Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

December 11, 2019 12:00 pm
Boardroom: Fall River Mills

Attendees

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

1	**CALL MEETING TO ORDER**		Chair Laura Beyer			
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					**Approx. Time Allotted**
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – November 13, 2019		Attachment A	**Action Item**	2 min.
4	**DEPARTMENT REPORTS**					
	4.1	Respiratory Therapy	Keith Earnest		Report	10 min.
	4.3	Information Technology	Chris Broadway	Attachment B	Report	10 min.
	4.4	Physical Therapy	Daryl Schneider		Report	10 min.
	4.5	Surgery/Anesthesia	Theresa Overton	Attachment C	Report	10 min.
5	**QUARTERLY REPORTS**					
	5.1	Blood Transfusion	Theresa Overton		Report	10 min.
	5.2	Social Services Acute & SNF	JB Burke Marinda May	Attachments D & E	Report	10 min.
	5.3	Staff Development	Brigid Doyle	Attachment F	Report	10 min.
	5.4	Compliance	Jack Hathaway	Attachment G	Report	10 min.
6	**STANDING MONTHLY REPORTS**					
	6.1	Quality/Performance Improvement	Jack Hathaway		Report	10 min.
	6.2	PRIME	Jack Hathaway		Report	10 min.
	6.3	SNF Events/Survey	Candy Vculek		Report	10 min.
	6.4	Infection Control	Dawn Jacobson		Report	10 min.
7	**ADMINISTRATIVE REPORT**		Louis Ward		Report	10 min.
8	**NEW BUSINESS**					

9	**OTHER INFORMATION/ANNOUNCEMENTS**	Information	5 min.
10	**ADJOURNMENT**		

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Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes

November 13, 2019 and 12:00pm
Boardroom (Fall River Mills)

Attachment A
DRAFT

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

1 **CALL MEETING TO ORDER:** Board Chair Laura Beyer called the meeting to order at 12:05 on the above date.

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

ABSENT:

OTHERS PRESENT:

STAFF PRESENT:
Louis Ward, CEO
Jack Hathaway, DOQ
Theresa Overton, DON, Acute
Dawn Jacobson, Infection Preventionist
JD Phipps, Dir. of Ancillary Services
Barbara Spalding, Volunteer Services
Pam Sweet, Board Clerk

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

3 **APPROVAL OF MINUTES**

3.1	A motion/second carried; committee members accepted the minutes of October 16, 2019	Utterback/ Hathaway	**Approved All**

4 **DEPARTMENT REPORTS**

4.1 **Volunteer Services**: Submitted written report.
- Working to complete paper work on all volunteers. Some have been with us so long, we never got paperwork

4.2 **Emergency Department:** Submitted written report.
- Auditing Vitals within 60 minutes of discharge and Vitals every 2 hours. The most current month graphed was preliminary data. The actual vitals numbers are better than the chart shows
- It was set up with the state that we would be 100% compliant. We are going to look at the data to see what is an acceptable margin of error and reset our goal. It is unknown what other facilities do.

4.3 **Hospice:** Submitted written report.

4.4 **Outpatient Services**: Submitted written report.
- Transportation has always been an issue especially for Partnership/MediCal patients. We tried to hire a driver ourselves, but got no applicants

4.5 **Respiratory:** No Report. Reschedule for December

4.6 **Med-Surg/Swing:** Submitted written report.

- Auditing Vitals within 60 minutes of discharge and Vitals every 2 hours. Appears to be people driven. We are currently coaching individuals.
- SBAR is a reporting template when reporting on a patient's status to a physician, or anyone who needs to know
- Working on recruitment. Other facilities have opened up to hiring new graduates, so we are not getting as many of them the way we used to. We are using more travelers and registry than we wish.

4.7 **Med Staff:** Submitted written report. No questions or comments

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5 **QUARTERLY REPORTS**

5.1 **Safety:** Submitted written report. No questions or comments.

5.2 **CMS Core Measures:**

- We are #8 in the state compared to other CAH hospitals. Improved from last year, but we expect to climb into the top 5 group
- Going through resubmission for core measures at the end of this month

5.3 **5-Star Rating Monitoring:**

- Staffing rating change is showing improvement
- Health Inspection rating will improve over the next year

5.4 **Employee Health:**

- No trending data is available
- This quarter, we had GI issues with staff.
- Still having trouble getting the monthly illness reports
- Only have 16 staff wo have not gotten a flu shot

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6 **STANDING MONTHLY REPORTS**

6.1 **Quality/Performance Improvement**:

- Transitioning to LEAN as a management tool

6.2 **PRIME**:

- 6/2020 – the PRIME funding ends. 1/1/21 the current iteration of PRIME ends and we will have to find another project to report on

6.3 **SNF Events/Survey**: No Report

6.4 **Infection Control**:

- Actively working on getting the NHIS reporting caught up
- Seeing CDIFF from the community several times per month

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7 **ADMINISTRATIVE REPORT**:

- Building Project: crews are working on finishes and PG&E is setting up power. Expect to have temporary power next week
- Pharmacy: all the numbers are positive. Still can't accept regular MediCal
- District Hospital Leadership group meets tomorrow. Louis sits on the executive committee
- Statewide drill is coming up. Scenario is a flooding incident
- Employee Christmas party is December 13
- Employee of the year voting is underway
- Hospitalist: have a number of NP and 1 PA who we are considering. Will be supervised by the ER physician
- Burney Clinic: Happy to have already received 3 notices of intent to bid. Hope to have 5 or 6 bids to choose from

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8 **OTHER INFORMATION/ANNOUNCEMENTS**: None

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9 **ADJOURNMENT:** 1:39pm - Next Regular Meeting – December 11, 2019 (Fall River Mills)

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Attachment B

Board Quality Report Template

Name:

Christopher Broadway

Department:

Information Technology

Last Quality project reported:

IT Support Survey

Update on last Quality project reported:

Need to complete follow up survey.

Current report date to Board Quality:

12/11/19

Last report date to Board Quality:

06/12/19

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

We have revised our ticketing system and have seen a huge increase in use over the previous solution. We have fully implemented an IT telephone solution to reach agents faster. We have actionable data for problems and resolution since the system go live, 10/01/2019.

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

Needed better problem tracking, accountability, and a comprehensive solution to address end user computing issues.

PLAN: What plan was implemented to address those issues?

We completed a roll out and deployment of the Sysaid Help Desk software solution for the IT department, as well as the rest of the hospital staff. This provides a desktop access to the system allowing users to create problem tickets, review and remain up to date on the progress, and provide feedback for the resolution.

DO: How did the implementation of that plan go?

As users become familiar with the system, they are able to quickly put in tickets and we are able to monitor and address issues quickly. Getting the users properly using the system and knowing when to call vs putting in a ticket.

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

At this point, I do not have a tremendous amount of data but I am notified of closed tickets that need to be review and it allows me to easily oversee and provide feedback on problem resolution or issues.

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

Every member of the IT staff was trained. End user training was created and implemented. As more data is collected we will be able to make determinations on best course of actions, identify trends. We expect to see a reduction in reported problems once we are fully implemented with the Citrix end user platform.

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Security Risk Assessment (SRA) and analysis	Improving problem resolution instances and high rating on customer satisfaction responses.

Data/Graphics supporting project outcomes:

Attachment C

Board Quality Report Template

Name:

Theresa Overton, RN

Department:

Outpatient Surgery

Last Quality project reported:

Sitings from Survey 2018: 7-issues

Update on last Quality project reported:

All sitings have been addressed and no new occurrences noted at this time.

Current report date to Board Quality:

12/11/19

Last report date to Board Quality:

06/05/19

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

Humidity compliance resolved in OR 1 and 2.

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

1. CRNA coverage.
2. Anesthesia carts being left open by CRNA's after their departure.

PLAN: What plan was implemented to address those issues?

1. Established 2 contract CRNA's who work through the schedule together.
2. Education and compliance discussed with each CRNA.

DO: How did the implementation of that plan go?

1. This has been successful with coverage of all surgery days with a 6-month time-frame schedule completed.

2. Still in progress as to audit compliance.

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

1. Consistency of CRNA's schedule.
2. Still in progress.

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

1. Communication with CRNA's for schedule and any changes to schedule.
2. Still to determine.

Upcoming Quality Items:	Quality Related Goals for the Department:
Outdated meds in the anesthesia cart and refrigerator not checked.	Establishing work plan foe responsibility of checking out dates monthly by CRNA or Pharmacy.

Data/Graphics supporting project outcomes:

Attachmen D

Board Quality Report Template

Name:

Marinda May

Department:

Acute

Last Quality project reported:

streamlining process from Acute to LTC

Update on last Quality project reported:

Moving our patients has become faster and more effective. We are working better as a team to improve the patient experiene.

Current report date to Board Quality:

12/11/19

Last report date to Board Quality:

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

There has been better continuity of transitioning our patients from the Acute floor to LTC in both facilities. We have streamlined the process and identified key members of the team.

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

TIme it takes to get patients approved for medi-cal in their respective counties. Shasta County is minimum 45, but usually closer to 50-60. Lassen & Modoc County are also hard to get a hold of anyone that can help expedite the process.

PLAN: What plan was implemented to address those issues?

We are currently working on developing a bigger social services department. We will meet on 12/5/2019 to discuss this.

DO: How did the implementation of that plan go?

TBD

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

(Anticipated) Coverage of both LTC & Acute when BJ and myself are gone. Providing coverage in each other's departments when needed.

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

TBD

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Expanding social services here at the hospital. Crossing over into LTC. Adding more tasks to my role.	Continuing to find better ways to communicate with counties regarding medi-cal approval. Educating patients.

Data/Graphics supporting project outcomes:

Attachment E

Board Quality Report Template

Name:

BJ Burks

Department:

Social Services

Last Quality project reported:

New admission structure for Long Term Care.

Current report date to Board Quality:

12/11/19

Last report date to Board Quality:

06/12/19

Update on last Quality project reported:

Meetings with the admission team have been held. The admission process is going through the Lean model structure and Map streaming process. These steps have redesigned the admission process and structure to be more efficient and timely. The admission process is still in the developing stage of improvement through change.

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

The reduction in time for some of the admissions has been very successful. There were some very serious situations that we were able to address and admit quickly for safety.

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

Related to the admission process : Staff availability at times when the admission is ready.
Available male or female beds when admits are ready.

PLAN: What plan was implemented to address those issues?

New staff hired to help the admitting MD.
Room changes for existing residents to open up needed beds.

DO: How did the implementation of that plan go?

Four beds were opened for new admits
The assistants for MD is just starting

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

Positive results. Four beds were designated for admission and are currently being filled.

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

Documents have been created for effective communication process between family members and facilities to facilitate a more streamlined efficient communication and information flow. This is still a work in progress.

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Development of Social Service role in various programs for Long Term Care	Improve quality of life for residents and experience for families by Social Services interventions and new programs.

Data/Graphics supporting project outcomes:

Attachment F

Board Quality Report Template

Name:
Brigid Doyle, RN Clinical Nurse Educator

Department:
Nursing Administration

Current report date to Board Quality:
12/11/19

Last report date to Board Quality:
06/12/19

Last Quality project reported:

Assure contract and registry nursing staff competencies are validated at the level of MMHD staff (in progress)
Develop and implement a competency based Nursing New Employment Orientation as an addition to HR NEO
Assess competencies and build orientations based on results

Update on last Quality project reported:

100% Completion and compliance with contract and registry nursing staff competencies

Competency based New Employee Orientation initiated with RN and CNA new hired staff based on pre-hire assessments

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

Competency Assessment process was operationalized and initiated jointly with HR and Registries for a successful rate of 100% compliance

Nursing New Employee Orientation has been initiated with 1 new hire RN and is ongoing

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

CMS SNF Survey was conducted in September and deficiencies were cited regarding Hand Hygiene and Abuse Reporting

CMS Phase 3 planned and initiated prior to 11/28 per mandate

Need for PI in Code Blue Response

PLAN: What plan was implemented to address those issues?

Plan of Correction submitted to CDPH included Policy and Procedure Review, Relias Training Modules, and skills validations, developed for implementation in regards to Handy Hygiene and Abuse Reporting.

CMS Phase 3 implementation was planned and initiated prior to 11/28 per mandate regarding Compliance and Ethics including Corporate compliance and Standards of Behavior: QAPI program, Residents Rights, Trauma-informed care, Hand off Communication (SBAR).

Policy and Procedure Review of Mock Code Blues have been increased in ED/Acute Care with return demonstrations of rescusitation and code management

DO: How did the implementation of that plan go?

Plan of Correction was approved by CDPH. Training and Skills validation is ongoing
Phase 3 implementation is at
3 mock codes have demonstrated increase in Code management cohesion, role and performance of core skills per Nurse Leadership, Physicians and staff.

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

Results of Hand Hygiene validation and compliance are pending. Training is almost complete at
Implementation of Trauma-Informed care is 100% for new admissions care planning.
Nurse leaders, Physicians and staff report greater comfort and familiarity with role and performance of code blue skills

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

Hand Hygiene compliance is discussed amongst staff and a culture of permission to remind others to perform HH initiated.
Trauma-Informed Care Planning is performed on all admissions to the SNF
SBAR communication is used during hand off communication between shifts and to MD.
Mock Code Management drills increased in frequency with Nursing Leaders and MD providing analysis and feedback

Upcoming Quality Items:

Finalize 2020 Training Calendar
Extend Mock Code Blue drills to SNF
Initiate Competency Assessments on current staff

Quality Related Goals for the Department:

Increase Training opportunities in 2020
Increase role cohesion and competency with Code Blue
Increase clinical competenciesdevelopment using Relias tools

Data/Graphics supporting project outcomes:

Attachment G

MAYERS MEMORIAL HOSPITAL DISTRICT COMPLIANCE REPORT

12/02/19 FOR Q3 2019

TRAINING AND EDUCATION

Type	Completion Target	Actual
New Hire Compliance	100%	100%
POC Education	100%	100%

EXCLUDED PROVIDERS

Type	Number
Employees	0
Physicians/Providers	0
Vendors	0

EXPIRED LICENSES

Expired licenses
0

PAYROLL-BASED JOURNAL (PBJ) FOR MOST RECENT AVAILABLE QUARTER

PBJ Issue	Number
Total Nursing Staffing	**MMHD 1hr 43min, CA 1hr 47min, US 1hr 34 min**
RN Staffing	**MMHD 18min, CA 38min, US 41 min**
LVN Staffing	**MMHD 1hr 24min, CA 1hr 09min, US 52min**
CNA Staffing	**MMHD 3hr 04min, 2hr 33min, 2hr 18min**
Days No RN Coverage > 4	**2**
Staffing Domain Star Rating	**3 stars overall for staffing**

INVESTIGATIONS BY INTAKE

Type	Number
Hotline	0
Direct to Compliance	6
RL6	50

REPORTS AND INVESTIGATIONS BY TYPE

Issue	New	Open	Closed	Unsubstantiated	Substantiated	Terminations
Abuse/Neglect	4	0	4	3	1	2
Code of Ethics/ Policy	0	0	0	0	0	0
Documentation	0	0	0	0	0	0
Elder Justice	0	0	0	0	0	0
False Claims	0	0	0	0	0	0
Gifts	0	0	0	0	0	0
HIPAA	0	0	0	0	0	0
Licensure	0	0	0	0	0	0
OIG Investigations	0	0	0	0	0	0
Other	1	1	0	0	1	0
Resident Rights	1	0	0	0	1	0
Resident Charges	0	0	0	0	0	0
Non-Monetary	0	0	0	0	0	0
STARK	0	0	0	0	0	0
Total	5	0	0	0	0	0

COMPLIANCE CALLS AND INVESTIGATIONS BY ENTITY

Entity	New	Open	Closed	Unsubstantiated	Substantiated	Terminations
Total						