Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Quality Committee
Meeting Agenda

March 13, 2019 12:00 p.m.
Boardroom (Fall River Mills)

Attendees

Beatriz Vasquez, PhD, Chair, Board Member
Laura Beyer, Board Member
Louis Ward, CEO
Dan Dahle MD, Chief of Staff
Candy Vculek, CNO

						Approx. Time Allotted
1	**CALL MEETING TO ORDER**		Chair Beatriz Vasquez			
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**					
3	**APPROVAL OF MINUTES**					
	3.1	Regular Meeting – February 12, 2019		Attachment A	**Action Item**	2 min.
4	**DEPARTMENT REPORTS**					
	4.1	Pharmacy	Keith Earnest	Attachment B	Report	10 min.
	4.2	Dietary	Susan Garcia	Attachment C	Report	10 min.
	4.3	Maintenance	Alex Johnson	Attachment D	Report	10 min.
	4.4	Personnel	Libby Mee	Attachment E	Report	10 min.
	4.5	Purchasing	Steve Sweet		Report	10 min.
5	**QUARTERLY REPORTS**					
	5.1	Blood Transfusion	Theresa Overton	Attachment F	Report	10 min.
	5.2	Compliance	Jack Hathaway	Attachment G	Report	10 min.
	5.3	CMS Core Measures	Jack Hathaway	Attachment H	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	Coleen Beck		Report	10 min.
7	**ADMINISTRATIVE REPORT**		Louis Ward		Report	10 min.
8	**NEW BUSINESS**					

9	**OTHER INFORMATION/ANNOUNCEMENTS**			Information	5 min.
10	**ANNOUNCEMENT OF CLOSED SESSION**				
	10.1	**Government Code Section 54962:** Chief of Staff Report (Health & Safety Code §32155)	Dr. Dan Dahle, Chief of Staff	Report	
	10.2	**STAFF STATUS CHANGE** 1. Rhett Wiggen, CRNA to Inactive **AHP APPOINTMENT** 1. Kirk Lott, CRNA 2. Kenneth Childers, CRNA 3. Erica Haedrich, PA 4. Thomas Peterson, FNP **MEDICAL STAFF APPOINTMENT** 1. Robert Adams, DO – Emergency Medicine 2. Aditi Bhaduri, MD – Endocrinology, Telemedicine 3. Thomas Kurian, MD – Neurology, Telemedicine 4. Tommy Saborido, MD – Emergency Medicine 5. Baharak Bagheri, MD – Radiology, Telemedicine 6. Frank Snyder, MD – Radiology, Telemedicine 7. Shree Shah, MD – Radiology, Telemedicine **MEDICAL STAFF REAPPOINTMENT** 1. Michael Dillon – Emergency Medicine			
11	**RECONVENE OPEN SESSION** – report closed session action			Information	
12	**ADJOURNMENT:** Next Regular Meeting – April 10, 2019 (Fall River Mills)				

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Chief Executive Officer
Louis Ward, MHA

Mayers Memorial Hospital District

Board of Directors
Quality Committee
Minutes

February 12, 2019 - 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 Beatriz Vasquez called the meeting to order at 12:01pm on the above date.

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

ABSENT:
Jack Hathaway, DOQ

OTHERS PRESENT:

STAFF PRESENT:
Louis Ward, CEO
Ryan Harris, DOO
Diana Groendyke, DON SNF
Candy Vculek, CNO
Chris Hall, Lab
BJ Burks, Snf-Activities
Valerie Lakey, Safety
Coleen Beck, Infection Preventionist
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 January 19, 2019 Utterback/Ward **Approved All**

4 **DEPARTMENT REPORTS**
4.1 **SNF:** Submitted written report
- Attention to Skin & Weights has improved quality of care. Team meets every Wednesday and is driven by the Registered Dietitian to discuss weight variances
- Just started "stop-light" report. Start with employees, then will create something similar for patients and families
- Applying for a grant to buy a sling for each patient. Is an infection control best practice

4.2 **Lab:** Submitted written report
- Communication between MMHD and MVHC is improved. Working on resolving discrepancies
- Goal is Point Click Care and Paragon integration this year

4.3 Finance: Submitted written report
- Being careful about spending so we have funds available to invest in IGT

4.4 Volunteer Services:
- Looking forward to an update to the plan for flu immunizations and TB tests

- MMHD pays for immunizations and tests
- Developing a "men's" day to accompany "women's" day. Working to get a male barber to do their hair. Not quite in place

4.5 SNF Activities: Submitted written report

5 **QUARTERLY REPORTS**

5.1 **Safety:**

- Emphasis has been on Emergency Preparedness as part of the Fire, Life, Safety survey. Just completed our 2nd survey and surveyor commented on how important it is the entire staff be trained in emergency preparedness.
  - We have a really good cross section of staff trained. Problem getting to CNA's due to their time constraints. Emphasis is on Maintenance and Environmental Services staff. All Staff have to have a basic knowledge
  - CMS has made Emergency Preparedness a priority.
  - Risk assessments are performed to identify the greatest risks for our community
  - Want to have a couple of people from each department that are well versed in communications and safety
  - Deadline is June 30 to have everyone trained. Currently have 90%
  - Discuss at orientation and are developing a reorientation test
  - Relias system gives us the ability to track and trend keeping people compliant

6 **STANDING MONTHLY REPORTS**

6.1 **Quality/Performance Improvement**: Tabled

6.2 **PRIME**: Louis reported we have chosen a project that is more facility centered than community wide and that is keeping a healthy lifestyle in the hospital. Food options were a big change; offering more healthy options. Offering biometrics. Now pushing against brown drinks. Decided to get rid of all soda's in the cafeteria and machines. There is still 1 vending machine that has soda because it is run by an outside vending source.

6.3 **SNF Events/Survey**: Nothing from the state yet

6.4 **Infection Control**: Submitted written report

7 **ADMINISTRATIVE REPORT**:

- On Call Pay Rates: Looking to standardize all rates. We now have 2 groups: clinical and non-clinical
- Scope of Practice Complaints: An RN and EMT have been disciplined. Goal is to educate and change the culture. It will take all the providers to comply
- SEMSA: Met with SEMSA leadership yesterday and talked with Aiden Board last night.
  - SEMSA has committed to continue ground transportation a Mayers, but it's not complete. Need quality metrics set in place (i.e., response times).
  - They will supply us an ALS crew and a backup crew
  - Considering the benefits of investing in equipment as opposed to staffing
  - Will know by the end of February if SEMSA is our vendor
  - Seeing reductions in volunteer staff and expect to see that more
  - Will have more information on the helicopter 2/25/19 board meeting. It looks positive. Possibly will be based at the FR airport
- Manager's meeting is at 2:30pm today. Will discuss orientation, reorientation and training
- Meaningful Use is due at the end of February. A report showing how much we are using the EHR

8	**NEW BUSINESS**: None
9	**OTHER INFORMATION/ANNOUNCEMENTS**: None
10	**ANNOUNCEMENT OF CLOSED SESSION**:
11	**RECONVENE OPEN SESSION**: No action
12	**ADJOURNMENT:** 2:15 pm - Next Regular Meeting – March 13, 2019 (Fall River Mills)

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Board Quality Departmental Report Template

Last Quality project reported: *ER dispensing labeling and board of pharmacy inspection plan of corrections* **Update on last Quality project reported:** *Labels have been implemented. Initial trial period was 2/2019. Quality improvement continues, as staff compliance with process was poor during trial period. The process is being closely monitored and staff is being educated on a personal level.*	**Current report date to Board Quality:** 3/13/2019 **Last report date to Board Quality:** 10/2018
What successes have you seen based on the outcome of previous Quality projects? *At this point, nursing compliance is too low to claim success.*	
What issues have come up in your department relating to Quality? *In SNF carts, insulin pens were not labeled with patient information and expiration date. The facility has been cited on this problem twice in the past.*	

INITIAL PDCA

PLAN: What plan was implemented to address those issues?

Meeting conducted with charge nurses and DON to discuss a solution. Decided to use posters and staff meeting.

DO: How did the implementation of that plan go?

Posters were placed on the refrigerators reminding nursing staff to label pens and affix an expiration date sticker to pen. Dispenser of expiration date labels was adjacent to refrigerator.

Nursing staff informed at staff meeting of expectation.

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

Carts checks were conducted weekly by RPh to evaluate success of implementation.

Sporadic compliance noted, but overall compliance was unacceptable.

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

After a 6 week trial period, it was determined that additional intervention was needed.

SECONDARY PDCA

PLAN: What plan was implemented to address those issues?

Reconvened initial team to discuss lack of success and determine next steps. The following plan was developed: Have a baggy labeled for each pen (5 per box) with blank expiration stickers affixed to bag. When a pen is removed from the box in the fridge, the expiration date is completed and it is placed in the bag in the resident's drawer.

DO: How did the implementation of that plan go?

Implementation on pharmacy side was successful with 100% compliance. Nursing was in-serviced via staff meeting.

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

Carts were checked weekly. Compliance worsened. Piles of bags found in resident's med drawers. Pens in wrong bag. Expiration dates not filled in.

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

This change was discarded as a failed intervention.

TERTIARY PDSA

PLAN: What plan was implemented to address those issues?

The team met again. A new solution was developed. Pharmacy will open the boxes and label the individual pens with a patient label and expiration label. The nurse will fill in the expiration date upon removal from fridge.

No baggies.

DO: How did the implementation of that plan go?

Implemented in pharmacy 3/1/19. Further in-services of nursing staff pending by DON.

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

Will continue to monitor weekly.

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

Pending

Upcoming Quality Items:	**Quality Related Goals for the Department:**
Pharmacy processing times in Paragon.	

CALIFORNIA ASSOCIATION CAHF OF HEALTH FACILITIES

DIETARY SERVICES PROJECT

Food & Nutrition: Meal Tray Accuracy - Quality Assurance Report

Date:	Meal B=breakfast L=lunch D=Dinner	Correct Diet	All items served per menu	No missing items	Correct utensils	Attractive	Errors
Sample #1	Example:		✓			✓	2
Sample #2	Example:	✓					1
Sample #3							
Sample #4							
Sample #5							
Sample #6							
Sample #7							
Sample #8							
Sample #9							
Sample #10							
Trending		Current month		Prior Month			Past Prior Month
		Ex: 3/60		Ex: 5/60			Ex: 4/60

Instructions: Place a check for any error for each requirement of the randomly reviewed meal and tray. Total the total omissions for all 10 reviewed and place total under the current month. Keep the prior months rates on the form back two months to review improvement trend. Complete the Meal Tray Accuracy report at a minimum once monthly per mealtime. Any negative trend or value above the threshold needs to have an action initiated to correct.
Threshold: less than 10% error rate

Root Cause Analysis/Discussion: _____

_____

Action plan: _____

_____

CALIFORNIA ASSOCIATION CAHF OF HEALTH FACILITIES

DIETARY SERVICES PROJECT

Food & Nutrition: Dietary Hand Washing - Quality Assurance Report

Month:	Total # of employees observed	Entering Kitchen	Between Tasks	Between Glove Changes	Total Observed	Total Expected	Compliance Rate
Observation #1	Ex: III	Ex: II	EX: ~~III~~	Ex: III	Ex: 13	Ex: 15	Ex: 87%
Observation #2							
Observation #3							
Observation #4							
Observation #5							
Observation #6							
Observation #7							
Observation #8							
Monthly Totals							

Trending of Compliance Rate	Current Month	Prior Month	Past Prior Month

Instructions: Observe hand washing for a significant period of time 2-3 times each week, vary the time of day. Tally to indicate each time hands are washed with the proper method and the total expected opportunities. Keep the prior months rates on the form back two months to review improvement trend. Any negative trend or value above the threshold needs to have an action initiated to correct.
Threshold: 100% compliance with hand washing policy

Root Cause Analysis/Discussion: _____

Action plan: _____

CALIFORNIA ASSOCIATION CAHF OF HEALTH FACILITIES

DIETARY SERVICES PROJECT

Food & Nutrition: Resident Satisfaction Survey

This survey is being conducted as part of a continuing effort to provide quality food service.
You cooperation in completing this questionnaire is most appreciated.

	Question	Poor	Fair	Good	Very Good	N/A
1	How would you rate the overall quality of meals provided?					
2	How would you rate the quality of breakfasts?					
3	How would you rate the quality of lunches?					
4	How would you rate the quality of evening meals?					
5	Do you like the snacks served between meals?					
6	Are the portion sizes appropriate?					
7	Is the temperature of your hot food appropriate?					
8	Is the temperature of your cold food appropriate?					
9	Does the food taste meet your expectations?					
10	How would you rate the presentation of the food (i.e. does it look appetizing)?					
11	Is the staff helpful at mealtimes?					

Resident's Name: _____

Additional comments: _____

_____

_____

_____

INSTRUCTIONS: Submit completed form to Quality Assurance Committee for tracking and performance improvement.

1. Menus

Sunday	Monday	Tuesday	Wednesda
Breakfast	Breakfast	Breakfast	Breakfast
Orange Juice*	Cranberry Juice Cocktail*	Apple Juice*	4 oz Pineapple Juice*
Scrambled Egg*	Fried Egg*	Cheese Omelet Bites*	Country Scrambled Egg
Bacon*	Corn Beef Hash*	Sausage & Gravy *	Cornflakes*
Cream of Wheat*	Oatmeal*	Cream of Rice Cereal*	Hashbrowns*
Muffin*	Toast*	Milk, Whole*	Assorted Pastry*
Milk, Whole*	Milk, Whole*	Margarine*	Milk, Whole*
Margarine*	Margarine		Margarine**
	Jelly		

2. Spreadsheets

Mechanical Soft	Puree	2gm Na	Low Fat/Chol	No Con Sweet
4 oz Orange Juice*	4 oz Orange Juice*	4 oz Orange Juice*	4 oz Orange Juice*	4 oz Orange Juice*
4 oz Potato Omelet*	4 oz Pur Potato Omelet*	4 oz Potato Omelet*	4 oz Potato Omelet*	4 oz Potato Omelet*
2 oz Or Sausage Patty*	2 oz Pur Sausage Patty*	2 oz LS Turkey Sausage*	2 oz LS Turkey Sausage*	2 oz Bacon*
6 oz Cream of Wheat*	6 oz Cream of Wheat*	6 oz Cream of Wheat*	6 oz Cream of Wheat*	6 oz Cream of Wheat
1 oz Toast*	2 oz Pur Bread*	1 oz Toast*	1 oz Toast*	1 oz Toast
8 oz Milk, Whole*	8 oz Milk, Whole*	8 oz Milk, Whole*	8 oz Milk, Skim*	4 oz Milk, Whole*
1 pkt Jelly*	1 pkt Jelly*	1 pkt Jelly*	1 pkt Jelly*	1 pkt SF Jelly
1 pkt Margarine*	1 pkt Margarine*	1 pkt Margarine, Unsalted*	1 pkt Margarine*	1 pkt Margarine

1500 Cal	1800 Cal	2000 Cal	Finger Food	MS Finger Food
4 oz Orange Juice*	4 oz Orange Juice*	4 oz Orange Juice*	4 oz Orange Juice*	4 oz Orange Juice*
4 oz Potato Omelet*	4 oz Potato Omelet*	4 oz Potato Omelet*	4 oz Potato Omelet*	4 oz Potato Omelet*
1 oz Bacon*	1 oz Bacon*	2 oz Bacon*	2 oz Bacon*	2 oz Or Sausage Patty*
6 oz Cream of Wheat*	6 oz Cream of Wheat*	6 oz Cream of Wheat*	6 oz Cream of Wheat in Mug*	6 oz Cream of Wheat in Mug*
1 oz Toast*	1 oz Toast*	1 oz Toast*	1 oz Toast*	1 oz Toast*
8 oz Milk, 2%*	8 oz Milk, 2%*	8 oz Milk, Whole*	8 oz Milk, Whole*	8 oz Milk, Whole*
1 pkt SF Jelly*	1 pkt SF Jelly*	1 pkt Jelly*	1 pkt Jelly*	1 pkt Jelly*
1 pkt Margarine*	1 pkt Margarine*	1 pkt Margarine*	1 pkt Margarine*	1 pkt Margarine*

3. Recipes

Smothered Hamburger Steak - 4118

Recipe Summary Card
Source: Custom

Yield: 50
No. Ingredients: 8

Category: Meat, Beef
Manufacturer: (None)

Ingredient	25 Servings	50 Servings
2 1/2 lb. Beef, Ground, Patty, Frozen, Raw	6 1/4 pounds	12 1/2 pound
gal. Gravy, Beef, Instant, Mix	1/2 gallon	1 gallon
lb. Onions, Sweet, Raw	2 pounds	4 pounds
can #10 Mushrooms, Sliced, Drained	1/2 can	1 can
T. Salt, Seasoned	1 tablespoon	2 tablespoon
T. Garlic Powder	1 tablespoon	2 tablespoon
T. Pepper, Black, Ground	1 tablespoon	2 tablespoon
c. Parsley, Dried	2 tablespoons	1/4 cup

Instructions

Preheat oven to 350°F.
Follow manufacturers instructions on packaging for making 1 gallon of beef gravy.

Smothered Steak - 4119

Recipe Summary Card
Source: Custom

Yield: 50
No. Ingredients: 9

Category: Meat, Beef
Manufacturer: (None)

Ingredient	25 Servings	50
12 1/2 lb. Beef, Flank, Steak, Choice	6 1/4 pounds	12
1 gal. Gravy, Beef, Instant, Mix	1/2 gallon	1 g
4 lb. Onions, Sweet, Raw	2 pounds	4 p
1 can # 10 can Mushrooms, Sliced, Drained	1/2 can	1 c
	1 tablespoon	2 t

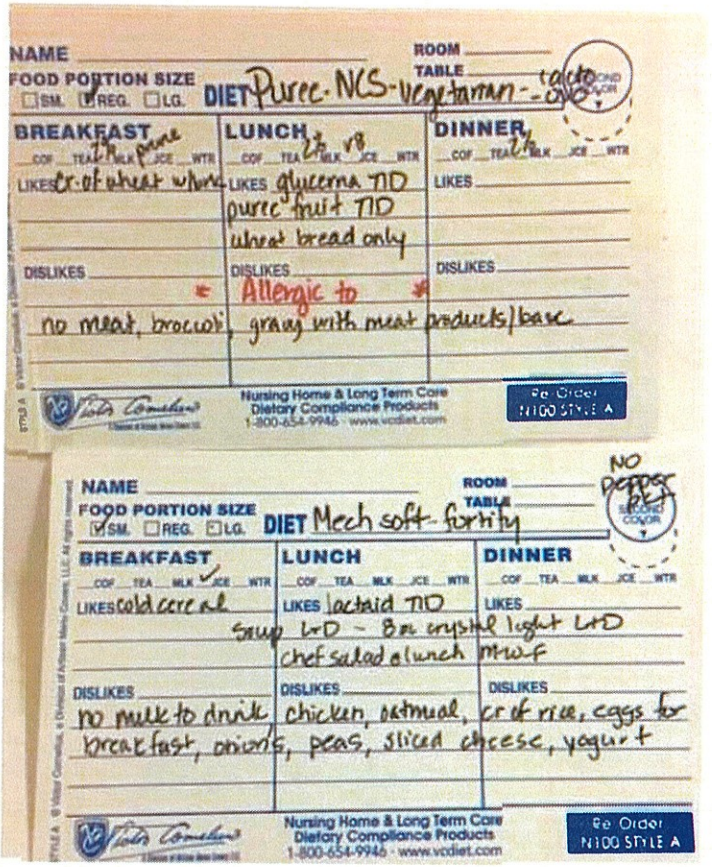
4. Temperature logs

Attachment C

FOOD PREPARATION TEMPERATURES

Breakfast	Temp.	SUN	MON	TUE	WED	THU
Item:						
Hot Cereal	160°F					
Pancake/Fr. toast	155°F					
Eggs	155°F					
Meats	165°F					
Juice	<40°F					
Milk	<40°F					
Glass beverages	<40°F					
Lunch						
Item:						

5. Tray cards



6. Test trays

MAYERS MEMORIAL HOSPITAL DISTRICT
QUALITY ASSESSMENT OF A PATIENT'S TRAY

Sent to
Date
Meal
Diet

Tray completeness and cleanliness TRAY TRAY COVER
NAPKIN DISHES FLATWARE GLASSWARE

MENU ITEM	SOUP	ENTRÉE	POT.	VEG	HOT BEV.	SALAD
Temp standard on serving line	180-190°	160°	160°	160°	180-190°	Cool Crisp
a. On serving line						
Temp standard of food on tray	120°-140°	120°-140°	120°-140°	120°-140°	120°-140°	Cool Crisp
a. Temp of food on tray						

Attachment D
Maintenance

Board Quality Departmental Report Template

Last Quality project reported: Burney Laundry Facility. **Update on last Quality project reported:** The laundry facility is completed and operational. The building will be have it's final inspection from Shasta County once the ada bathroom is complete.	**Current report date to Board Quality:** 3-13-2019 **Last report date to Board Quality:**

What successes have you seen based on the outcome of previous Quality projects?
The creation of the engineering department has enabled the hospital to accomplish a multitude of construction projects that otherwise would have been sent out to bid. These include the laundry facility, 5th street sleeper house, training center, snf refresh project and restriping the parking lot. The security fence and access control at the Burney Annex have reduced unwelcome visitors significantly.

What issues have come up in your department relating to Quality?
The main quality issue in my department was trying to educate the previous maintenance staff about the new direction and standards that I expect of my department.

PLAN: What plan was implemented to address those issues?
I had one on one conversations with each staff member regarding the projects our department would be undertaking and the opportunity for them to be a part of a team that would work together and build off of each other toward a common goal. I placed an emphasis on performance and results and the satisfaction of a job done right.

DO: How did the implementation of that plan go?
A large majority of the previous maintenance crew decided to pursue work elsewhere and I hired a more motivated and skilled staff.

STUDY: What kind of results did the implementation of the plan yield?
We have a fun and cohesive group of guys working in maintenance and engineering that approach each day with a problem solving attitude. We have been able to accomplish goals passed down from management in a timely fashion with quality workmanship.

ACT: What changes were made based on the results of the plan implementation?
None.

Upcoming Quality Items:	Quality Related Goals for the Department:
Phase 2 of the SNF Refresh, Riverview House Remodel, Burney Annex paint and cabinet skins, Burney Sleeper House, Conversion of Mountain Valleys Building into office space.	

Data/Graphics supporting project outcomes:

Attachment E
Personnel

Board Quality Departmental Report Template

Last Quality project reported:

EverCheck Software System - HR round table with local facilites - Code Lavender

Update on last Quality project reported:

1. EverCheck Software working really well
2. Weekly email HR counterparts from round table, sharing ideas, questions and policies
3. Putting together committee to manage the Code Lavender program

Current report date to Board Quality:

03/13/19

Last report date to Board Quality:

07/11/18

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

1. Employee, Managers and HR have active knowledge of when license and certs are approaching expiration so no staff is working out of compliance.
2. When networking with HR counterparts, I have access and support to more knowledge and processes.
3. Code Lavender project is just getting underway.

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

1. Due to new requirements and regulation, needing to add additional orientation content and adjust length of orientation.
2. Received negative feedback from potential employees that had applied for positions but had not heard back from Mayers
3. Provide MMHD Management resources during a newly hired employees probationary period.

PLAN: What plan was implemented to address those issues?

1. Planning on extending New Hire Orientation from one day to two and utilizing new Relias software content. Will also be looking to move away from paper based process and use technology to present content.
2.The HR Assistant communicates with every potential employee that puts in an application.
3. Provide MMHD managers a Probationary Evaluation appraisal in Trakstar system.

DO: How did the implementation of that plan go?

1. Currently in progress. Looking into purchasing tablets to distribute content during orientation. Researching in Relias system to see what content exist and what needs to be added.
2. HR Assistant sends every potential employee an email confirming receipt of application and info about review process.
3. Currently in Progress. Evaluation has been built and will be educating manager and updating policies.

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

1. Unknown - Study not complete
2. Potential employees are at ease knowing HR has received their application and are informed of next steps.
3. Unknown - Study not complete

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

1. None as the plan is incomplete
2. None
3. None as the plan is incomplete

Upcoming Quality Items:	Quality Related Goals for the Department:
Utilizing new One Content software system to move from paper HR files to electronically stored HR information	To provide professional and personal support to all members of Team Mayers, while adhering to policies, procedures and State and Federal regulations.

Data/Graphics supporting project outcomes:

Attachment F

BLOOD TRANSFUSION CHART
DATE: October 2018

TRANSFUSION DATE	MR#	DR	NUMBER OF UNITS	INDICATIONS DOCUMENTED Y N	INFORMED CONSENT SIGNED	BLOOD BANK ARMBAND	VITALS DOCUMENTED Y N	BLOOD PRODUCT APPROP.
10/7/18	64334	Nix	2	Y	Y	Y	Y	Y
10/18/18	50408	Dahle	2	Y	Y	Y	Y	Y
10/25/18	24291	Dahle	2	Y	Y	Y	Y	Assess response after 1st unit before 2nd unit
10/29/18	50408	Dahle	2	Y	Y	Y	Y	Assess response after 1st unit before 2nd unit
TOTAL			**8**					

BLOOD TRANSFUSION CHART
DATE: November 2018

TRANSFUSION DATE	MR#	DR	NUMBER OF UNITS	INDICATIONS DOCUMENTED Y N	INFORMED CONSENT SIGNED	BLOOD BANK ARMBAND	VITALS DOCUMENTED Y N	BLOOD PRODUCT APPROP.
11/15/18	66516	Dahle	2	Y	Y	Y	Y	Assess response after 1st unit before 2nd unit
11/20/18	22511	Dykes	1	Y	Emergent	Emergent	Completed by transfer crew in route	Y
11/29/18	14922	Dahle	3	Y	Y	Y	Y	Y
TOTAL			**6**					

Attachment F

BLOOD TRANSFUSION CHART
DATE: December 2018

TRANSFUSION DATE	MR#	DR	NUMBER OF UNITS	INDICATIONS DOCUMENTED Y N	INFORMED CONSENT SIGNED	BLOOD BANK ARMBAND	VITALS DOCUMENTED Y N	BLOOD PRODUCT APPROP.
12/12-13/18	18972	Colas	2	Y	Y	Y	Y	Y
12/13/18	66516	Colas	2	Y	Y	Y	Yes on 1st unit and missing data on 2nd unit	Y
12/17-18/18	26729	Dykes	3	Y	Y	Y	Y	Y
TOTAL			**7**					

BLOOD TRANSFUSION REPORT
Quarterly Report/2nd quarter 2019

MD	CHARTS REVIEWED	NUMBER OF UNITS
Colas	2	4
Dahle	5	11
Dykes	2	4
Nix	1	2
TOTAL	**10**	**21**

Attachment G
Compliance

Board Quality Departmental Report Template

Last Quality project reported: Compliance Plan update **Update on last Quality project reported:** It seems that every time I go to an education for anything dealing with legal or compliance the compliance plan comes up in conversation. Most recently it was stated the plan should be a list of expectations and a clear description of how to deal with falling below those expectations.	**Current report date to Board Quality:** 03/13/19 **Last report date to Board Quality:**

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

We have revised our Compliance Plan - however, I am sure that it needs to be updated again, I am beginning to believe that it will be an annual project to be truly accurate in addressing the changing face of health care.

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

Education for staff in regards to their role in compliance and the impact that their compliance has on patient care.

PLAN: What plan was implemented to address those issues?

Compliance Blast program. This is a monthly MMH all compliance blast with a short video that relates a specific topic in compliance to staff.

DO: How did the implementation of that plan go?

So far so good - 2 months in seems to be working.

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

I believe that we will see that the regulatory side is met - we are offering - and under the regulatory guidance offering is all that is mandated.

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

Looking to the future I think that building the program to have meaning that all employees can buy into will require that we have some reoccurring in person trainings where I can take some de-identified real situations and have education and after action review (AAR) with all staff who attend. I believe that this is the only way that we can really build the value to the employees in total.

Upcoming Quality Items:	Quality Related Goals for the Department:
Update to the Compliance Plan and Education plan for next year.	Moving to in person training and AAR.

Data/Graphics supporting project outcomes:

Attachment H
CMS Core Me

Board Quality Departmental Report Template

Last Quality project reported: PREMIER eCQMs **Update on last Quality project reported:** We have submitted our first Meaningful Use PI year with PREMIER and it seems to be successful - I am sure that we will see that when the final reports come back from CMS	**Current report date to Board Quality:** 03/13/19 **Last report date to Board Quality:**

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

Having a third party pull the data for reporting to CMS has been very helpful - rather than having to populate and verify now we only have to verify and it seems to be much easier and the data that will come from it will be very good. As that data becomes available I will bring it to share with the Board. It is not available in a meaningful way as of yet.

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

We are still looking to optimize our core measures that are not eCQM reported by PREMIER

PLAN: What plan was implemented to address those issues?

I am working with JD to get the OQR (Outpatient Quality Reporting) measures squared away and we will create standard work where it fits and educate to that specifically.

DO: How did the implementation of that plan go?

Still in process

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

We have been looking at what core measures will be the most meaning full for us based on need in the community and population that we have seen over the past 12 months. Then based on that we can build a plan to have a meaningful block of core measures to report on over the next 3 to 5 years.

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

As we move forward with the 12 month look back we will have to be considerate of the time lapse that CMS has in reporting - data that we get back from CMS can be up to 18 months old - usually for the last year - and if we change things annually we will never have a standardized report to CMS and that could affect our star ratings. So finding some long term goals will be essential

Upcoming Quality Items:	Quality Related Goals for the Department:
Standardizing the IQR (Inpatient Quality Reporting) like the OQR will be the next big project.	To have meaningful OQR and IQR reporting going in to CMS that positively affects our star rating for the hospital.

Data/Graphics supporting project outcomes: