MAYERS MEMORIAL HEALTHCARE DISTRICT

Quality Committee
Meeting Agenda

January 18, 2023 1:00 PM
Microsoft Teams Meeting: LINK
Call In Number: 1-279-895-6380
Phone Conference ID: 514 499 291#
Meeting ID: 228 738 363 744
Passcode: 5UQzrc

Attendees

Tom Guyn, M.D., Quality Committee Chair
Les Cufaude, Director

Chris Bjornberg, CEO
Jack Hathaway, Director of Quality

1	**CALL MEETING TO ORDER**	Chair Tom Guyn, M.D.			**Approx. Time Allotted**
2	**CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS**				
3	**APPROVAL OF MINUTES**				
	3.1 Regular Meeting – October 19, 2022		Attachment A	**Action Item**	2 min.
4	**HOSPITAL QUALITY COMMITTEE REPORT**			Report	10 min.
5	**DIRECTOR OF QUALITY**	Jack Hathaway	Attachment B	Report	5 min.
6	**OTHER INFORMATION/ANNOUNCEMENTS**			Information	5 min.
7	**ADJOURNMENT:** Next Regular Meeting – February 15, 2023				

MAYERS MEMORIAL HEALTHCARE DISTRICT

Board of Directors
Quality Committee
Minutes
October 19, 2022 @ 1:00 PM
Fully Remote Teams Meeting

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 Jeanne Utterback called the meeting to order at 1:04 pm on the above date.			
	BOARD MEMBERS PRESENT:		**STAFF PRESENT:**	
	Jeanne Utterback, President Tom Guyn, MD., Director		Jack Hathaway, Director of Quality Keith Earnest, CCO Pam Sweet, Scribe	
	Excused ABSENT: Chris Bjornberg, CEO			
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 September 21, 2022	***Guyn, Hathaway***	**Approved by All**
4	**Hospital Quality Committee Report**			
	Written report submitted. There are problems with data validity we expect to be resolved with implementation of Cerner. Data pulled by reports does not match the input in some cases (example Imaging). Also, need to encourage staff to enter data as it occurs and correct workflow issues. It is important to identify the workflow issues now and not carry them over to Cerner.			
5	**Director of Quality Report** Written report submitted. ACHC vs. TJC: Met with ACHC representatives. ACHC focuses more on critical access hospitals. Agree TJC is the gold standard but may not be best for our needs. Talked with UC Davis about Centers for Rural Excellence designation. They will accept any accreditation, not just TJC. Waiting for ACHC to send us information on the differences. Dealing with Covid in Long Term Care.			
6	**OTHER INFORMATION/ANNOUNCEMENTS**: None			
7	**ANNOUNCEMENT OF CLOSED SESSION:** 2:15 pm			
	7.1	**MEDICAL STAFF CREDENTIALS – GOVERNMENT CODE 54962**		
	MEDICAL STAFF APPOINTMENT Haroon Rehman, MD – Oncology **MEDICAL STAFF REAPPOINTMENT** David Panossian, MD – Pulmonary Care Julia Mooney, MD – Pathology			
	MED STAFF CREDENTIALS UNANIMOUSLY APPROVED.			
8	**RECONVENE OPEN SESSION:** 2:20 pm			
9	**ADJOURNMENT:** at 2:25 pm Next Regular Meeting – November 16, 2022			

Report to accompany the data provided.

This month you will see 3 excel documents that I have provided 2 of them are LEAN documents that help in tracking changes that we have made or are making in the hospital. The SNF BP Med Errors work has been completed and the changes and tracking are captured in the RL6 Dashboard. The ACHC Master LEAN plan speaks to the future and how we will be working towards accreditation on that front.

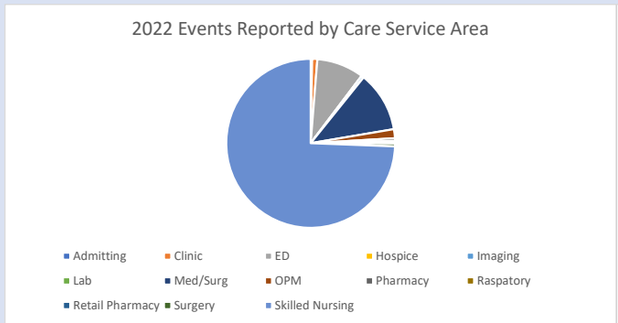
The RL6 Dashboard shows all of the reports that we have had in 2021 and 2022 in a graphic representation – just to give an idea of what we have been reporting internally – I can go into more detail about actions taken or improvements documented through our discussion.

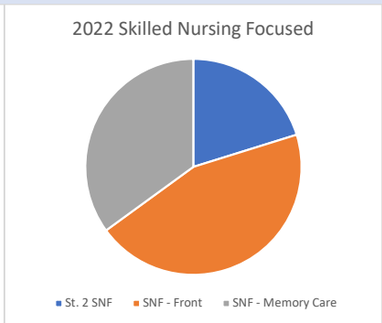
Give everything a look and we can review and discuss as you like during the meeting. I plan to be using these LEAN tools to track our QAPI progress and any special or specific projects that we will be identifying and working on through the accreditation process with ACHC or as we identify the need to change workflows internally. So, this is a kind of soft introduction to how I hope to continue things into the future.

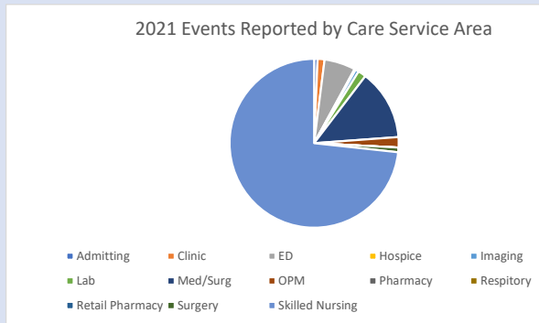
Thank you,

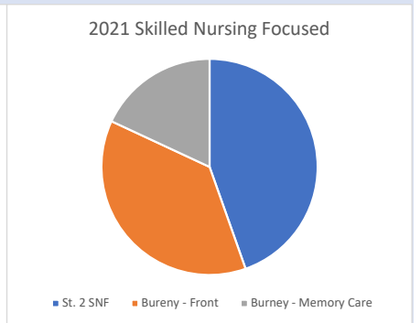
Jack Hathaway | Director of Quality

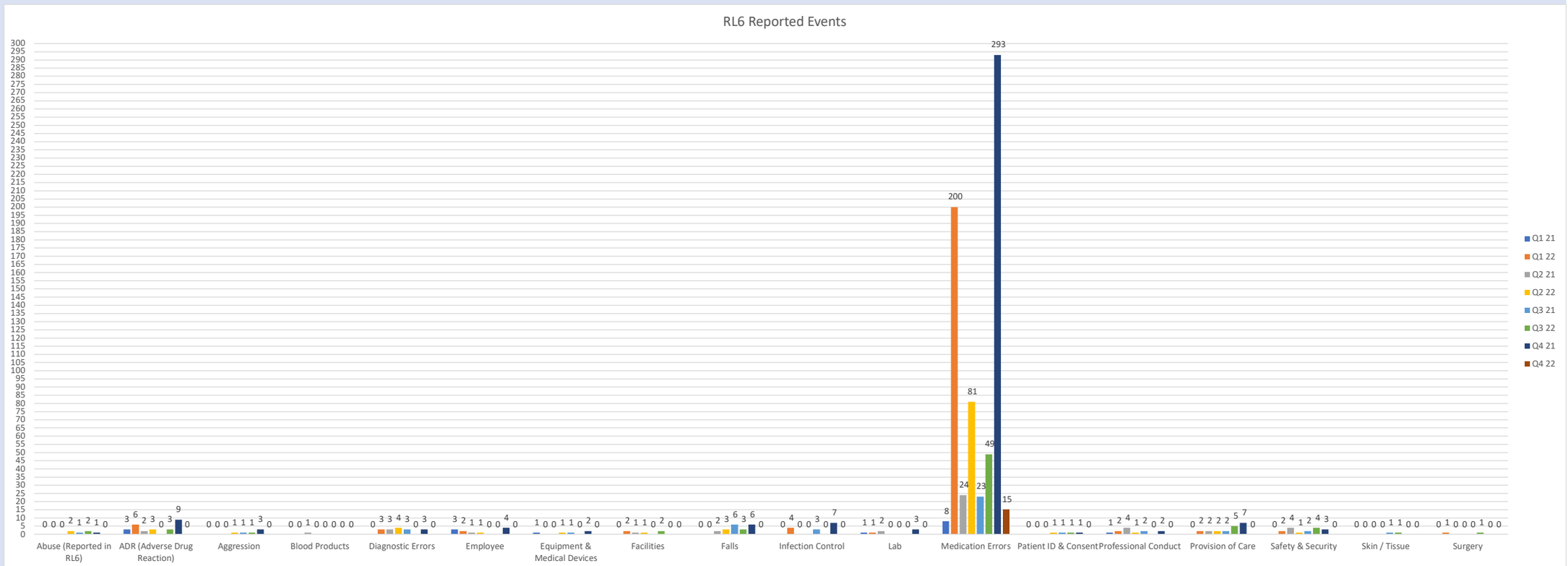
Mayers Memorial Healthcare District - RL6 Dashboard

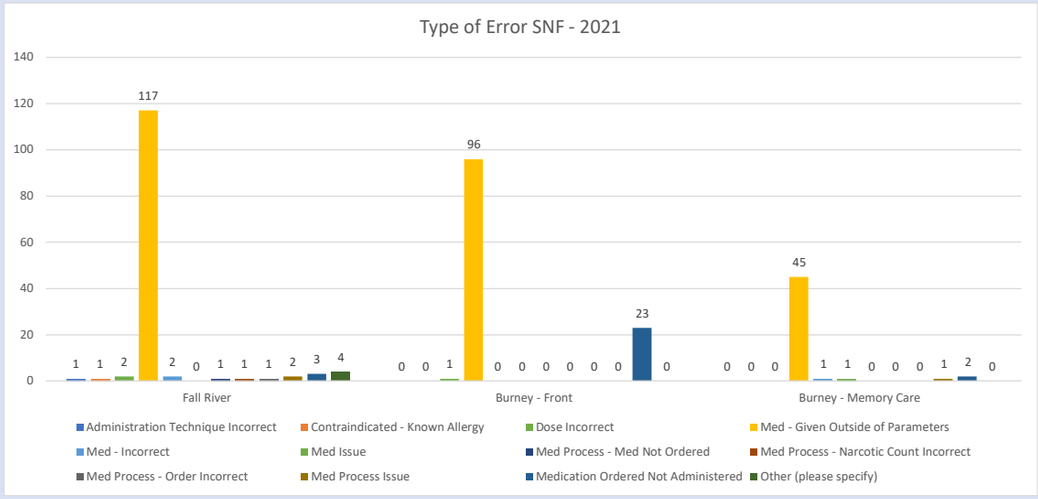








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140
120
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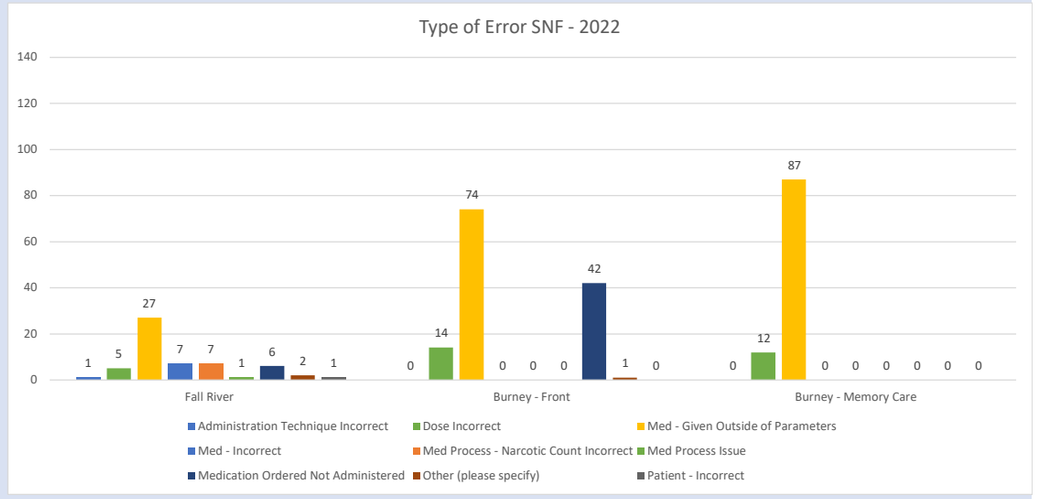
1 1 2 117 2 0 1 1 1 2 3 4
0 0 1 96 0 0 0 0 0 0 23 0
0 0 0 45 1 1 0 0 0 1 2 0
Fall River
Burney - Front
Burney - Memory Care
Administration Technique Incorrect
Contraindicated - Known Allergy
Dose Incorrect
Med - Given Outside of Parameters
Med - Incorrect
Med Issue
Med Process - Med Not Ordered
Med Process - Narcotic Count Incorrect
Med Process - Order Incorrect
Med Process Issue
Medication Ordered Not Administered
Other (please specify)


Type of Error SNF - 2022
140
120
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1 5 27 7 7 1 6 2 1
0 14 74 0 0 0 42 1 0
0 12 87 0 0 0 0 0 0
Fall River
Burney - Front
Burney - Memory Care
Administration Technique Incorrect
Dose Incorrect
Med - Given Outside of Parameters
Med - Incorrect
Med Process - Narcotic Count Incorrect
Med Process Issue
Medication Ordered Not Administered
Other (please specify)
Patient - Incorrect

MMHD ACHC QAPI Implementation A3

Mayers Memorial Hospital District -

Sponsor: Chris Bjornberg **Process Owner:** Jack Hathaway **Author:** Jack Hathaway **Revision #:** 1

Team: MMH District Wide **Trainee:** N/A **Last Update:** 1/5/23

1. Background: ***What problem are you talking about and why?***

Mayers Memorial Hospital District leadership has decided to move forward with third-party accreditation for deemed status through ACHC. In order to be successful in the accreditation survey the Quality department and managers throughout the district will have to work together to get the new standards out and get everyone educated on where we need to make adjustments to our current state to succeed.

2. Current Conditions: Where do things stand now?

Currently, our hospital has been working under the licensing and certification surveys provided by the California Department of Public Health. We have been successful in all of our past licensing and certification surveys done with the state, finding only normal level deficiencies during survey. While there is work to be done as a part of a true QAPI process that is living and ongoing, the service provided in our hospital to the patients who come is always within the standard of care and in compliance with all of the conditions of participation mandated by CMS.

3. Target Conditions (Goal(s)): ***What specific outcome is required?***

Our goal is to have successful accreditation through ACHC and continue to raise the bar for care and quality outcomes for all those that we serve.

4. Gap Analysis: ***Why does the problem or need exist?***

The need arose as we continued to improve and see room for growth. There are certain advantages to third-party accreditation that can assist us in our work to become the provider of choice in our region. With the knowledge that thrid-party accreditation brings a higher standard would be held with the state survey process we choose to move forward towards that higher standard to help drive us in the right direction, towards that high reliable organization goal of consistently better outcomes on the path to zero harm.

5. Experiments: ***What do you propose and why?***

This is a pretty straightforward proposal - we read the accreditation manual - or at least get failure enough to know it's contents and how all of it will apply to all of our services and we make changes to be sure that we are in line with the requirements for accreditation. This will consist of working with our ACHC accreditation team and all of our staff to be sure that we are at the right place at the right time to be successful in our move for ACHC accreditation and recognition.

6. Action Plan: How will you implement? 4Ws, 1H

This plan will be implemented by working together with our ACHC counterparts and moving the work we do to meet the standards published by ACHC where needed.

7. Study, Reflect, Plan Next Steps: ***How will you assure ongoing PDSA?***

This process will become the center of our QAPI work and be followed closely to be sure that we can meet our tri-annual survey requirements.

Suppliers	Inputs	Process	Outputs	Customers
MMHD	Current Process and workflows	Current state processes	Baseline for starting work	ACHC
ACHC	Standards and Conditions of Participation	ACHC Survey	Accreditation	MMHD
MMHD	Standard work and process improvement	QAPI	Improved patient outcomes	Those we serve
Those we serve	Patient Encounters	Patient Care	Improved patient outcomes	Those we serve
Those we serve	Improved patient experience	HCAHPS	Improved HCAHPS scores and overall view of the District	MMHD

ACHC Accreditation Master Plan

Solution	Task Name	Assigned to:	Est. Start	Actual Start	Est. Finish	Actual Finish	% Complete	NOTES	Last Updated
1	**Assess Current State**	**Jack**	**1/1**				0%		
1.1	Meet with the ACHC clinical and life safety teams and conduct a self assessment of our current state survey readiness.	Clinical and Life/Safety Teams, Jack	1/18				0%		
1.2	Based on results of self assessment form plans for bridging the gaps.	Jack					0%		
1.3	Work with leadership using LEAN principles to implement changes and create new standard work for meeting the needed changes	Jack					0%		
							0%		
2	**Educate Standard Work**	**Jack**	**2/1**				0%		
2.1	Put the standard work out for staff to review and give feedback.						0%		
2.2	Take feedback and integrate into feedback as appropriate						0%		
2.3	Confirm standard work and publish as final						0%		
2.4	Educate final standard work out for staff						0%		
2.5	Have staff redemonstrate standard work to freeze change						0%		
2.5	Hold standard work as expectation for the process						0%		
							0%		
							0%		
3	**Monitor new process**	**Jack**	**3/1**				0%		
3.1	Work with monthly feedback from work groups to identify any gaps in performance identified through audits						0%		
3.2	Focus on gaps and see if there is additional improvement for process that has been created						0%		
3.3	Continue to educate expectations or changes as necessary depending on what is discovered in audits						0%		
							0%		
							0%		
							0%		
4	**Survey**	**Jack**	**5/1**				0%		
4.1	Survey with ACHC for accreditation.						0%		
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Standardized Work Sheet

Process:

Owner: **Revision #:** **Trigger:** **Takt Time:**

Revised by: **Last Update:** **Done:** **Work in Process:**

Sequence	**Major Process Steps** (Include main steps that advance the process)	**Responsibility** (Role)	**Key Points** (Provides the "How to")	**Reasons** (Describe why the job is done in the particular way	Notes

#	Task	Owner	Q1			Q2			Q3			Q4			Status
			J	F	M	A	M	J	J	A	S	O	N	D	
1															
2															
3															
4															
5															
6															
7															

Status: Not Yet Started | On Schedule | Behind Schedule | Complete

MMHD SNF Blood Pressure Medication Administration A3

True North -

Sponsor: Keith Earnest **Process Owner:** Britany Hammons **Author:** Jack Hathaway **Revision #:** 1

Team: SNF/Pharm **Trainee:** N/A **Last Update:** 12/14/22

1. Background: *What problem are you talking about and why?*

As a normal part of monthly reviews our Pharmacist follows administration of medications in our skilled nursing. This review found a trend that some blood pressure medications were being given incorrectly - outside of order parameters.

2. Current Conditions: Where do things stand now?

Currently, after tracking and education and work with the providers to make orders more clear for staff, we have found that this trend is on the right path; there has been a reduction of this kind of error in skilled nursing. Monthly reviews are still a normal part of our review process and they have shown improvemnet.

3. Target Conditions (Goal(s)): *What specific outcome is required?*

Our goal is to have a zero harm and highly reliable process where we know that all medications are given to our residents in skilled nursing are given following all of the parameters of the orders that the providers have given. The specific outcome required is that we become 100% effective in our medication administration in the skilled nursing facility.

4. Gap Analysis: *Why does the problem or need exist?*

From our initial analysis we found that checking the vitals (blood pressure) before the administration of blood pressure medication, was not happening in an effective manner. At times CNAs would check the blood pressure and there was no standardized process for the necessary communication to the nurse administering the medication. If fact, there was no standard work on communicating blood pressure information at all - so if the measured pressure was extremely high or low there was no standard communication to the nurses to alert them to the issues found by the CNAs. We also found that at the time it was not a common practice for nurses administering medications to check vitals themselves before administering medications. This led to nurses administering medications being unaware of blood pressures and therefore not being able to follow the order parameters - because they did not know if the blood pressure fell within the parameters for administering the medication.

5. Experiments: *What do you propose and why?*

Education is vital to helping staff understand the why behind the ask. To address this education is centered around communicating expectations held for staff that they follow orders and why that is so important to follow orders including the parameters around the orders that have to do with vitals and give/hold instructions from providers. Additionally, when conventional education and explainiations of why do not lend themselves to improvement we will move to individal coachng and other specific individually designed interventions that can work at the individual staff level.

6. Action Plan: How will you implement? 4Ws, 1H

Who: At the end of the month pharmacy supplies us with data about our success in following order parameters for administering blood pressure medications (and all other medications) as a part of his monthly review. Then we pass that information along to Brit who can then have conversations (when necessary) with staff to continue to see improvements.
What: Monthly review from pharmacy is the key to this improvement data.
When: This will be followed monthly until we come to a level of compliance that we are comfortable with as a team (over 95% success in compliance with order parameters)
Where: This is a project that is in Skilled Nursing.
How: Keith (our pharmacist) will continue to provide information to us with his monthly reviews and we then (Theresa, Brit, and myself) will continue to analyze the data and take needed actions (education, coaching, planning for additional change, and so on) to be sure that we can meet this change in process as needed to deliver the best care possible.

7. Study, Reflect, Plan Next Steps: *How will you assure ongoing PDSA?*

This process will be monitored monthly until we have 3 consecutive months of success (95% or better) then it will be monitored quarterly moving forward.

Suppliers	Inputs	Process	Outputs	Customers
Providers	Medication order parameters	Medication Ordering	Safe and necessary medication administration	Nurses
Nurses	Medications out for administration	Medication Administration	Safe and necessary medication administration	Residents
Residents	Vitals for measurement	Taking Vitals (SNF)	Measurement of vitals to inform care for our residents	Nurses
Nurses	Decision to give or hold medications	Medication Administration	Safe and necessary medication administration	Residents

Plan									
Solution	Task Name	Assigned to:	Est. Start	Actual Start	Est. Finish	Actual Finish	% Complete	NOTES	Last Updated
1	**Create Standard Work**	**Brit, Jack**	**1/1**				0%		
1.1	Create a standard work for nursing to have for medication administration and the expectations around screening vitals in relation to order parameters.	Brit, Jack	1/1				0%		
							0%		
							0%		
							0%		
2	**Educate Standard Work**		**1/10**				0%		
2.1	Put the standard work out for staff to review and give feedback.						0%		
2.2	Take feedback and integrate into feedback as appropriate						0%		
2.3	Confirm standard work and publish as final						0%		
2.4	Educate final standard work out for staff						0%		
2.5	Have staff redemonstrate standard work to freeze change						0%		
2.5	Hold standard work as expectation for the process						0%		
							0%		
							0%		
3	**Monitor new process**		**2/1**				0%		
3.1	Work with monthly feedback from pharmacy to identify any gaps in performance identified through audits						0%		
3.2	Focus on gaps and see if there is additional improvement for process that has been created						0%		
3.3	Continue to educate expectations or changes as necessary depending on what is discovered in audits						0%		
3.4							0%		
							0%		
							0%		
4	**Amend process as necessary**		**3/1**				0%		
4.1	Based on feedback from staff and audit process adjust standard work as necessary to ensure that we are best serving our residents and our medication administration process is flawless.						0%		
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Standardized Work Sheet

Process: Administering medications

Owner: **Revision #:** 1 **Trigger:** Administering medications to residents **Takt Time:**

Revised by: **Last Update:** 12/19/2022 **Done:** **Work in Process:**

Sequence	**Major Process Steps** (Include main steps that advance the process)	**Responsibility** (Role)	**Key Points** (Provides the "How to")	**Reasons** (Describe why the job is done in the particular way	Notes
1	Assess patient and take a set of vitals to be aware of vitals and their relationship to order parameters	Nurse administering medications	Before administering medications to residents - always check vitals to be sure that they fall within order parameters.	According to policy and best practices providers are allowed to make parameters for orders to ensure that medications are used when needed and held when they are not. This serves resident centered care and ensures that residents only get the medications that they are in need of and no medications that are unnecessary.	
2	Review orders to see if there are applicable parameters that have been met or triggered by the vitals that were just taken	Nurse administering medications	Administering nurse should be sure that vitals are with in any parameters given by the provider.	Parameters are set by providers because they feel they are necessary for residents to be receiving their best care.	
3	Administer medications based on vitals and parameters that are applicable	Nurse administering medications	If vitals show that the medication should be held - hold the medication. If the vitals show that the medication should be administered administer the medication.	Following orders is an essential part of excellent care.	This point - of following orders - is not meant to replace the critical thinking skills of our nurses. If there are issues with an order, or the nurse has made observations that are reasonably believed to effect an order or their parameters, the nurse should reach out to the provider and make their observations known so orders can as accurate and effective as possible.
3b	If vitals are out of parameters and indicate that medications should not be given - hold medications	Nurse administering medications	If the parameters around the order indicate in hold the medication - hold the medication.		
4	Complete administering medications to resident as indicated by orders and provider set parameters - and document actions taken and why	Nurse administering medications			

#	Task	Owner	Q1			Q2			Q3			Q4			Status
			J	F	M	A	M	J	J	A	S	O	N	D	
1															
2															
3															
4															
5															
6															
7															

Status: Not Yet Started | On Schedule | Behind Schedule | Complete