side effects, and interactions with food medications.

Activities of Daily Living:

- Place patient articles within reach.
- Provide a physically safe environment: eliminate spills, clutter, electrical cords, and unnecessary equipment.
- Provide adequate lighting.
- Use bathmats outside of the showers.
- Place yellow "Fall Risk" sticker on identification band. ~~on the same extremity as the admission identification band. Place "Fall Leaf" magnet outside door.~~

Revised: 11/07
Attached to P&P Fall Prevention Program, Acute Care

FALL INTERVENTIONS - HIGH RISK

Instructions: The following actions are suggestions for use in patients who meet the criteria for **High Risk** for falls. They are provided to aid the nursing staff as potential interventions for patients who are at risk for falls. Please place this form on the patient record and refer to it as necessary. All interventions must be individualized, as appropriate, to each patient, in conjunction with the physician. To be used for patients whose **Morse scale score is 51 or greater**, in addition to the Standard Fall Interventions.

- Place yellow "Fall Risk" sticker on identification band ~~on the same extremity as the admission identification band~~.
- Consider placing patient in a room with direct visualization from the nurse's station.
- Bed Alarm in place.
- Consider use of non-skid floor mat, floor cushion, and hip protectors.
- Clear the patient environment of ALL hazards.
- ~~Ask physician for~~ Order Physical Therapy consult per protocol.
- Use TABS alarm monitor if up out of bed in wheelchair, etc.
- Do frequent visual checks as determined by patient need.
- Offer fluids/nutrition as appropriate.
- Assist the patient out of bed to chair and back to prevent discomfort, stiffness.
- Use Gaitbelt.
- Ambulate patient to the bathroom.
- Ambulate patient in the hallway.
- Use of side rails may or may not be necessary-to be assessed by RN.
- Incorporate the family in the care of the patient, when appropriate.
- ~~Put "Fall Leaf" magnet outside door.~~

Revised: 11/07
Attached to P&P Fall Prevention Program, Acute Care

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

ITEMS ISSUED FROM INVENTORY

DEFINITION: An "Issued Item" is a stock item that is received directly into the general inventory of the supply room to later be issued to the various departments as needed.

POLICY:

It is the policy of Mayers Memorial Hospital to process all inventory using the Paragon Computer Inventory System (PCIS). This will enable the Purchasing Department to track quantity of items more accurately. Each item that is taken from inventory must be logged out using PCIS.

PROCEDURE:

The Purchasing Supplies Sign Out sheets will be updated throughout the day by the Purchasing Clerk. The following procedure will be followed:

- In PCIS, click on Issuing
- Click on Walk Up button located on the bottom, left hand side of screen
- Enter the department name in the "Issue To" box
- Enter Purchasing Clerk's name in the "Reference" box
- Enter Item ID, tab, curser will proceed to "Qty" box
- Enter quantity on noted on sign out sheet
- Check to verify the "UOM" is accurate (ie. box, case, each, pk)
- Check to verify there is a location listed in the "Bin" box
- If needed fill in the "GL Account" box with the appropriate GL code
- Click "Issue/Transfer" button located on the bottom, right hand side of screen
- Follow directions in pop up windows as needed
- Click NO to skip printing "Picklist", click OK, OK, close, close

Once Issuing item is complete:

- Go into Inventory Management
- At the top, click the "Stock Issues" tab
- Click "Retrieve"
- You need to record the "Req ID" into the "Leave Blank" column on the Purchasing Supplies Sign Out Sheet" in red ink. Be sure the req id you are recording is the correct number
- Click "Close"

COMMITTEE APPROVALS:

Purchasing: 02/16/2016
P&P Committee:
Author: DT
Computer Used: Purchasing

MAYERS MEMORIAL HOSPITAL DISTRICT

ENDORSEMENTS

, MD, has applied for reappointment to our medical staff with active privileges in (**Specialty**). Appropriate documents have been submitted, reviewed and substantiated.

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS:

☐ Reappointment recommended based on review of his/her individual character, professional performance, experience, judgment and clinical and/or technical skills, as well as his additional training, i.e., Continuing Medical Education (CME) courses.

☐ Reappointment **not** recommended based on: _____

_____

_____

_____

_____

_____ _____

Chief of Staff - A. J. Weinhold, MD Date

BOARD QUALITY COMMITTEE RECOMMENDATION:

BOARD QUALITY COMMITTEE RECOMMENDATION TO BOD: Upon review, the appropriate documents have been submitted, reviewed and substantiated. Based on recommendation of the Medical Executive Committee and evaluation of the education, training, experience, demonstrated professional competence and judgment, and clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), BQC:

☐ Concurs ☐ Does NOT concur with the Medical Executive Committee's recommendation.
☐ Back to Medical Staff for to clarify the following:

_____

_____

Board Quality Committee (Signature)
Date

GOVERNING BOARD:

☐ **GRANTS** ☐ **DOES NOT GRANT** _____ **PRIVILEGES**

_____ _____

Board President Date

MAYERS MEMORIAL HOSPITAL DISTRICT

ENDORSEMENTS

(Applicant & Title), has applied for reappointment to Allied Health Professional status and has been granted approval of his Delineation of Clinical Privileges as (**Privileges**). Appropriate documents have been submitted, reviewed and substantiated.

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS

☐ Reappointment recommended based on evaluation of this practitioner's education, training, experience, demonstrated professional competence and judgment and clinical performance, as confirmed by peers knowledgeable of the applicant's professional performance.

☐ Reappointment **not** recommended based on: _____

_____

_____

☐ No Change in Staff Category

☐ Change in Staff Category from _____ to _____
based on _____

_____

_____

_____ _____

Chief of Staff - A. J. Weinhold, MD Date

BOARD QUALITY COMMITTEE RECOMMENDATION:

BOARD QUALITY COMMITTEE RECOMMENDATION TO BOD: Upon review, the appropriate documents have been submitted, reviewed and substantiated. Based on recommendation of the Medical Executive Committee and evaluation of the education, training, experience, demonstrated professional competence and judgment, and clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), BQC:

☐ Concurs ☐ Does NOT concur with the Medical Executive Committee's recommendation.
☐ Back to Medical Staff for to clarify the following:

_____

_____

_____

Board Quality Committee (Signature) Date

GOVERNING BOARD

☐ **GRANTS** ☐ **DOES NOT GRANT** _____ **PRIVILEGES**

_____ _____

Board President Date

MAYERS MEMORIAL HOSPITAL DISTRICT

ENDORSEMENTS

(Applicant & Title), has applied for Allied Health Professional Status as a **(Privileges)**. Appropriate documents have been submitted, reviewed, and substantiated.

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS:

☐ Appointment recommended based on review of his/her individual character, professional performance, experience, judgment and clinical and/or technical skills, as well as his/her additional training, i.e., Continuing Medical Education (CME) courses.

☐ Appointment **not** recommended based on: _____

_____

_____

_____

_____

_____ _____

Chief of Staff Date

BOARD QUALITY COMMITTEE RECOMMENDATION:

BOARD QUALITY COMMITTEE RECOMMENDATION TO BOD: Upon review, the appropriate documents have been submitted, reviewed and substantiated. Based on recommendation of the Medical Executive Committee and evaluation of the education, training, experience, demonstrated professional competence and judgment, and clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), BQC:

☐ Concurs ☐ Does NOT concur with the Medical Executive Committee's recommendation.
☐ Back to Medical Staff for to clarify the following:

_____

_____

_____

Board Quality Committee (Signature) Date

GOVERNING BOARD:

☐ **GRANTS** ☐ **DOES NOT GRANT** _____ **PRIVILEGES**

_____ _____

Board President Date

MAYERS MEMORIAL HOSPITAL DISTRICT

ENDORSEMENTS

(Name & Title), has applied additional privileges to include **(Privilege)**. Appropriate documents have been submitted, reviewed and substantiated.

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS:

☐ Privileges recommended based on review of his/her individual character, professional performance, experience, judgment and clinical and/or technical skills.

☐ Privileges **not** recommended based on: _____

_____

_____

_____

_____

_____ _____

Chief of Staff Date

BOARD QUALITY COMMITTEE RECOMMENDATION:

BOARD QUALITY COMMITTEE RECOMMENDATION TO BOD: Upon review, the appropriate documents have been submitted, reviewed and substantiated. Based on recommendation of the Medical Executive Committee and evaluation of the education, training, experience, demonstrated professional competence and judgment, and clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), BQC:

☐ Concurs ☐ Does NOT concur with the Medical Executive Committee's recommendation.
☐ Back to Medical Staff for to clarify the following:

_____

Board Quality Committee (Signature) Date

GOVERNING BOARD:

☐ **GRANTS** ☐ **DOES NOT GRANT** _____ **PRIVILEGES**

_____ _____

Board President Date

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

MEDICATION ERRORS

POLICY:

All errors identified will be documented through the Medical Staff Medication Error Reduction Task Force. All significant medication error reports will be reviewed by the Medicine/Pharmacy and Therapeutics Committee (P&T). The Performance Improvement Department will review medication error data as part of the Hospital's improvement process. All documentation in regards to medication errors is protected from discovery.

DEFINITIONS:

1. Significant medication errors are those which require medical intervention and/or result in possible or confirmed morbidity or mortality.
    - **Level 0**--No error occurred, potential error
    - **Level 1**--Error occurred without harm to patient
    - **Level 2**--Error occurred, increase monitoring but no change in vital signs or any patient harm
    - **Level 3**--Error resulted in need for increased monitoring, there was change in vital signs but no ultimate patient harm; any error needing increased laboratory monitoring
    - **Level 4**--Error resulted in need for treatment with another drug, increased length of stay, patient transfer to a higher level of care (i.e. another facility or addition of telemetry), or required intervention to prevent permanent impairment or damage
    - **Level 5**-- Error resulted in permanent patient harm
    - **Level 6**--Error resulted in patient death

2. Types of medication errors include:
    - Wrong: drug, dose, route, or time
    - Omission (not administered before next schedule dose due)
    - Unordered dose

PROCEDURE:

1. When a medication error occurs the following should occur in this order:
    - Notify the physician and evaluate the patient.
    - Record the medication as given in the medical record.
    - Report the error in detail with a Quality Review Report (QRR).

2. The practitioner who identifies an error will document all relevant particulars on the Quality Review Report form. The practitioner who identifies an error will also complete the Medication Error Analysis Tool.

3. The Performance Improvement department (in cooperation with the Director of Pharmacy and the Directors of Nursing) will complete medication error reports and categorize them according to severity, type, cause and drug class involved (using attached analysis tool or other tool as deemed appropriate.)

4. All medication error reports evaluated as significant (Level 4 or above) will be referred the Medicine/Pharmacy and Therapeutics Committee.

5. Summary data and trend analysis from information on QRR reports will be performed by Program Beta and the results forwarded to the Performance Improvement Department.

6. Summary data and trend analysis from the Medication Error Analysis Tool will be performed by the Performance Improvement Department and the results forwarded to the Medication Error Task Force.

MEDICATION ERROR ANALYSIS TOOL

Date/Time of Error: _____ Med Record #: _____ Drug/Name: _____

Doses Involved: _____ Patient Name: _____ Room #: _____

Summary of Occurrence: _____

_____

The Medication Error Level: (Please circle the level that applies to this error.)

Level 0: No error occurred, potential error.	Level 1: Error occurred without harm to patient.
Level 2: Error occurred, increased monitoring but no change in vital signs or any patient harm.	Level 3: Error resulted in need for increased monitoring, there was change in vital signs but no ultimate patient harm; any error needing increases laboratory monitoring.
Level 4: Error resulted in need for treatment with another drug, increased length of stay, patient transfer to a higher level of care (e.g., ICU), or required intervention to prevent permanent impairment of damage.	Level 5: Error resulted in permanent patient harm. Level 6: Error resulted in patient death.

Error Type: (check all that apply)

- ❑ wrong drug ❑ or solution
- ❑ unordered drug
- ❑ wrong dose ❑ or rate
- ❑ omission
- ❑ wrong dosage form
- ❑ expired drug
- ❑ wrong route
- ❑ wrong patient
- ❑ incompatible infusions administered
- ❑ wrong administration time
- ❑ prescribing error
- ❑ other _____

Factors Contributing to Error: (check all that apply)

- ❑ verbal order
- ❑ illegible order
- ❑ continued after order to discontinue
- ❑ monitoring guidelines not followed
- ❑ midnight check done incorrectly
- ❑ medication delivery delay
- ❑ telephone order
- ❑ routine medications not in cassette
- ❑ ambiguous written order
- ❑ MAR printed incorrectly
- ❑ dispensed incorrectly by Pharmacy
- ❑ drug selected from floor stock
- ❑ pump malfunction (specify pump type) _____
- ❑ pump misprogrammed (specify pump type) _____
- ❑ RN verified incorrect transcription
- ❑ drug or solution mislabeled by Pharmacy
- ❑ misread MAR
- ❑ new bag not reordered until present bag very low or empty
- ❑ medications unavailable from Pharmacy
- ❑ IVPB hung ahead of time
- ❑ Other _____

Personnel involved: (check all that apply)

- ❑ RN ❑ LVN ❑ PT ❑ Unit Secretary
- ❑ Pharmacist ❑ Per Diem ❑ Registry ❑ MD ❑ Other _____

Problem Resolution/Outcome (use back of form if more room needed):

_____

Signature: _____ Date: _____

(5/00, kle, RX Computer)

Protected from Discovery

MEDICATION ERROR ANALYSIS TOOL

Use in conjunction with QRR

Date/Time of Error: _____ Med Record #: _____ Drug/Name: _____

Summary of Occurrence: _____

_____

The Medication Error Level: (Please circle the level that applies to this error.)

Level 0: No error occurred, potential error.	Level 1: Error occurred without harm to patient.
Level 2: Error occurred, increased monitoring but no change in vital signs or any patient harm.	Level 3: Error resulted in need for increased monitoring, there was change in vital signs but no ultimate patient harm; any error needing increases laboratory monitoring.
Level 4: Error resulted in need for treatment with another drug, increased length of stay, patient transfer to a higher level of care (e.g., ICU), or required intervention to prevent permanent impairment of damage.	Level 5: Error resulted in permanent patient harm. Level 6: Error resulted in patient death.

Error Type: (check all that apply)

- ❑ wrong drug ❑ or solution
- ❑ unordered drug
- ❑ wrong dose ❑ or rate
- ❑ omission
- ❑ wrong dosage form
- ❑ expired drug
- ❑ wrong route
- ❑ wrong patient
- ❑ incompatible infusions administered
- ❑ wrong administration time
- ❑ prescribing error
- ❑ other _____

Factors Contributing to Error: (check all that apply)

- ❑ verbal order
- ❑ illegible order
- ❑ continued after order to discontinue
- ❑ monitoring guidelines not followed
- ❑ midnight check done incorrectly
- ❑ medication delivery delay
- ❑ telephone order
- ❑ routine medications not in cassette
- ❑ ambiguous written order
- ❑ MAR printed incorrectly
- ❑ dispensed incorrectly by Pharmacy
- ❑ drug selected from floor stock
- ❑ pump malfunction (specify pump type) _____
- ❑ pump misprogrammed (specify pump type) _____
- ❑ RN verified incorrect transcription
- ❑ drug or solution mislabeled by Pharmacy
- ❑ misread MAR
- ❑ new bag not reordered until present bag very low or empty
- ❑ medications unavailable from Pharmacy
- ❑ IVPB hung ahead of time
- ❑ Other _____

Personnel involved: (check all that apply)

- ❑ RN ❑ LVN ❑ PT ❑ Unit Secretary ❑ Pharmacist
- ❑ Per Diem ❑ Registry ❑ MD ❑ Other _____

This error occurred because:

- ☐ Didn't know what to do/ or how to do it
- ☐ Didn't have the resources
- ☐ Forgot what to do
- ☐ The expectation is unreasonable
- ☐ Didn't realize the specific tasks involved
- ☐ Other

This error could have been prevented by _____

_____

Signature: _____ Date: _____

PROTECTED FROM DISCOVERY

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

MINIMAL PATIENT LIFT POLICY

DEFINITION:

For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in Mayers Memorial Hospital District facilities, including inpatients, outpatients, residents and clients.

POLICY:

Mayers Memorial Hospital District requires the use of lifts and other appliances and strategies to minimize the manual lifting of patients and residents. Approved patient handling aids will be used to prevent or minimize the physical exertion required to assist patients in positioning except when absolutely necessary, such as in a medical emergency.
It is the responsibility of each employee to avoid hazardous patient handling and movement tasks and to take reasonable care of their own health and safety. Each employee shall be expected to use mechanical lifts and/or patient assistive devices at appropriate times even though the risk assessment guide and/or other assessment tools used may not indicate that assistance is required.

Facility preference is: 2 staff members are present while lift equipment is being used for resident and employee safety. This procedure allows for:

- 1 staff member on duty operating the equipment
- 1 staff member on duty focusing on the resident

ACUTE, OUT PATIENT, X-RAY, ER, SURGERY, PHYSICAL THERAPY:

Shall adhere to the policy statement and may develop distinct department policies in support of the no lift policy.

PROCEDURE FOR FACILITY:

1. Each patient is assessed upon admission and upon any significant change in condition for needs related to movement in bed, transfers out of bed and ambulation needs.
2. The assessment is identified in the patient room by means of a **"LEVEL OF CARE COLOR CODE SYSTEM"**. This form can be located at the head of the patient's bed or on the bedside bulletin board.
3. Transfer and assistance code for the patient is found in the **"GREEN GLOW" DOT** and "Independent" patients have no colored dot on the Level of Care card.
   The codes are as follows:
   - **Ind = independent**
   - **1 = 1 person may assist in positioning**

- **M = mechanical assistance required. (This code replaces the 2 person assist)**
  (V= VERA LIFT, VAN= VANDER LIFT, M= MAXI LIFT)

4. EXPLANATION OF EQUIPMENT:
   a. **V= VERA LIFT**-Is a stand assist lift with a scale. This lift is used with residents that are able to assist, to some degree, with standing.
   b. **VAN= VANDER LIFT**- is a full body lift w/ a scale. This lift is used on residents that cannot stand. This lift can also be used to get residents off of the floor.
   c. **M= MAXI LIFT**- is a full body lift without a scale. This lift is used on residents that cannot stand. This lift can also be used to get residents off of the floor.
5. The **GREEN GLOW STICKER (DOT)** = "Turn Sheet" uses the same codes for assistance but does allow an additional code of "2" indicating a 2 person assist for turning is required.
6. **AMBULATION:**
   1. The ARJO walker shall be used in cases involving restorative activities where there is fall risk. Patients undergoing gait training that is a transition from the ARJO to independent use of a cane or walker shall have a gait belt used during restorative training.
7. All staff is charged with the responsibility to educate and motivate patients in safe practices related to positioning, transfers, and ambulation.
8. When problems arise regarding patient cooperation or changing abilities, immediate communication with the charge nurse is appropriate.
9. If, after following attempts to resolve a problem, resolution is not achieved, it is appropriate to document your concerns on the safety/security report form and to process accordingly.
   2. The ARJO platform walker replaces the 2-person ambulation with a gait belt. It may be necessary, for a patient who has transitioned away from the ARJO walker to return to the ARJO walker to build strength and coordination.

REFERENCES:

1. California Hospital Association (CHA) *Color Coded Patient Identification Wristband Standardization*, 07/18/07.
2. Manuals and/or CDs associated with each lift located at the nurse's station.

MAYERS MEMORIAL HOSPITAL DISTRICT
POLICY AND PROCEDURE

PARENTERAL PRODUCTS—QUALITY ASSURANCE

POLICY:

To maintain quality of compounded parenteral solutions the following data is collected and monitored. (CCR 8, 1751(d), 1751.7, 1751.8, 1735.8)

PROCEDURE:

Barrier Isolator Cleaning

- See Policy and Procedure: **Barrier Isolator—Sanitizing and Cleaning**
- The barrier isolator is cleaned daily prior to admixing any solution.
- The barrier isolator is sanitized weekly.
- If the pharmacy is closed the barrier isolator is not cleaned
- The barrier isolator cleaning log is initialed upon completion of the cleaning
- Records of glove box isolator cleaning are maintained for 3 years
- Monitoring
    - Swabs—performed twice a year.
        - To monitor cleaning of the barrier isolator, a swab is taken of a sleeve and the work surface.
        - The swabs are sent to the laboratory where they are plated and observed for bacterial contamination.
    - Glove Tip Testing. See Policy and Procedure: **Barrier Isolator—Glove Tip Touch Test**

Barrier isolator Inspection

- A qualified technician will certify the laminar airflow barrier isolator twice a year in accordance with Federal Standard 209(b).
    - This certification includes dynamic particle level testing.
    - Viable particles (viable air samples for bacterial and fungal) are included in the certification. If testing for viable particle testing is not performed in concert with the certification, a settle plate will be used to assess presence of viable particles. The settle plate test will be performed twice yearly after the certification.
    - Certification records will be maintained for 3 years.

Refrigerator

- Refrigerator temperatures are monitored electronically. An audible alarm sounds if the temperature is out of range. A text message is sent to the pharmacist and nurse supervisor if the refrigerator temperature is out of range.
- Refrigerators on nursing units where parenteral products are stored have temperatures monitored electronically.
- Records of temperatures will be maintained for 3 years.

End Product Testing

- Performed at least twice a year. If there is no returned product to test an additional technique testing may be performed.
- See Policy and Procedure: **End Product Testing**

Qualitative and Quantitative Analysis

- Qualitative and quantitative analysis is performed at least twice a year.
- A product is compounded via standard procedure and shipped overnight to the analytic laboratory (e.g., Analytical Research Laboratory).
- Care should be taken to keep the product at the correct storage temperature during shipping.

Training

- Staff who prepares parenteral products will complete a self directed training session each calendar year.
- Routinely this in-service will consist of video and packet entitled "Qualify Assurance for Pharmacy-Prepared Sterile Products" produced by the American Society of Health System Pharmacists.

Pharmacist/Technician Competency Assessment

- Only individuals who prepare parenteral products will perform competency assessment
- Each calendar year compounding technique will be assessed by using a VALITEQ® kit or other similar system for medium risk compounding.
- The manufacturers' direction will be followed.
- The samples are incubated and observed in the laboratory. An electronic printout is provided by the laboratory at the end of the monitoring period.
- If the test product indicates contamination, the individual will be retrained via video in-services or a supervised training visit at another facility and retested.
- Records are maintained for 3 years.

Non-Sterile Chemicals

- Parenteral compounding with non-sterile chemicals is not performed in this facility.

Drug Recall

- See Policy and Procedure: **Medication Recalls**

Expiration Dates

- See **Admixture Expiration Dates**

References:

- CCR 8, 1751(d), 1751.7, 1751.8, 1735.8
- CETA Certification Application Guide USP <797> Viable Environmental Sampling & Gowning Evaluation CAG-009-00 Effective January 31, 2012
- Pharmacy Services / Analytical Research Laboratories http://arlok.com/compounded_services.asp accessed 10/2015

APPROVALS:
QI:

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

POST FALL ASSESSMENT AND DOCUMENTATION

Page 1 of 2, plus the following attachment(s)
Post Fall Huddle Packet MMH559
Fall Risk Assessment Form MMH186
Care Plan – Fall with Injury MMH130P
Neuro Check Sheet MMH154
Skin Evaluation and Assessment Sheet MMH128

DEFINITION:

For all intent and purposes, the word patient refers to all customers receiving health care services in our facility's, including inpatients, outpatients, residents and clients.

Fall: An unintentional change in position coming to rest on the ground, floor or onto the next lower surface (eg., onto a bed, chair, or bedside mat.)

Fall With Significant Injury: An unintentional change in position comi9ng to rest on the ground, floor or onto the next lower surface that results in an injury or evidence of a fracture that requires the patient to be transferred to a hospital.

POLICY:

To provide information necessary in the assessment of residents after a fall episode and to facilitate fall prevention. Nursing staff takes appropriate actions to reduce the risk of patient harm due to falls.

PROCEDURE:

1. At the time of the initial assessment, the LVN on duty will:
    a. Complete a full body assessment including vitals, pain scale, neurological assessment, oxygen saturation, and any signs or symptoms of injury including a complete skin assessment and severity
        - Documentation in the nurses notes is to be completed each shift for 72 hours and includes vital signs, neuro checks, pain assessment (using the pain scale) and any new evidence of signs or symptoms of injury. NOTE: Neuro checks are required on patients that have had an unwitnessed fall or a head injury (per P&P Neurologic Checks).
    b. If an injury occurs initiate care plan Fall With Injury form MMH130P.
    c. Notify the resident's doctor, responsible party and the CNO.
    d. Notify Ombudsman, and DHS immediately or as soon as possible, but within 24 hrs for falls with a significant injury.
    e. Complete the Post Fall Assessment form MMH147.
    f. Update the Fall Risk Assessment form MMH186 in the chart, filed in the fall section.

g. Complete the Quality Review Report (QRR) and submit to the Charge Nurse with a copy of the Post Fall Assessment MMH147. (QRR's are trended monthly and reported to the Quality Care Team committee by the CNO.)
h. Direct a Post Fall Huddle including all available multi-disciplinary team members available, such as nursing staff and CNA's as soon as possible, but within 24 hours of the fall to determine
    - what happened
    - how the fall occurred
    - why the fall happened e.g.; medical condition, medications, other factors
    - where appropriate interventions in place prior to the fall
    - how can similar outcomes be avoided
    - what care plan interventions will be implemented or discontinued
    - what specific considerations as to why the fall might have occurred
    - was the call light on, and for how long
    - staffing at the time of the fall
    - environmental factors, if any
    - other resident or visitor involvement
i. Notify the Resident Assessment Coordinator (RAC) by leaving a message by phone and placing a copy of the Post Fall Assessment MMH147 and Post Fall Huddle Packet MMH559 packet in the RAC's box.
j. Fax a copy of the Post Fall Huddle Packet MMH559 to the Physical Therapy department.

2. RN Supervisor for Skilled Nursing reviews all fall documentation, nursing notes, skin assessment, and care plans for effectiveness of the interventions and attend the IDT meeting
3. All falls will be discussed in the next Inter-Disciplinary Team Meeting (IDT)
4. The Post Fall Assessment Form MMH186and Post Fall Huddle Packet MMH559 will be placed in the Physicians Progress Note section and remain there for 30 days and then moved to the Fall Assessment section of the medical medical record

SPECIAL CONSIDERATIONS:

Staff education: The Director of Staff Development, or designee, will conduct incidental in-service when Fall With Injury Occurs and as needed for staff review of policy and procedure and Fall Prevention strategies.

REFERENCES:

F-Tag 324 Sec483.25(h)(2) Accidents: Supervision and assistance provided for prevention.

APPROVALS:
QI:

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Patient Name _____ **Date** _____ **Time** _____**of Huddle**

Directions: This form can be used for all falls. This analysis should be done as soon as possible after the fall, but less than 24 hr. This review should include staff involved in the resident fall and the staff who found the fall and is facilitated by the nurse caring for the resident at the time of the fall. This report is not intended to place blame or serve for disciplinary action.

Section 1 - Information About the Patient Fall

Date of Fall:	Time of Fall:	Unit where fall occurred:	Location of fall:
Describe Event: Include patient activity and symptoms at time of fall and just prior to fall.			
How was the patient evaluated/treated for injury?	Describe the actual or suspected patient injury(s):		
Nuero Checks:	Did the patient hit their head? ☐ Yes ☐ No		
Glascow Coma Scale: _____	Was the fall witnessed? ☐ Yes ☐ No		
What footwear was the patient wearing? ☐ Shoes ☐ Slippers ☐ Other: _____			
Was the call light on at the time of the fall? ☐ Yes ☐ No			
What was the staffing at the time of the fall? ___ RN's ___ LVN's ___ CNA's ___ RNA's ___ Other (enter the number of each)			
What other residents or visitors were involved in the fall? _____			

Section 2 - What Was the Fall Risk Assessment for This Patient Prior to the Fall?

What was the patient's fall risk score and level of risk prior to this fall?	Score: ☐ High Risk ☐ Standard Risk ☐ Other_____		
What was the date/time of the patient's last fall risk assessment?	Date_____ Time_____ ☐ NA		
Was fall risk assessment documented on admission to unit?	☐ Yes	☐ No	☐ N/A
Q24h since admission?	☐ Yes	☐ No	☐ N/A
Each change in level of care?	☐ Yes	☐ No	☐ N/A
Has the patient had a fall in the past 3 months?	☐ Yes	☐ No	☐ N/A
Was the patient alone at the time of the fall?	☐ Yes	☐ No	☐ N/A
What was the date of the patient's last PT evaluation?	_____ Date		☐ N/A

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Section 3 - What actions were taken to prevent this patient fall?

Was the patient identified as a fall risk by bracelet, sign on door & sticker on chart? ☐ Yes ☐ No
If NO, explain:

Was the fall related to:
- ☐ Diagnosis (hypoglemcia, Seizure, Hypotension, Parkinson, Dementia)
- ☐ Physical Condition (poor balance, weakness)
- ☐ Impaired Communication
- ☐ Environmental Factors
- ☐ Altered metal status
- ☐ Medications
- ☐ Pain or Discomfort
- ☐ Loss of Balance
- ☐ Age > 85

Is there plan of care documentation, if the patient is high risk for fall? ☐ Yes ☐ No ☐ N/A

List medications administered to patient in last 8 hrs that may have contributed to the fall?
- ☐ None
- ☐ Opiates
- ☐ Anticonvulsants
- ☐ Antihypertensive s
- ☐ Antiarrhythemias
- ☐ Diuretics
- ☐ Hypnotics
- ☐ Sedatives
- ☐ Laxatives
- ☐ Antiphychotics
- ☐ Benzos
- ☐ Antihistamines
- ☐ Antiparkinsonians
- ☐ Alzheimer Drugs
- ☐ Antidepressents

Is patient on anticoagulation therapy e.g., Warfarin, Rivaroxaban, Dabigatran ☐ Yes ☐ No

If yes, what is most recent anticoagulation lab value and Hb/HCT?

Preventative measures in place prior to the fall?

☐ Low Bed ☐ Chair Pad ☐ Bed Pad ☐ 1:1 ☐ Floor Pad/Alarm ☐ Tab Alarm ☐ Other:

What was implemented to prevent patient from falling again?

Staff involved in Post Fall Huddle:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Who was included in the post fall huddle?

- ☐ Patient
- ☐ Primary Nurse
- ☐ Physical Therapy
- ☐ Family Caregiver
- ☐ C.N.A.
- ☐ Pharmacist
- ☐ PT Assistant
- ☐ Charge Nurse
- ☐ Quality Improvement
- ☐ Dr. _____

Other: _____

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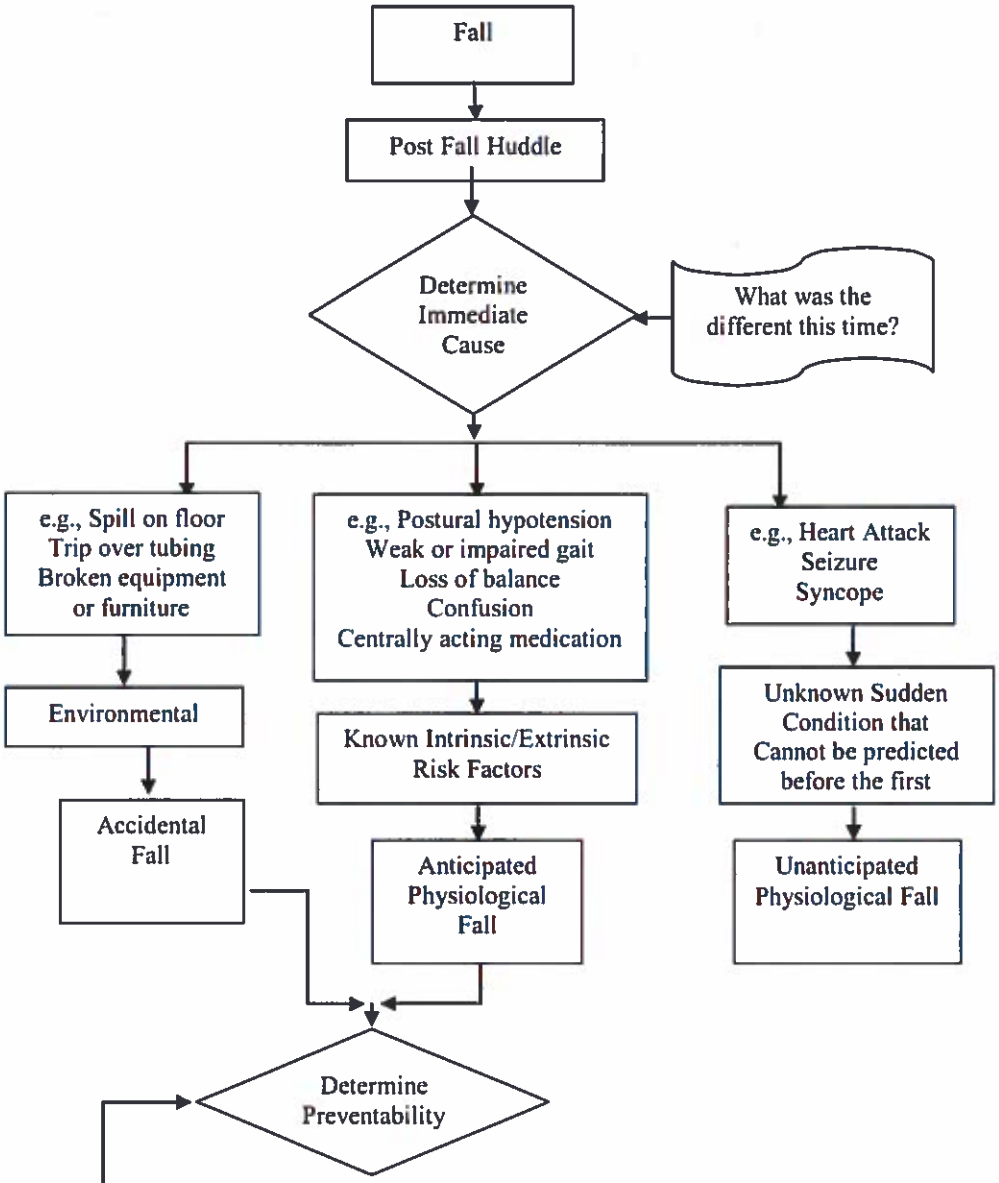
Decision Tree for Types of Falls



To be completed by IDT/Quality Care Team

3. What type of error(s) occurred? Check all that apply

- ☐ Were there judgement errors? (e.g. decisions has to be made about uncertain processes)
- ☐ Were there task error? (e.g. planned interventions were not in place as intended)
- ☐ Were there care corrdination errors?
- ☐ Were there system interaction errors?
- ☐ Explain: _____

MAYERS MEMORIAL HOSPITAL DISTRICT

IDT Post Fall Discussion

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY & PROCEDURE

QUALITY REVIEW REPORT

DEFINITION:
For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, out patients, residents and clients

Incident/Occurrence: Any unanticipated event that deviates from regular hospital operations or occurring to patients, residents or visitors. Injury may or may not result. This form will also be used in the event of suspected or actual abuse to patients or residents so incident will be documented and follow up investigation report can be entered. (A State Elder Abuse Form must also be filed).

POLICY:
The primary purpose of the Quality Review Report is to provide a mechanism for communicating incidents potentially affecting quality of care, to the medical staff committee responsible for quality of care and safety. The information from the Quality Review Report will be sent to the QA/RM/UR/Medical Record Committee, through the Performance Improvement Director and will assist in identifying patterns or trends and/or significant quality of care issues. Further, the Quality Review Report will provide a means of focusing on performance improvement and risk management activities.

PROCEDURE:
When an incident or unusual event occurs, a Quality Review Report should be completed in a timely manner by a hospital employee or medical staff member who was directly involved or discovered the incident. *Failure to report an incident may be grounds for disciplinary action.* The report should be factual and objective, avoiding inappropriate comments that point blame or attempt to establish negligence. The name of the person initiating the report shall remain confidential.

The form shall be completed as follows:

1. Access the Quality Review Report from your Department.
2. Print or write legibly in black ballpoint pen, pushing firmly.
3. Complete all required information in the designated spaces, including front and back of first page.
4. Stamp addressograph in upper right hand corner (if applicable).
5. Enter Mayers in the boxes labeled "hospital code".

6. Enter date and time of occurrence, using military time.

7. Note status and shift when event occurred.
8. Enter department code after referring to the list on the back of the form.
9. Complete location code (if you know it).
10. Leave diagnosis code blank.
11. Enter **medical** diagnosis.
12. Complete patient/family information.
13. Select one category from the 17 major categories listed under Occurrence Information Section.
14. Select as many boxes as allowed under any one of the 17 categories. **With the exception of visitor falls, all selections must be completed. The name of the drug must be documented under Section 5 (medications).**
15. Complete the "severity of outcome" sections. **You may choose up to two selections**.
16. By using one or two sentences, briefly describe the incident.
17. Anyone witnessing the incident should be listed by full name and title.
18. Document under "Event Discipline" section on Page 3.
19. Sign and date report.
20. **The Reportable Incident Page should be completed by the Risk Managers, as needed, and in the Risk Manager's Analysis Section.**
21. The individual who initiated the Quality Review Report should complete the form by the end of the shift and should forward the report to the supervisor/manager for the department involved for appropriate follow-up activities.
22. The supervisor/manager, after conducting an initial assessment, will use the back of the front page to document any actions, conclusions and/or recommendations and will forward the report to the Performance Improvement Department within 24-hours of receipt.
23. The Performance Improvement Director will review the report. After reviewed, he/she will send the report to Administration who in turn will submit the report to **Program Beta** for tracking.
24. The Performance Improvement Department personnel will oversee the trending processes and will facilitate the flow of information to and from the QA/RM/UR/Medical Record Committee (the Committee who is responsible for assuring the quality of care and safety to our facility).

SPECIAL CONSIDERATIONS:

Sentinel (an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof, i.e. loss of limb, significant drug reaction, significant medication error, suicide, infant abduction, surgery on the wrong patient or body part, etc.) and other significant events must be **REPORTED IMMEDIATELY**, by phone or in person, to the Performance Improvement Director (or designee).

The Quality Review Report form should **NOT** be used in lieu of a workers' compensation claim form to report an employee injury.

If used in conjunction with a child, domestic or elder abuse case, those particular forms must also be completed and reporting per legal time lines to respective agencies.

To maintain confidentiality, Quality Review Report should not:

1. Be completed by or shared with a patient or visitor
2. Filed or made reference to in the Medical Record
3. Filed or made reference to in an employee's personnel record
4. Openly displayed, e.g., left out or on a Nursing Unit desk
5. Removed from the premises
6. Copied or duplicated in any way.

Mayers Memorial Hospital District

Quality Improvement and Patient Safety Plan

INTRODUCTION

The United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) and the California Department of Public Health (CDPH) require that each Critical Access Hospital (CAH) have a Quality Improvement and Patient Safety Plan (QIPSP) which meets the specified standards outlined in the CMS Conditions of Participation and in California Senate Bill 158 (Florez), Health and Safety Code §1279.6. These standards have been developed in an effort to increase safety, efficiency, and effectiveness across the healthcare industry. In complete agreement with these goals, Mayers Memorial Hospital District (MMHD) strives to meet and exceed the standards set forth by CMS and CDPH as we provide patient care in accordance with:

Our missions statement-

Mayers Memorial Hospital District serves the Intermountain area providing outstanding patient centered
healthcare to improve quality of life through dedicated, compassionate staff and
innovative technology.

Adopted by the Board of Directors 1/25/12

Our vision statement-

The vision of Mayers Memorial Hospital District is to become the provider of first choice for our community by being a leader in rural healthcare.

Adopted by the Board of Directors 1/25/12

Our organizational values-

Teamwork ~ Leadership ~ Commitment ~ Quality ~ Responsibility ~ Safety
Adopted by the Board of Directors 1/25/12

Adopted by the Board of Directors 1/25/12

In addition to meeting the CMS and CDPH standards and requirements, the plan is also designed to meet the standards of other agencies and programs, such as:

- Beta Healthcare Group Patient Safety Initiatives
- Hospital Council of California Patient Safety First Program
- The Joint Commission Critical Access Hospital National Patient Safety Goals

PURPOSE

The purpose of this plan is to provide a mechanism for continuous improvement in organizational performance, patient outcomes, and processes and systems. Assessment of performance is carried out in order to determine the appropriateness of services and the efficacy of treatment in accomplishing the desired outcome. Services are also assessed for availability, timeliness, effectiveness, continuity, safety, efficiency, and patient satisfaction associated with their delivery. Educational programs are developed to focus on topics as deemed appropriate by the findings of the QIPSP activities. Mayers Memorial Hospital District is dedicated to striving for excellence in healthcare for the members of the Intermountain community. As such, the organization as a whole participates in quality improvement and patient safety efforts which are a part of everyday activities for all staff, eliciting interdisciplinary cooperation.

OBJECTIVES

1. Demonstrate a consistent endeavor to provide patient and resident care and interventions in an efficacious, appropriate, and timely manner that is coordinated, effective, safe, respectful and caring.
2. Create a high performance culture that reflects Mayers Memorial Hospital District's commitment to quality care, service and patient satisfaction.
3. Coordinate and integrate quality improvement and patient safety activities throughout the organization and provide for collaboration of all departments.
4. Effectively reduce factors that contribute to unanticipated adverse events and/or unusual occurrences.
5. Identify root causes of events or processes that produce less than desirable quality outcomes and/or are not within "best practice" procedures through quality improvement monitoring and evaluation activities.
6. Provide for communication of quality improvement activities between all departments, administration, medical staff and the Board of Directors.

7. Identify educational needs of the staff.

PROGRAM COMPONENTS

The Quality Improvement and Patient Safety program consists of several individual plans in addition to the QIPSP. The program incorporates those individual plans into overall QIPSP activities. Those individual plans include:

- MMHD Safety Plan
- Medication Error Reduction Plan
- Infection Control Plan
- Disaster Management/Emergency Operations Plan
- Corporate Compliance Plan

AUTHORITYAND STRUCTURE

The Mayers Memorial Hospital District Board of Directors is ultimately responsible for assuring that high quality care is provided to all patients. The Board delegates the authority to the Medical Staff and Chief Executive Officer (CEO) to establish a Quality Improvement and Patient Safety Plan that will address system wide issues. The Medical Staff and CEO delegate the authority and day-to-day supervision of the plan to the Chief Nursing Officer - Acute Nursing Division/Risk Manager (CNO-A). The CNO-A has established the Quality Improvement and Patient Safety program to develop} implement} coordinate and monitor all components of the QIPSP within the MMHD system and its provider network.

ACCOUNTABILITY AND RESPONSIBILITIES

1) Board of Directors

The Board of Directors is responsible for assessing the delivery of quality patient care hospital-wide throughout the District. Assessment of quality} implementation of quality improvement measures} and risk management activities as outlined in this QIPSP are reviewed and approved by the Board on an annual basis. On-going Board oversight is provided through the Board Quality Committee.

Board Quality Committee

a) Composition

1. The committee shall consist of two directors from the Board} the CEO} one medical staff member} and management related to quality risk management patient satisfaction and patient complaints.

2. Role/Function

   The committee shall assist in determining the need for policies and procedures that result in the achievement} through continuous quality improvement} of the maximum benefit to patients in the District in a customer-oriented and cost efficient manner.

   In fulfilling its charge the quality committee is responsible for the following activities and functions:

   (1) Recommend policies and procedures that enable the medical staff to process medical staff applications and reappointments and that expedite the Board's decisions with respect to granting clinical privileges.

   (2) Monitor the performance of the medical staff in carrying out its responsibilities for evaluating and improving patient care.

      (a) Peer review (medical staff) lab, etc.)

      (b) Quality indicators as a measure of quality of care patients receive in hospital

3. Monitor the performance of all District programs in developing and implementing quality improvement responsibilities and review to assure that the organization remains} nationally} regionally and locally recognized for its quality of care.

4. Review periodic trend reports quarterly that reflect the overall performance of the District in quality.

5. Ensure that quality services and their quantification is a District-wide expectation.

6. Ensure that all operating programs develop a specific plan for implementing the concept of continuous quality improvement through individual and team initiative. This includes implementation} ongoing evaluation and oversight processes within the appropriate medical/administrative/governance structures.

b) Meeting Schedule

   This committee shall meet at least ten times per year.

2) Medical Executive Committee

a) Role/Function

   The Medical Executive Committee (MEC) shall be responsible for implementing and maintaining an effective system to monitor and evaluate the quality and appropriateness of care through ongoing monitoring functions. The MEC delegates ongoing monitoring functions to its Quality Improvement Committee (QIC). The MEC

receives regular reports on QIC activities at MEC meetings from the QIC Chairperson who is a member ofthe medical staff. The MEC is responsible for reviewing all QIC information and making appropriate procedural changes as needed. Results of quality improvement activities and reports that involve medical staff are used by MEC in any considerations for medical staff membership and/or clinical privileges. The MEC shall report its quality related activities to the Board of Directors.

b) Meeting Schedule

The MEC meets no fewer than six times per year.

3) Administration

a) Role

The Administration supports the maintenance of the QIPSP and provides adequate financial and staff support for the activities of the QIPS program. The CEO, in conjunction with Medical Staff, is responsible to the Board of Directors for ensuring quality review, quality improvement and risk management activities of the District promote patient safety and enhance patient satisfaction.

b) Functions

1. Provides support for active medical staff involvement in the risk identification in all areas of patient care and safety and in monitoring and evaluation of activities.
2. Ensures a means of reducing risk and correcting patient care and safety problems.
3. Ensures a means for collecting, interpreting, and reporting relevant data regarding patient satisfaction.
4. Ensures monitoring and evaluation of the quality and appropriateness of patient care in nursing and clinical support services, with modification of practices and procedures in these areas of responsibility as necessary.
5. Communicates problems related to the clinical aspects of patient care and patient safety, which are identified through risk management activities to the QIC via the CNO-A/Risk Manager.
6. Reports potential and current liability claims and litigation to the Board of Directors via the CEO or CNO-A/Risk Manager.

4) CNO-A/Risk Manager

a) Role

The CNO-A is responsible for coordinating all activities related to the design, implementation and evaluation of the Quality Improvement and Patient Safety (QIPS) program and monitoring the quality and appropriateness of care provided to patients. The CNO-A reports directly to the CEO.

b) Functions

1. Collects, analyzes and reports data obtained through all quality assessment mechanisms and risk management activities to the QIC.

2. Integrates information from all quality assessment activities to facilitate the identification of trends, patterns of performance, or potential problems that affect one or more departments or services.

3. Identifies known or suspected problems and refers to QIC for review and resolution.

4. Facilitates the reporting of departmental reports to the QIC, MEC and Board of Directors.

5. Facilitates the reporting of medical staff monitoring to the QIC committee.

6. Provides information from quality assessment activities for use in the credentialing and reappointment process of the Medical Staff.

7. Provides follow-up on Medical Staff recommendations.

8. Reports patient satisfaction survey results to the QIC and Administration.

9. Offers educational and technical assistance to all staff for quality improvement and risk management activities.

10. Assists in development of all committee agendas as they relate to performance improvement opportunities, potential risk, development of policies and procedures, national patient safety standards} etc.

11. Reviews minutes from hospital committees for appropriate involvement in quality improvement and risk management process.

5) Quality Improvement Committee

The Quality Improvement Committee is a multi-disciplinary medical staff committee whose primary objective is to establish and maintain an appropriate and safe level of clinical care for patients, staff members} and other individuals in the hospital. The QIC will monitor all quality activities that impact patient safety and patient satisfaction. The QIC reports to the MEC via the committee chairperson and the CNO-A.

A. Composition

- Two members of the Active Medical Staff, one of whom shall be Chairperson
- and the other shall be Vice-Chairperson

- Chief Nursing Officer-Acute/Risk Manager

- Chief Executive Officer

- Chief Clinical Officer/Director of Pharmacy Services
- Infection Preventionist
- Director of Emergency Services
- Safety Committee Chairperson
- Health Information Management Supervisor
- Chief Nursing Officer-SNF
- Laboratory Services Manager
- Radiology Services Manager

And representatives from Dietary, Environmental Services, Employee Health, Hospice, Utilization Review and Discharge Planning.

B. Role

The role of the QIC is to provide leadership in measuring, assessing and improving care given to patients in the Mayers Memorial Hospital District system. The QIC shall direct and integrate all quality management activities conducted throughout the District to assure an ongoing and comprehensive Quality Improvement and Patient Safety Program designed to improve patient care services; to assure integration of data to enhance effectiveness and eliminate duplicative efforts; to assure appropriate actions are taken to eliminate identified problems; to monitor corrective actions through to resolution; and to maintain records that substantiate program effectiveness in improving patient care.

C. Functions

Utilizes Quality Improvement and Patient Safety Program activities, monitoring and reviewing reports, and implementing changes to ensure District compliance with federal, state and stake-holder requirements in the areas of:

1. Provision of care, treatment and services standards

   (1) Procedure Appropriateness

   (2) Quality Control Activities

   (3) Record Review

   (4) Adverse Event Reporting

   (5) Medical Device Reporting

(6) Infection Prevention Plan

(7) Disaster Management Plan

(8) Safety Plan

2. Medication management

(1) Medication Error Reduction Plan

(2) Judicious Use of Antibiotics

(3) Adverse Drug Reactions

3. Ethics, Rights, and Responsibilities

(1) Patient Satisfaction

(2) Organ Procurement/Donation

(3) Patient Transfers

4. Blood usage

(1) Ordering, Distributing, Administering

(2) Blood Transfusion Reactions

5. Staffing Acuity

(1) Clinical Staffing Monitoring

6. Management of Information

(1) Breach of Medical Information Reporting

(2) Medical Record Delinquency

7. Core Measures

(1) Congestive Heart Failure

(2) Pneumonia

(3) Acute MI

(4) Surgical Infections

(5) Hospital Acquired Infections

(6) Obstetrical Complications

D. Meeting Schedule

The QIC meets on a monthly basis.

VI. Safety Committee

The Safety Committee (SC) is tasked with maintaining a safe and healthful environment for patients, visitors and staff of Mayers Memorial Hospital District. In conjunction with the QIC, the SC will coordinate the overall Safety Program and facilitate practices which support the National Patient Safety Standards utilizing the methodology set forth by the QIPS program.

A. Composition

- Facilities Manager
- Director of Medical/Surgical/Swing Nursing Units
- Environmental Services Manager
- Infection Preventionist
- Dietary Services Manager
- SNF representative
- Personnel Manager
- Employee Health Nurse
- Emergency Services Manager
- Laboratory Services Manager

B. Functions
1. Develop, implement and review general employee and environmental safety policies.
2. Work with department heads to evaluate the safetyof department-specific practices and assist in development of policies that reflect safety-minded techniques.
3. Oversee district-wide programs such as:
i. Hazard Communication Program
ii. Fire Plan Program
iii. Disaster Preparedness
iv. Safety and Security (Violence in the Workplace Program)
v. Ergonomics
4. Review employee injury reports; identifying problems, noting trends, making recommendations for correction of problem and providing for training needs
5. Responsible for the accurate completion and review of safety surveys.
6. Reports all activities to the QIC
C. Meeting Schedule
This committee meets monthly.
VII. Medicine, Pharmacy and Therapeutics Committee
The Medicine, Pharmacy and Therapeutics Committee (MP&T) is a multidisciplinary, medical staff committee established to develop, implement and monitor professional policies regarding evaluation, selection, and procurement of drugs comprising the Hospital formulary, distribution, administration, safety, and effect (including reactions and interactions) of drug usage, patient education and other matters pertinent to drug use in the Hospital. The MP&T committee has overall responsibility for the MMHD Medication Error Reduction Plan (MERP) and the Pain Management Program. MP&T develops and implements policies and procedures relative to the care of medical patients.
A. Composition

• Two members of the Active Medical Staff, one ofwhom shall be Chairperson and the other shall be Vice-Chairperson •
• Chief Clinical Officer/Director of Pharmacy Services
• Chief Nursing Officer/Risk Manager
• Director of Medical/Surgical/Swing Nursing Unit
• Infection Preventionist
• Laboratory Services Manager
• Radiology Services Manager
• Allied Health Practitioner

B. Functions

1. Develop and provide ongoing review with annual approval of policies and procedures regarding drugs and diagnostic testing materials.
2. Advise professional staff on matters pertaining to the choice of available drugs.
3. Define and evaluate all significant untoward drug reactions and medication errors.
4. Evaluate and approve all standardized drug procedures and drug orders.
5. Develop, maintain and annually approve current drug formulary identifying highrisk for placement on "high-risk list".
6. Annually approve hospital-wide therapeutic interchanges.
7. Coordinate and conduct medication usage evaluation activities and continually review data obtained in MEU studies.
8. Review identified drug product defects and manufacturer and FDA drug recalls.
9. Review ISMP alerts and Quarterly Action Agendas to determine potential applicability to the hospital.

C. Meeting Schedule

This committee shall meet at least quarterly.

VIII . Infection Prevention Committee

The Infection Prevention Committee (IPC) is a multidisciplinary} medical staff committee established to monitor the Districfs Infection Prevention Program and the Medical StaWs treatment of infectious disease.

A. Composition

• Two members of the Active Medical Staff} one of whom shall be Chairperson and the other shall be Vice-Chairperson
• Infection Preventionist
• Epidemiologist (if not the same person as the chairperson)
• CNO-A/Risk Manger
• Director of Medical/Surgical/Swing Nursing Unit
• Chief Clinical Officer/Director of Pharmacy Services Director of Surgical Services Outpatient Medical Manager
• Emergency Services Manager
• Employee Health Nurse
• Laboratory Services Manager

and representatives from Dietary} Environmental Services} and Facilities Management.

B. Functions

1. Review all infection prevention studies ensuring that best practice standards are being directed by the Infection Preventionist and followed by district staff.
2. Review and approve all policies and procedures related to infection surveillance} prevention and control activities in all departments and services.
3. Promote the application of organizational and departmental policies relating to infection prevention and control involving but not limited to isolation procedures

and techniques, sterilization procedures, prevention of cross-infection through equipment use, and the safe disposal of infectious or contaminated wastes. •
4. Reports all activities to the QIC.
C. Meeting Schedule
This committee shall meet at least quarterly.
IX. Emergency Care and Trauma/Outpatient Services Committee
The Emergency Care and Trauma/Outpatient Services Committee (EMCT/OPSC) is a multidisciplinary, medical staff committee established to ensure that the district is providing safe and effective emergency care based on community needs and the capabilities of the district.
A. Composition
• Two members of the Active Medical Staff, one of whom shall be Chairperson and the other shall be Vice-Chairperson
• Emergency Department Manager
• Outpatient Services Manager
Other attendees needed for consultation may include:
o Any member of Active Medical Staff with Emergency Medicine Privileges
o CNO-A/Risk Manager
o Director of Medical/Surgical/Swing Nursing Unit
o Chief Clinical Officer/Director of Pharmacy Services
o Any Nursing Supervisor with MICN privileges
B. Functions
1. Develop, implement, and maintain a well-defined plan for emergency care that assures that adequate appraisal, advice, or initial treatment shall be rendered to all ill or injured persons who present themselves at the Hospital.
2. Develop, implement and maintain a plan for continuous delivery of quality care as it relates to outpatient services.

3. Address requirements to maintain status as a Level IV Trauma Center.
4. Develop, implement, maintain the District's Disaster Manual. '
5. Monitor and evaluate effectiveness of management of disaster drills and actual events.
6. Reports all activities to the QIC.

C. Meeting Schedule

This committee shall meet at least quarterly.

Interdisciplinary Team

A sub-committee of QIC, the Interdisciplinary Team (IOT) provides weekday coordination of care between Medical Staff and other hospital staff involved in the dayto-day care of patients. The IOT monitors significant departures from established clinical patterns and patient and family education. The IOT reviews necessity for admissions, extended stays and services rendered working with Medical Staff to ensure the highest quality care monitoring for over-utilization, under-utilization and inefficient use of resources. Problems or trends identified through the IOT process are reported to the QIC.

A. Composition

- Director of Medical/Surgical/Swing Nursing Unit
- Chief Clinical Officer/Director of Pharmacy Services
- Social Worker/Discharge Planner
- Physical Therapist
- Registered Nurses

B. Meeting Schedule

This team meets every weekday.

Unusual Event Team

The Unusual Event Team (UET) is an ad hoc group formed in response to the occurrence of an unusual event. The first purpose ofthis team is to confirm the unusual event category initially determined by the Director of Quality Improvement/Risk Manager or

Administrator on Call. The second purpose ofthis team is to organize a task force that will conduct an analysis ofthe event and implement necessary actions identified by the • analysis. (See Unusual Event Policy and Procedure)

A. Composition

• Chief Executive Officer
• Chief Nursing Officer - Acute
• Chief Nursing Officer - Skilled Nursing Facility
• Chief Clinical Officer
• Corporate Compliance Officer
• Chief of Staff or designee
• Director/managing coordinator of involved department(s)

XII. Quality Improvement Team

The Quality Improvement Team (QIT) is an ad hoc team formed by the CNO-A/Risk Manager in response to a non-reportable, unusual event that requires immediate action • to prevent possible reoccurrence. The QIT will conduct an analysis and will implement identified changes that must occur to avoid reoccurrence of event. This team will be responsible for subsequent analysis and modifications of changes as necessary. The composition ofthis team will depend on the nature ofthe event and the departments involved. Composition will be determined by the CNO-A/Risk Manager.

XIII. Department Managers

Each department manager/director is responsible for implementing and maintaining a system for identifying, monitoring, evaluation and resolving problems. Staff members shall be involved in this process. Department managers/directors submit appropriate reports to the CNO-A/Risk Manager.

METHODOLOGY

Quality Improvement is a process to identify and act on any opportunities to improve the efficiency, effectiveness, value and safety of services. This process promotes a search for the common causes of problems that are inherent to a function rather than focusing on the aberrant performance of an individual.

The Quality Improvement program encourages staff to consider all the factors that influence and define quality. The methodology permits the staff to address clinical, administrative, regulatory, environmental, economic and ethical concerns. The focus of quality improvement is on aspects of care which occur frequently, affect large numbers of patients, or could put a patient at risk.

The driving force ofthis process emphasizes teamwork, communication, and consideration of the needs and expectations ofthe various recipients of our services. When successfully applied, the program empowers the management team to experiment with innovations even when traditional quality assurance data has not revealed problems or substandard outcomes.

I. Aim-POSA

Aim-POSA is an adaptation of The Model for Improvement developed by Associates in Process Improvement (The Improvement Guide, 1996) and promoted by the Institute for Healthcare Improvement. Aim-POSA is a simple yet powerful tool for accelerating improvement and has been used very successfully by hundreds of healthcare organizations in many countries to improve many different health care processes and outcomes.

Aim-POSA has two parts:

- Aim -three fundamental questions which can be addressed in any order---
- POSA - Plan-Oo-Study-Act cycle, to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine ifthe change is an improvement.

More than simply an easy acronym to remember, it represents a scientific way of thinking, gathering information, and developing a plan of action that leads to process improvements. Through Aim-POSA, teams and individuals within the district can gain a

clear understanding of how a process is performed and whether it is meeting *the* needs and expectations of customers. Applying this knowledge, they can plan and test changes • to the process. Permanent changes made as a result ofthe Aim-PDSA process ultimately lead to improvements in product or service, which in turn, directly affects customer satisfaction.

The first part ofthis process involves the creation ofthe Aim Statement. The Aim Statement has three basic questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

The Aim Statement should be time-specific and measurable. It should also define the specific population of patients that will be affected.

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

All improvement requires making changes, but not all changes result in improvement. Teams therefore must identify the changes that are most likely to result in improvement. •

The second part of this process involves testing change and can be utilized multiple times throughout the Aim process. The Plan-Do-Study-Act cycle is shorthand for testing a change in the real work setting. By planning the change, trying it, observing the results, and acting on what is learned, this is the scientific method used for action-oriented learning.

After testing a change on a small scale, learning from each test and refining the change through several PDSA cycles, the team can implement the change on a broader scale.

Steps in the PDSA cycle:

1. Plan

Plan the test or observation, including a plan for collecting data

a. State the objective ofthe test

b. Make predictions about what will happen and why

c. Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)

2. Do

Try out the test on a small scale

a. Carry out the test

b. Document problems and unexpected observations

c. Begin analysis of the data

3. Study

Set aside time to analyze the data and study the results

a. Complete the analysis ofthe data

b. Compare the data to your predictions

4.

c. Summarize and reflect on what was learned

Act

Refine the change, based on what was learned from the test

a. Determine what modifications should be made

b. Prepare a plan for the next test

(See Aim-PDSA Worksheet for Change)

II. Unusual Event Root Cause Analysis Tool

Mayers Memorial Hospital District ensures that an ongoing program for identifying risks to patient safety and reducing medical/health care errors is defined and implemented. The District seeks to prevent occurrences and reduce the incidence of Adverse Events by utilizing risk assessment tools and by using available information about Adverse Events known to occur in healthcare organizations.

The Unusual Event Root Cause Analysis Tool is utilized to determine why an undesirable event has occurred; to redesign the processes and/or underlying systems that may have caused the event to occur; to test and implement measures of effectiveness of process

redesign; and to implement a strategy for maintaining the effectiveness ofthe redesigned process over time. •
The Unusual Event Root Cause Analysis Tool looks at various levels of analysis and different possibilities of cause, asking multiple questions to gather information that helps determine corrective action. Once corrective action is identified, the Unusual Event Root Cause Analysis Tool utilizes PDSA to develop risk reduction strategies.
(See Unusual Event Root Cause Analysis Tool)
III. Quality Control Measures
Certain performance improvement measures must be maintained to ensure ongoing compliance and competency.
The particular role of each team member varies from project to project. For the most part, the Department Manager/Director and Staff provide the most active role in the action plans. They rely upon the input and guidance ofthe medical and administrative team members for determining the progress associated with their actions.

SCOPE AND FOCUS OF QIPSP ACTIVITIES

One ofthe duties ofthe QIC is to decide the scope and focus of quality improvement/patient safety activities. The QIC will prioritize activities based on their relation to MMHD's mission, available resources, and functions, as well as concerns of individuals served, their families, staff, payers, and other customers.
QIPSP activities may be prioritized according to the following criteria:
1. Life threatening
2. Patient outcomes
3. Safety
4. Regulatory compliance
5. Potential liability

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6. Decreased customer satisfaction
7. Ethics
8. Annualized cost
9. Public relations

This prioritization list is intended for use as a tool and not as a rigid standard for determining areas requiring specific methods for improvement.

DIMENSIONS OF QISP PROGRAM

I. Doing the Right Thing

The **effectiveness** ofthe procedure or treatment in relation to a patient's condition is the degree to which the care/intervention used for the patient has been shown to accomplish the desired/projected outcome(s).

The **appropriateness** of a specific test, procedure, or service to meet a patient's needs is the degree to which the care/interventions provided is relevant to meet a patient's clinical needs, given the current state ofthe art.

II. Doing the Right Thing Well

The **availability** of a needed test, procedure, treatment, or service to a patient who needs it is the degree to which the appropriate care/interventions are available to meet the needs of the patient served.

The **timeliness** with which a needed test, procedure, treatment, or service is provided to a patient is the degree to which the care/intervention is provided to the patient at the time it is most beneficial or necessary.

The **continuity** of the services provided to a patient with respect to other services, other practitioners, and other providers, and over time is the degree to which the care/intervention for the patient is coordinated among practitioners, between organizations, and across time.

The **safety** to the patient (and others) with which the services are provided is the degree to which the risk of an intervention and risk in the care environment are reduced for the • patient and healthcare provider.
The **efficiency** with which services are provided is the ratio ofthe outcomes (results of care) for a patient to the resources used to deliver the care.
The **respect and caring** with which services are provided is the degree to which a patient, or designee, is involved in his/her own care decisions, and that those providing services do so with sensitivity and respect for his/her needs and individual differences.

ANNUAL REVIEW

The Quality Improvement and Patient Safety Plan will be reviewed annually by the Board Quality Committee and Quality Improvement Committee. This annual review will assess, at a minimum, the objectives, scope, organizations, effectiveness, and appropriateness of the program. Topics for review will include but not be limited to:
1. Determining areas where improvement opportunities were identified, acted upon, and improvements made.
2. Evaluation of indicator use and data collection activities.
3. Comparing the written plan with the QIPS activities that were performed and adapting the plan as needed to accurately reflect the evolving process.
4. Assessing that documentation is being maintained of the entire process.
5. Determining whether QIPS information was communicated accurately and in a timely fashion to the appropriate persons, teams, task force, leaders, and/or committees.
6. Determining changes to departmental performance efforts for the coming year.
The QIPSP will be modified as needed based on the results of the annual evaluation.
Individual committees and departments will evaluate, review, and revise their QIPS activities and plans annually as part of the organization-wide review. Department managers will conduct an annual review of departmental indicators and quality improvement efforts to present to the BQC at a regularly scheduled monthly meeting. •

CONFIDENTIALITY

Quality Improvement and Patient Safety data related to patient-specific or practitioner-specific information and reports will only be accessible to those participants in the QIPS Program on a "need to know" basis between the QIC and the department and/or Medical Staff/Administrative Committee(s) involved} and those agencies responsible for ascertaining the existence of an ongoing and effective QIPSP. Pertinent QIPS activities will be reported to the Qle. Records of the Medical Staff evaluations/credentials will be maintained with the Medical Staff Coordinator.
Proceedings} minutes and reports remain confidential within the confines of the committee structure of the medical staff.

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QIPSP ACTIVITIES 2011-2012

In addition to the goals, objectives, and day-to-day activities described in the QIPSP, specific QIPSP activities will be identified on an annual basis with the expectation that these activities will be completed throughout the fiscal year. These additional activities are designed to facilitate quality management, communication, enhance organizational operations and/or improve staff functioning.

The activities for 2011-2012 are:

1. Educate MMHD managers and administration regarding QIPSP activities and process.
a. Quality Improvement and Patient Safety Plan
b. Unusual Event Reporting
c. Model for Improvement
i. Aim-PDSA
ii. Testing change
d. Quality Review Report process
2. Develop system that accurately compiles and reports all quality assurance activities currently performed by all district departments.
a. Hire support personnel to assist with data entry and spreadsheet development.
b. Meet with department managers individually to determine learn about departmental quality assurance activities, provide education and guidance regarding previously unidentified quality assurance activities, and establish reporting requirements.
c. Gather and analyze data.
d. Identify areas of needed improvement and assist with change process.
e. Facilitate departmental reporting and education for BQC.
f. Identify BQC areas of interest and develop reporting mechanism.

3. Evaluate hospital services and departments against the CMS Conditions of Participation.
a. Develop mock survey tool.
b. Form and educate ad hoc committee to assist in mock surveys.
c. Perform first survey and provide feedback to department managers.
d. Assist department managers with compliance-related activities.
e. Perform subsequent surveys and assistance as needed.
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ATTACHMENTS
1. Quality Improvement and Patient Safety Organizational Structure
2. MMHD Safety Plan
3. Medication Error Reduction Plan
4. Infection Control Plan
5. Disaster Management/Emergency Operations Plan
6. Corporate Compliance Plan
7. Unusual Event Policy and Procedure
• Unusual Event Flow Sheet
• Unusual Event Root Cause Analysis Tool
8. Aim-PDSA Worksheet

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QUALITY IMPROVEMENT AND PATIENT SAFETY ORGANIZATIONAL STRUCTURE