Agenda
MCHA
July 27, 2021 at 5:00 PM
City Administration Building 130 N Oklahoma Ave

The Trustees of the Mangum City Hospital Authority will meet in regular session on Tuesday, July 27, 2021, at 5:00 PM, in the Mangum City Administration Building at 130 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Trustees.

CALL TO ORDER

ROLL CALL AND DECLARATION OF A QUORUM

CONSENT AGENDA
The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

1. Approve June 22, 2021 regular meeting minutes.
2. Approve 6-10-21 QAPI minutes.
3. Approve 6-17-21 Medical Staff minutes.
4. Approve Claims for July 2021 and Estimated Claims for August 2021
5. Approve renewal of our agreement with the Oklahoma Blood Institute.
6. Approve Clinic Operations Report.
7. Approve CCO Report.
8. Approve CEO Report.
9. Approve the following policy revisions and updated formularies.

    Approval of Policy & Procedure: LS-400 Security Management Plan

    Approval of Policy & Procedure: LS-500 Fire Management Plan

    Approval of Policy & Procedure: LS-600 Equipment Management Plan

    Approval of Policy & Procedure: LS-700 Hazardous Materials Management Plan

    Approval of Policy & Procedure: LS-300 Utility Management

    Approval of Policy & Procedure: LS-305 Electrical Wiring

    Approval of Policy & Procedure: LS-306 Elevator

Approval of Policy & Procedure: GEN – 026A Consent for Photography/Multimedia and Authorization for Use or Disclosure

Approval of Policy & Procedure: GEN-026 Photography and Multimedia Imaging

Approval of Policy & Procedure: Emergency Department Policies - Table of Contents

Approval of Policy & Procedure: EMD-017A Pediatric Sepsis Screen

Approval of Policy & Procedure: EMD-017B Pediatric Sepsis Standing Orders

Approval of Policy & Procedure: EMD-017C Pediatric Sepsis Guidelines

Approval of Policy & Procedure: Nursing Services Policies - Table of Contents

Approval of Policy & Procedure: Nursing - 026B Adult Sepsis Standing Orders

Approval of Policy & Procedure: Nursing – 026 Sepsis - Care and Management Guidelines for the Adult Patient

Approval of Policy & Procedure: Nursing – 026A Adult Sepsis Screen

Approval of Updated Formulary: Casirivimab/Imdevimab (Combination Therapy) Emergency Use Authorization (EUA) Standing Orders

Approval of Fact Sheet for Patients, Parents and Caregivers – Emergency Use Authorization (EUA) of Regen-COVtm (casirivimab andimdevimab) for Coronavirus Disease 2019 (COVID-19)

Approval of Updated Formulary: Bamlanivimab/Etesevimab (Combination Therapy) Emergency Use Authorization (EUA) Standing Orders

Approval of Fact Sheet for Patients, Parents and Caregivers: Emergency Use Authorization (EUA) of Bamianivimab and Etesevimab for Coronavirus Disease 2019 (COVID-19)

FURTHER DISCUSSION

REMARKS
Remarks or inquiries by the audience not pertaining to any item on the agenda.

REPORTS

10. Financial Report

OTHER ITEMS

11. Discussion and possible action regarding our engagement of BKD CPAs & Advisors to prepare the Medicare cost report for Mangum Regional Medical Center for the year ended December 31, 2020.

12. Discussion and possible action regarding our Respiratory Protection Program Evaluation Summary for 2021.

13. Discussion and possible action regarding the appointment of Karli Bowles, RN, Respiratory Program Administrator.

14. Discussion and possible action regarding a Hospital debit card for the payment of specific board approved services such as a currently needed Language Line service.

EXECUTIVE SESSION

15. Discussion and possible action regarding the review and approval of medical staff privileges/credentials/contracts of the following providers with possible executive session in accordance with 25 O.S 307(B) (1):

OPEN SESSION

16. Discussion and possible action with regard to executive session, if necessary.

STAFF AND BOARD REMARKS
Remarks or inquiries by the governing body members, City Manager, City Attorney or City Employees

NEW BUSINESS
Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

ADJOURN

Duly filed and posted at **3:00 p.m. on the 23rd day of July, 2021**, by the Secretary of the Mangum City Hospital Authority.

_____
Billie Chilson, Secretary

Minutes
Mangum City Hospital Authority MeetingSession
June 22, 2021 at 5:00 PM
Mangum City Annex at 131 N Oklahoma Ave.

The Trustees of the Mangum City Hospital Authority will meet in regular session on Tuesday, June 22, 2021, at 5:00 PM, in the City Hall Annex at 131 N. Oklahoma Ave, Mangum, OK for such business as shall come before said Commission.

CALL TO ORDER

Chairman Vanzant called the meeting to order at 5:09 pm

ROLL CALL AND DECLARATION OF A QUORUM

PRESENT

Trustee Cheryl Lively
Trustee Ilka Heiskell
Trustee Laretha Vincent
Trustee Carson Vanzant

ALSO PRESENT

Billie Chilson, City Clerk/Secretary
Corry Kendall, City Attorney

CONSENT AGENDA
The following items are considered to be routine and will be enacted by one motion. There will be no separate discussion of these items unless a Board member (or a community member through a Board member) so requests, in which case the item will be removed from the Consent Agenda and considered separately. If any item involves a potential conflict of interest, Board members should so note before adoption of the Consent Agenda.

Approve items 1 through 7 as presented and remove items 8 through 15.

Motion made by Trustee Heiskell, Seconded by Trustee Lively.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

1. Approve May 28, 21 Special meeting minutes.
2. Approve 5-13-21 MRMC Quality Minutes.
3. Approve 6-15-21 MRMC Quality Ad Hoc minutes.
4. Approve 5-20-21 MRMC Medical Staff minutes.
5. Approve May 2021 Actual Claims and the July's Estimated Claims.
6. Approve MRMC Quality Management Report.

7. Approve Clinic Operations Report.

FURTHER DISCUSSION

Items 8 through 15 were discussed and approve as numbered below.

8. Approve CCO Report.

Daniel gave the CCO Report with the following highlights for the month of May 2021.

Excellent Patient Care

- Monthly Education topics included: Catheter Securement devices and uses, Peripherally Inserted Central Catheter Management.
- Non-Clinical staff initiated Rapid Response Code due to patient presentation including diaphoresis, facial flushing, and substernal chest pain. On duty staff responded, assessed, and transported the patient to Emergency Department within seconds.
- Emergency Department provided rapid treatment and transfer to a STEMI patient. Patient returned to work within just a few days.
- Respiratory, Nursing and Provider teams collaborated to wean and graduate a 2-year ventilator patient to Nasal Canula and C-Pap. Patient is looking forward to discharging home.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days increased from 281 in April to 345 in May. This represents an average daily census of 11.13. In addition, our ER and volumes continue to trend upward.
- May COVID-19 Stats at MRMC: 82 Swabs (39-PCR & 43-Antigen) 82 Negatives!
- Greer County May COVID-19 Statistics: 584 Positive Cases and 22 Deaths (3.77% death rate).

Preserve Rural Healthcare

Mangum Regional Medical Center												
2021 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Inpatient	15	15	11	16	36							
Swing Bed	10	20	13	19	22							
Observation	0	2	1	2	1							
Emergency Room	104	133	127	143	149							
Lab Completed/ Rad completed	2140/ 180	2286/ 246	2387/ 223	1984/ 222	1964 /200							

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN, and CNA.
- Open Director positions include Rehabilitation.
- For the clinical team MRMC has Hired the following core positions: Monitor Tech/Registration Clerk and LPN!
- Interviewing Core Candidates for Director of Quality/Risk Management

- Recruiting efforts included positing of positions on mangumregional.net and Facebook.
  - Hospital Week was a huge success! Staff received daily delicious meals and awesome gifts. Giveaways included Coin Collections, Gift Certificates, a Big Screen TV- totaling in values of over $3,000.00!!

9. Approve CEO Report.

Dale Clayton CEO gave his report as follows:

COVID - 19 Activity and Overview:

✓ We continue to participate in daily Region 3 Merc briefings.
✓ The Cohesive Task Force provided updated visitation policy for all patients who are not COVID-19 positive. This policy allows two visitors at a time who have been properly screened through the COVID screening protocol, agrees to properly observe hand hygiene and always appropriately wearing their mask while in the facility.
✓ Cohesive and hospital leadership continue to ensure the staff and providers are kept up to date regarding any changes or new policies pertaining to COVID-19.
✓ Participated in all OSDH Region 5 Vaccine Planning Meetings.

Hospital Staff and Operations Overview:

✓ Open positions include (1) Accounts Payable, (1) LPN and (2) RNs.
✓ We have several new positions filled recently. Matt Moran, IT Tech; Denise Jackson, RN, Quality Director; Chasity Howell, RN, Case Manager; Narmeen Vegdani, Full Time Contract PT; Kristen York, Dietary.
✓ New hires joining us soon are Brooke Rodriquez, RN and Stella O'Neal, MLT, Lab Tech.
✓ We are continuing the process of interviewing ER Providers for weekend shifts to replace the Residents who will be leaving the end of June.
✓ The Directors of each department have been working with the CEO and CCO regarding COVID expenses and purchases.
✓ The Directors of each department have been working with the CEO and CCO regarding Cares Act equipment purchases.
✓ Our census has remained good throughout May.
✓ We received our Oklahoma Department of Health hospital license renewal which is posted in the hospital.
✓ The staff has received a lot of positive feedback from patients and family members regarding the care received from the staff and providers.

10. Approve renewal of Greer County Health Dept. and MRMC Radiology Agreement.

Motion to approve the Greer County Health Dept. and MRMC Radiology Agreement.

Motion made by Trustee Vanzant, Seconded by Trustee Vincent.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

11. Approve appointment of Denise Jackson as the Quality/Risk Manager.

Motion to approve the appointment of Denise Jackson as the Quality/Risk Manager.

Motion made by Trustee Lively, Seconded by Trustee Heiskell.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

12. Approve appointment of Denise Jackson as the Compliance Officer.

Motion to approve appointment of Denise Jackson as the Compliance Officer.

Motion made by Trustee Heiskell, Seconded by Trustee Lively.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

13. Approve the appointment of Matthew Moran as the HIPAA Security Officer.

Motion to approve the appointment of Matthew Moran as the HIPAA Security Officer.

Motion made by Trustee Lively, Seconded by Trustee Vanzant.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

14. Approve Andrea Snider for access to First National Bank MRMC accounts.

Motion to approve Andrea Snider for access to First National Bank MRMC accounts.

Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

15. Approve revisions of the following policies:

Attachments EMD-008E and EMD-008I

Attachment EMD-011D

Attachments NUR-006A – NUR-006B

Attachments NUR-023A - NUR-023I

Motion to approve revisions of the following policies:

Attachments EMD-008E and EMD-008I

Attachment EMD-011D

Attachments NUR-006A – NUR-006B

Attachments NUR-023A - NUR-02

Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

REMARKS

Remarks or inquiries by the audience not pertaining to any item on the agenda.

None.

REPORTS

16. Hospital Financial Reports.

Andrea Snider gave the financial report with the following highlights.

May 2021 Financial Statement Overview

- Statistics
    - The average daily census (ADC) for May 2021 was 11.13. This exceeded our target of 11.0 and resulted in a continued increase over April (9.33) & March

(7.84). As a reminder, the 2021year began with a 2-year ADC low of only 5.90 in January. YTD the ADC for Mangum has now rebounded to 9.11.

- FY21YTD Medicare swing bed patient days through May were 1,033 as compared to the PY total of 1,471(approximately -30%). Accordingly, this is an area of focus.
- We experienced an increase in collections in May ($817K) over April ($743K) due to the ADC increase in April over March (generally speaking there is approximately a one-month lag between the net revenue generated each month & the majority of the cash collected). Accordingly, the cash collections in June should result in a material increase over May and a very material increase over April.

- Balance Sheet Highlights

  - The operating cash balance as of May 31st was $185K. This decrease of $100K from the April 2021 balance was primarily due to material payments made towards vendors combined with the YTD impact of an ADC still materially lower than our target of 11.0.
  - AR increased $186K from April. This was primarily volume-driven as the facility continued its rebounding trend to an ADC of 11.13.
  - The facility paid down approximately $273K in AP and cash receipts were approximately $74K greater than in April. The hospital also continues to make payments on MCR ERS loans of approximately $90K per month.

- Income Statement Highlights

  - Current month gross patient revenue is higher compared to PY primary due to OP volumes (COVID had a much higher impact on OP CAH & clinic volumes in FY20).
  - Current month total operating revenue is $176K higher than the prior year - primarily due to the increase in gross revenue & the recognition of COVID grant revenue ($610K). These increases, however, were materially offset by a MCR receivable ($792K) estimate recorded in May of FY20. *** The recognition of the $610K grant revenue is the driver of the positive margin in May.
  - Operating expenses remain very consistent with the prior year overall. Interest expense has materially decreased due to the cost report settlement applied to 2016 & 2017 Medicare ERS loans.
  - For the current month of May 2021, operating expenses were $80K over the APRIL YTD monthly average. This appears to be exclusively related to salary & benefits & is being investigated further at this time.

- Other

- Other attached reports include an income statement trend, CY financial statement comparisons to FY17-FY20, Accounts Payable Aging and estimated claims lists - updated estimated June claims list showing payments made MTD and the July 2021 estimated claims list.

OTHER ITEMS

17. Discussion and possible action regarding Mangum Drug Co. 340B Pharmacy Services Agreement.

    Motion to approve the Mangum Drug Co. 340B Pharmacy Services Agreement.

    Motion made by Trustee Heiskell, Seconded by Trustee Lively.
    Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

18. Discussion and possible action regarding Puckett Discount Drug 340B Pharmacy Services Agreement.

    Motion to approve the service agreement with Puckett Discount Drug 340B Pharmacy

    Motion made by Trustee Heiskell, Seconded by Trustee Vanzant.
    Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

19. Discussion and possible action regarding the review and approval of the COVID Grant Agreements/Contracts.

    ICU Medical IV Pumps

    APEX Medical Gas Upgrade

    Critical Alert Nurse Call Light System

    TytoCare Telehealth

    Radiology HVAC

    Medical Gas Patient Room Headwalls

    Bluestream Telehealth

    KnowBe4 Inc. HIPAA Training

    GE Portable X-Ray Machine

    GE X-Ray Machine

    GE Ultrasound Machine

    Motion to approve the COVID Grant Agreements/Contracts listed in the agenda item above.

    Motion made by Trustee Vanzant, Seconded by Trustee Vincent.
    Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

20. Discussion and possible action regarding the review and approval of additional COVID Grant Funds and Agreements/Contracts/Invoices.

GE 64 Slice Revolution Maxima CT Scanner

I-STAT Lab Testing System

GE X-Ray Machine Additional Service Agreement Expense

GE Portable X-Ray Machine Additional Service Agreement Expense

GE Ultrasound Machine Additional Service Agreement Expense

Linet ER Gurney Agreement

Dell Telemetry Server

TytoCare Telehealth Carts

OESCO Spacelabs Cabling

Evident Cardio Pulmonary CPSI Module

Evident Spacelabs & CPSI Interface

Misc. Covid Items List: Ultrasound Mattress; Sandbags for weighted X-Ray; Wipeable Positioning Kit; Lead X-Ray Aprons (5); Bariatric Patient Transfer Board

Motion to approve the additional COVID Grand Funds and Agreement/Contract/Invoices listed above.

Motion made by Trustee Vanzant, Seconded by Trustee Vincent.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

21. Discussion and possible action to approve the draft of the Settlement Agreement.

Motion to approve the draft of the Settlement Agreement.

Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

EXECUTIVE SESSION

22. Discussion and possible action regarding the review and approval of medical staff privileges/credentials of the following providers with possible executive session in accordance with 25 O.S. 307(B) (1):

a. Randy Benish, PA - Re-Credentialing

b. Suresh Chandrasekaran, MD - Re-Credentialing

Motion to enter into executive session at 6:20 pm.

Motion made by Trustee Vanzant, Seconded by Trustee Heiskell.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant. Chairman Vanzant declared out of executive session at 6:28 pm

OPEN SESSION

23. Discussion and possible action with regard to executive session, if necessary.

Motion to approve the re-credentialing of the following:

a. Randy Benish, PA - Re-Credentialing

b. Suresh Chandrasekaran, MD - Re-Credentialing

Motion made by Trustee Heiskell, Seconded by Trustee Vincent.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

STAFF AND BOARD REMARKS
Remarks or inquiries by the governing body members, City Manager, City Attorney or City Employees

Chairman Vanzant said it has been an incredible month to be part of the Hospital Board. Thank you for everything the Hospital and employees are doing.

Cindy Tilman said thank you for all your support.

NEW BUSINESS
Discussion and possible action on any new business which has arisen since the posting of the Agenda that could not have been reasonably foreseen prior to the time of the posting (25 O.S. 311-10)

None.

ADJOURN

Motion to adjourn at 6:35 pm.

Motion made by Trustee Vanzant, Seconded by Trustee Vincent.
Voting Yea: Trustee Lively, Trustee Heiskell, Trustee Vincent, Trustee Vanzant

Billie Chilson, Secretary

Carson Vanzant, Chairman

Name of Facility
Critical Access Hospital
Quality Assurance and Performance Improvement Committee Meeting
Date of Meeting:

	Print Name	***Signature***
Chairman		
Administrator		
CCO		
QM		
Respiratory		
Drug Room Supervisor		
Physical Therapy		
Dietary		
Case Management		
HIM		
BOM		
Infection Control		
Radiology		
Plant Operations		
Materials Management		
Environmental Services		
Lab		
Human Resources		
Other		
Other		

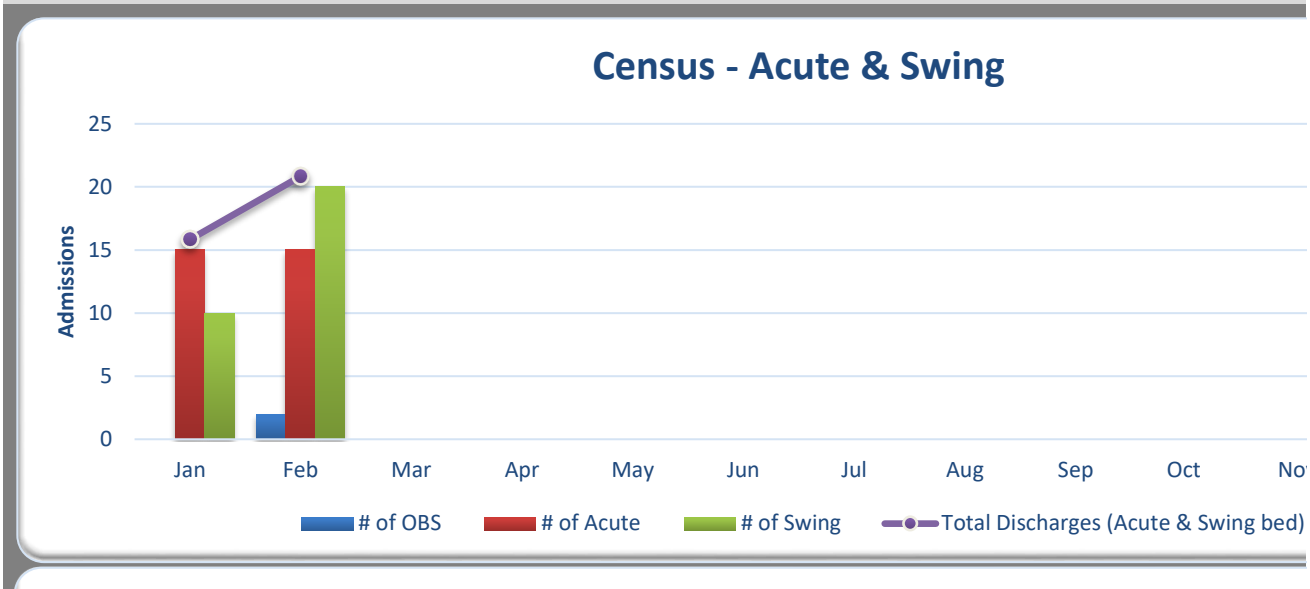
QUALITY CARE

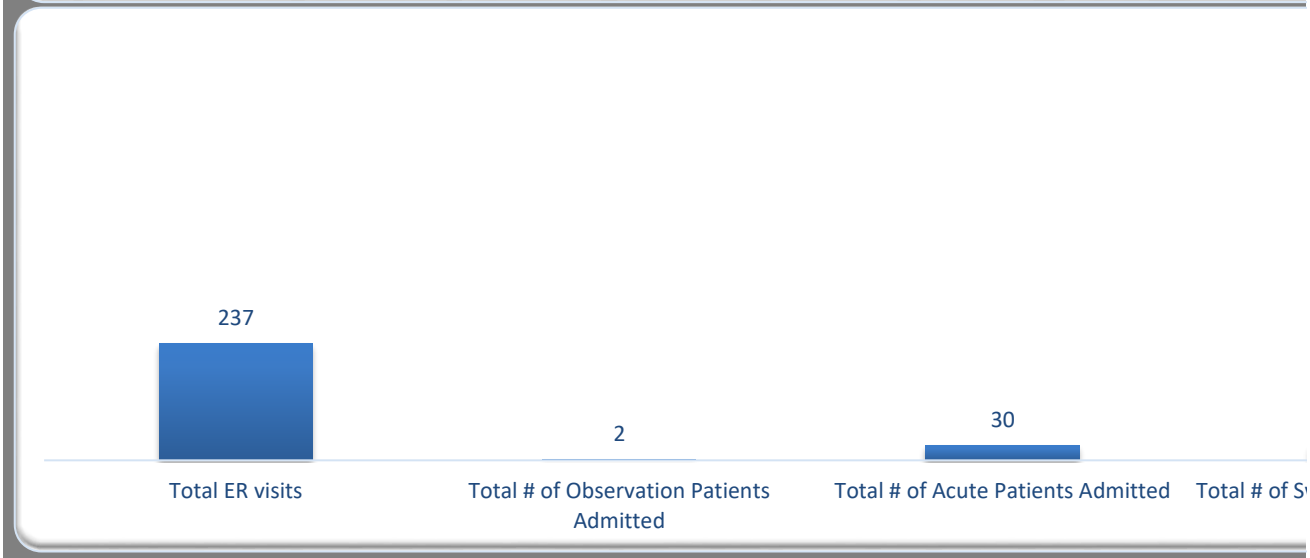
Name of Facility

QUALTIY ASSURANCE & PERFORMANCE IMPROVEMENT REPORT

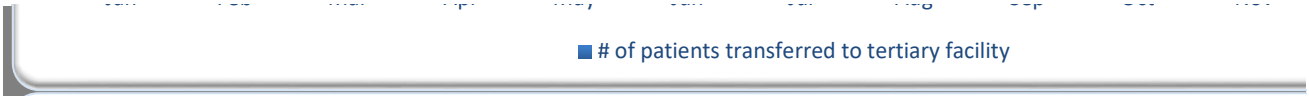
REPORTING PERIOD

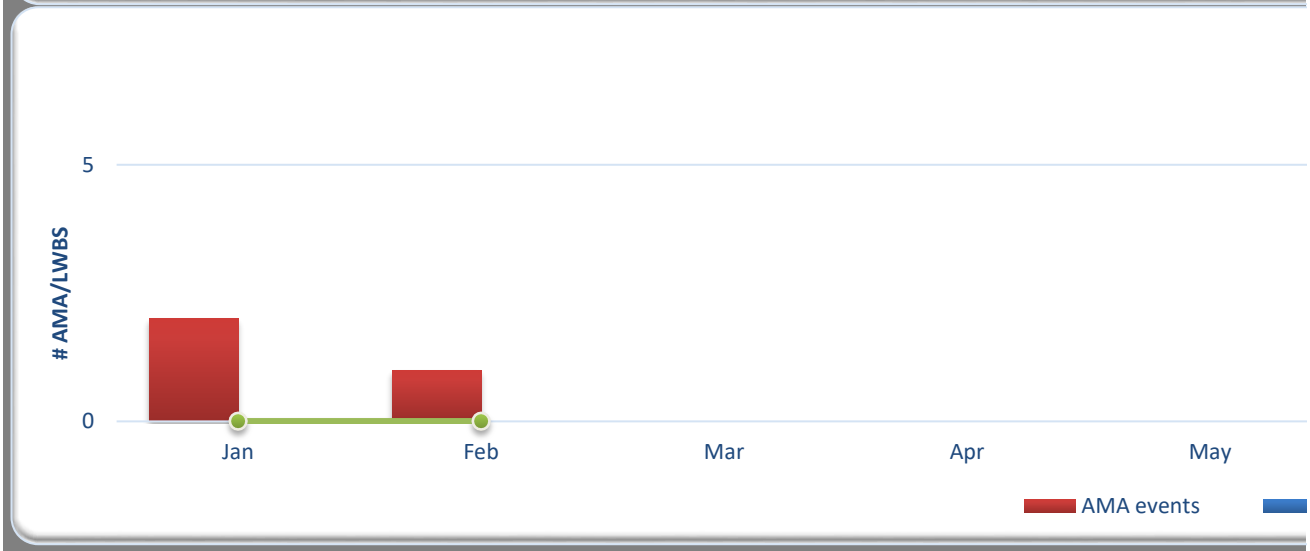
Date: Revised 2021

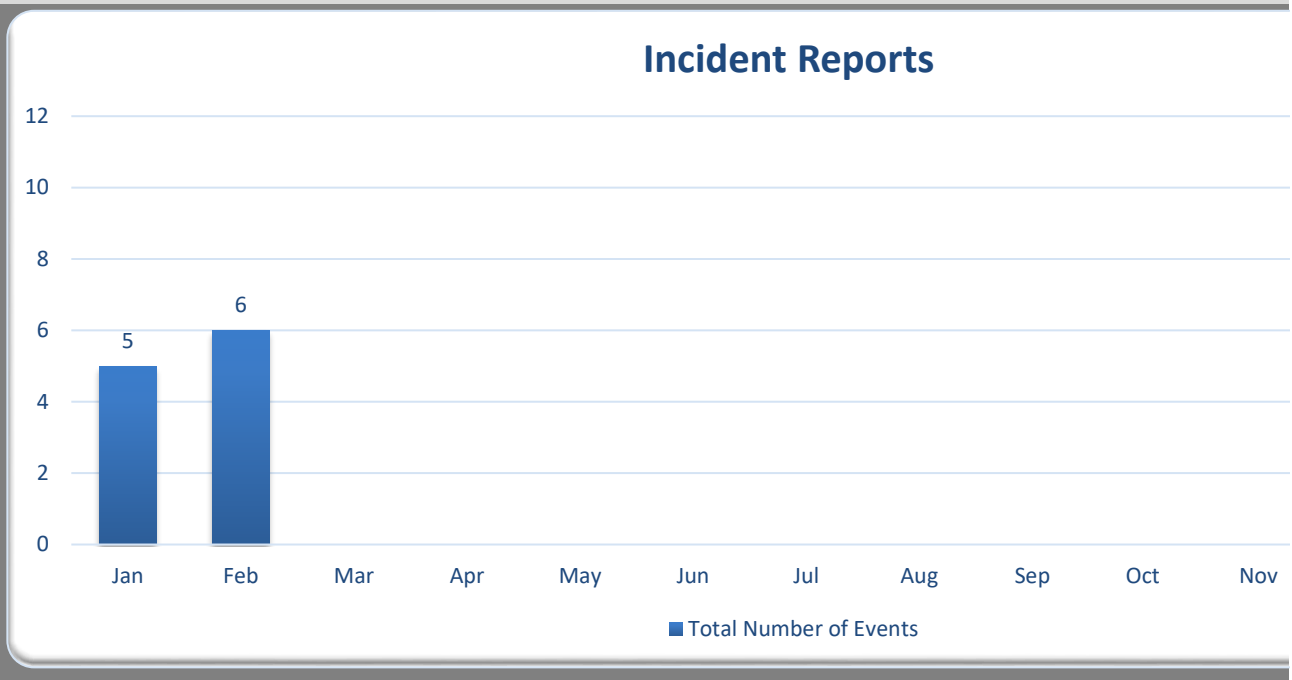

Census - Acute & Swing
25
20
15
10
5
0
Admissions
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
# of OBS
# of Acute
# of Swing
Total Discharges (Acute & Swing bed)

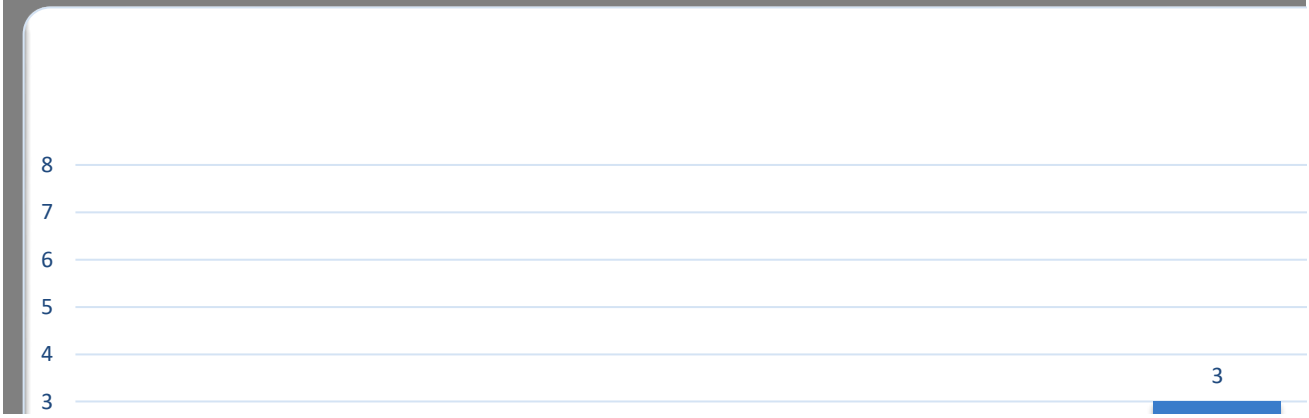

237
2
30
Total ER visits
Total # of Observation Patients Admitted
Total # of Acute Patients Admitted

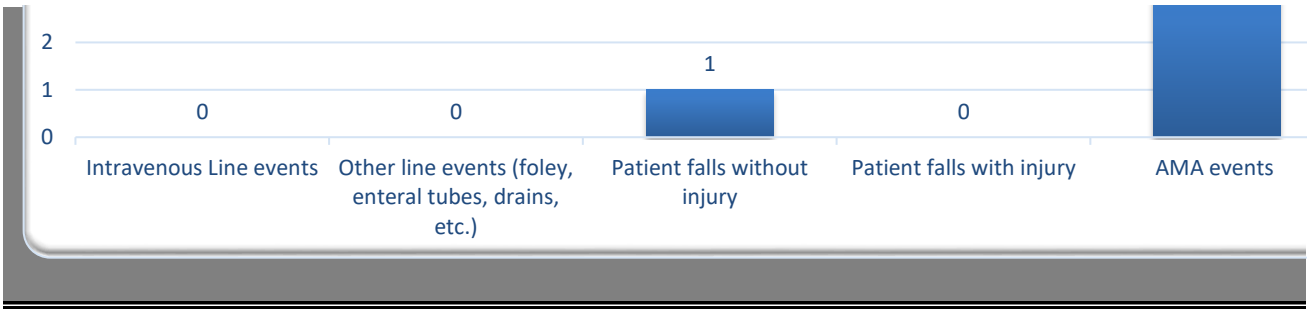

Transfers
5
0
1
1
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov

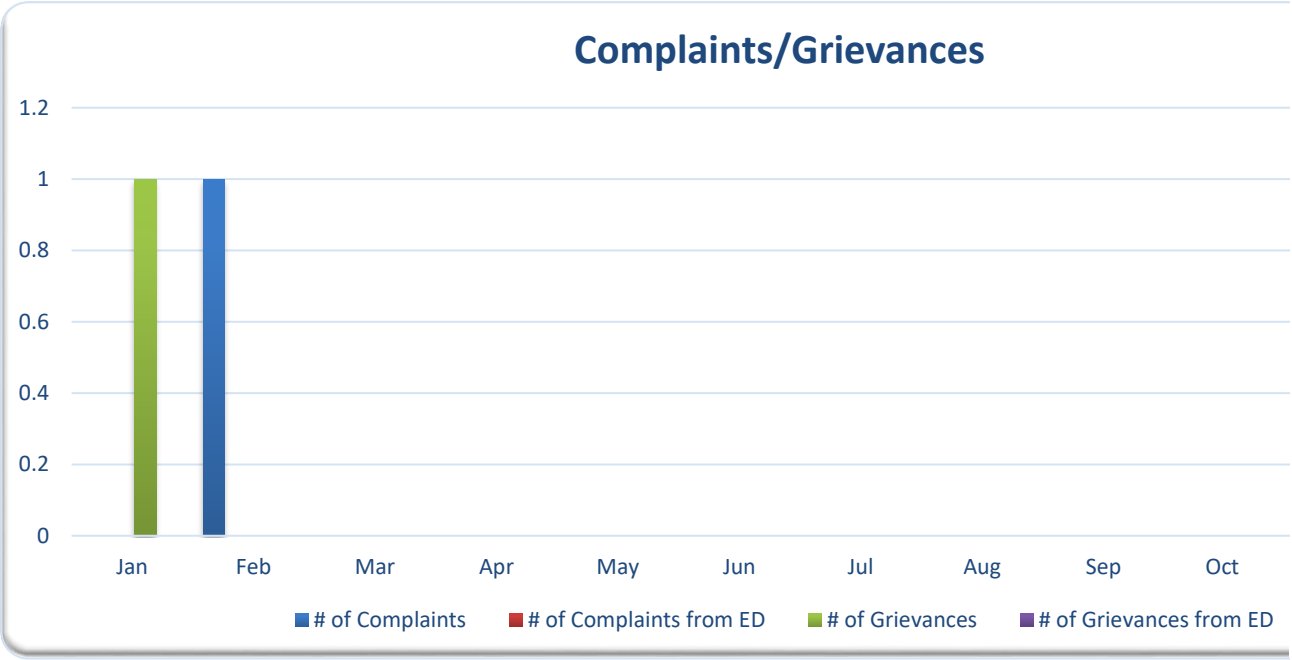

# of patients transferred to tertiary facility

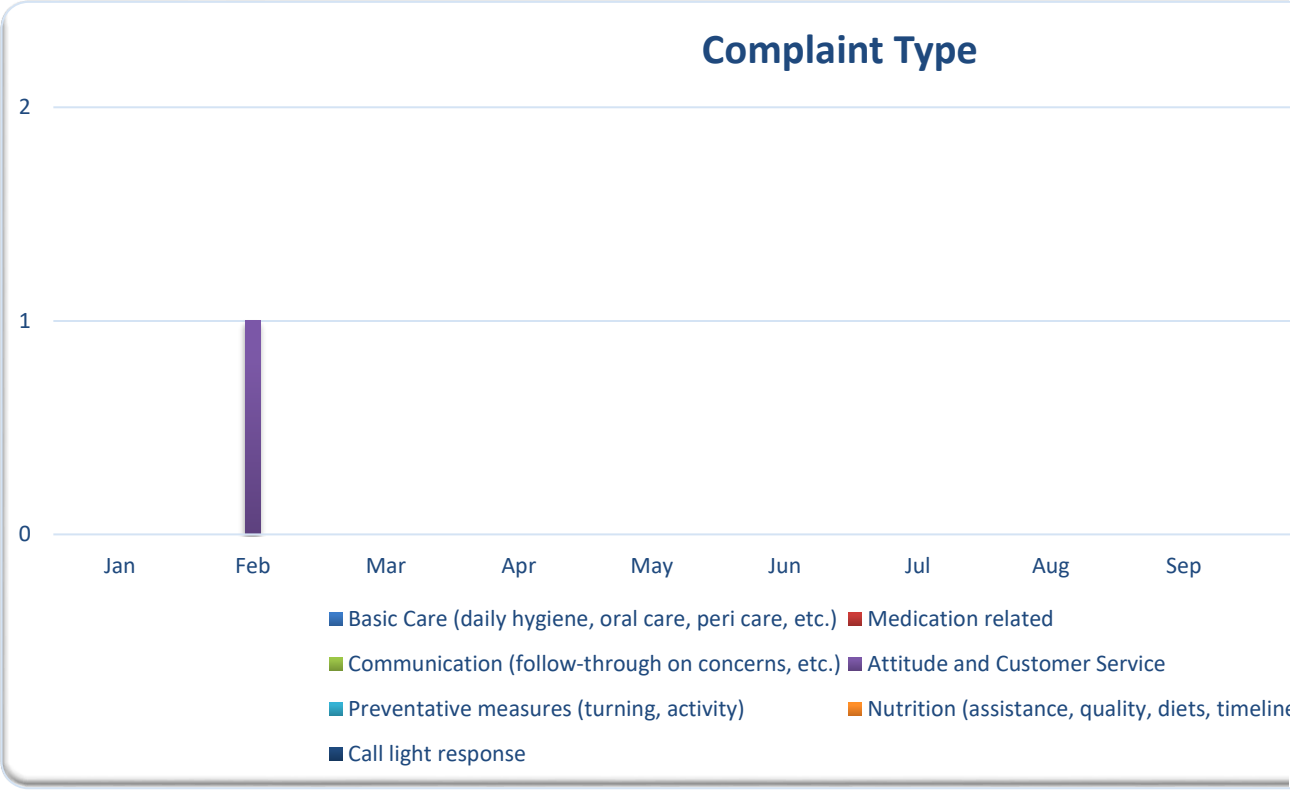

5
AMA/LWBS
0
Jan
Feb
Mar
Apr
May
AMA events

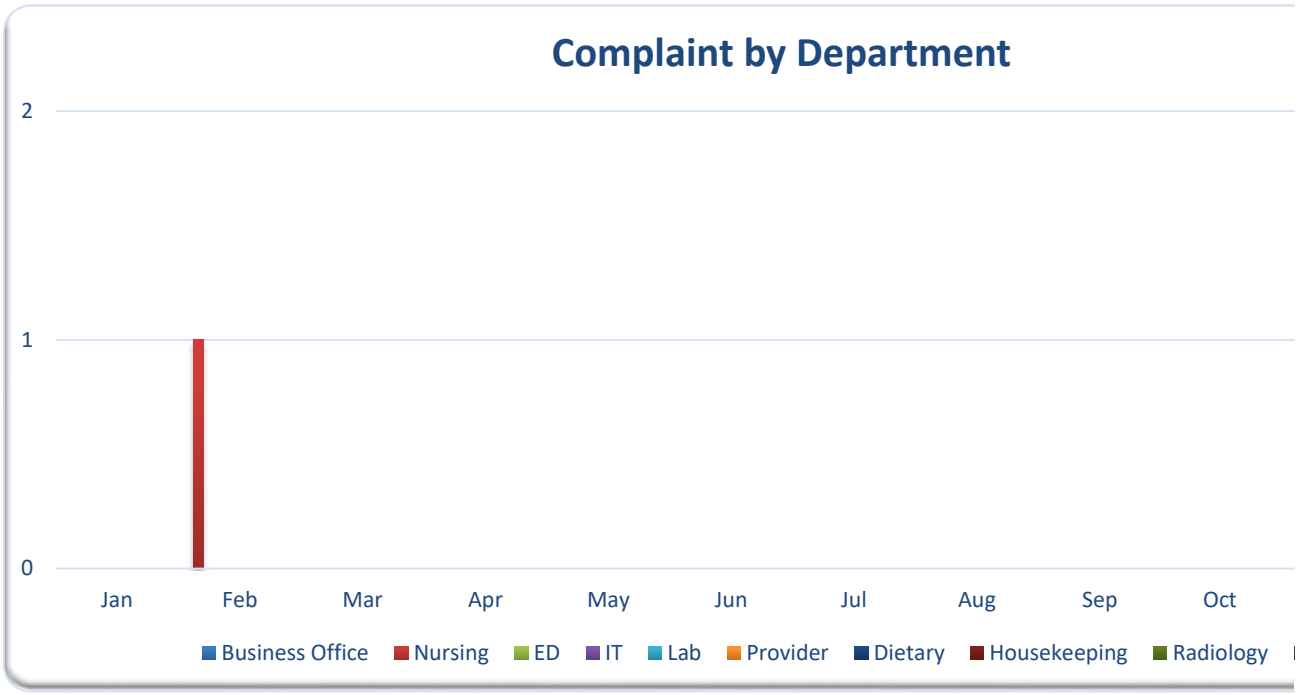

Incident Reports
12
10
8
6
4
2
0
5
6
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Total Number of Events


8
7
6
5
4
3
3

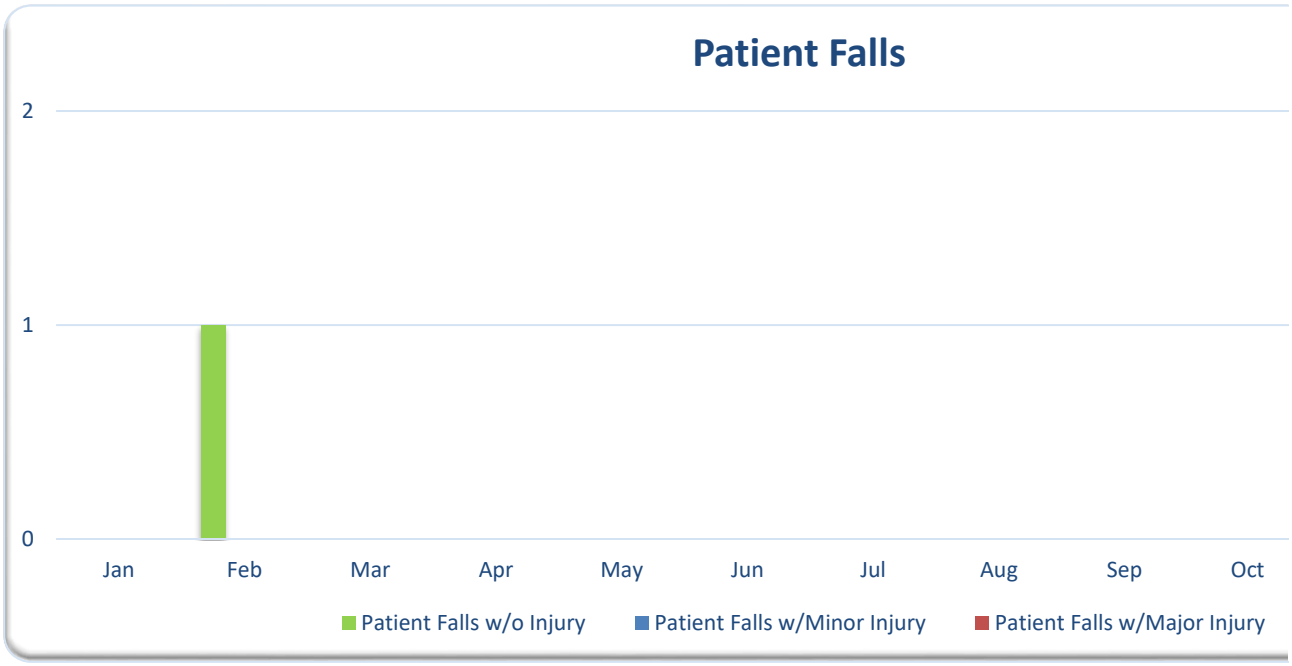

2
1
0
0
0
1
0
Intravenous Line events
Other line events (foley, enteral tubes, drains, etc.)
Patient falls without injury
Patient falls with injury
AMA events

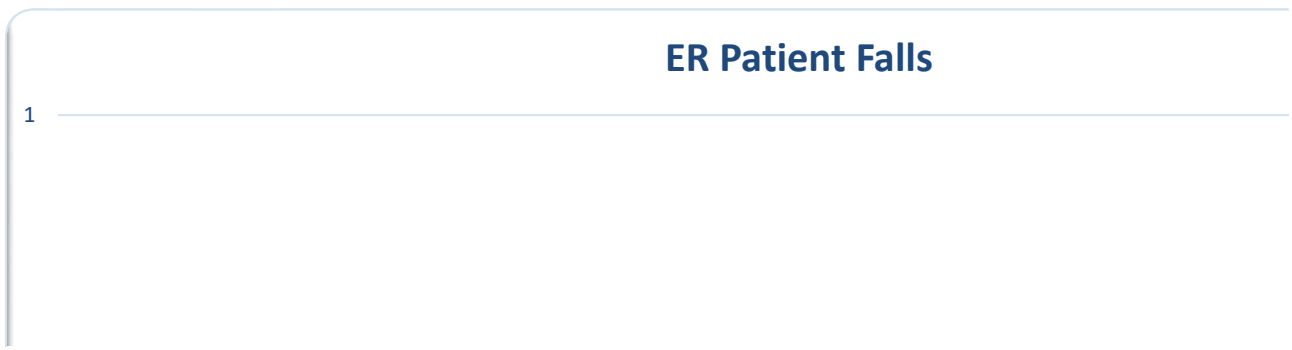

Complaints/Grievances
1.2
1
0.8
0.6
0.4
0.2
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
# of Complaints
# of Complaints from ED
# of Grievances
# of Grievances from ED


Complaint Type
2
1
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Basic Care (daily hygiene, oral care, peri care, etc.)
Medication related
Communication (follow-through on concerns, etc.)
Attitude and Customer Service
Preventative measures (turning, activity)
Nutrition (assistance, quality, diets, timeline
Call light response

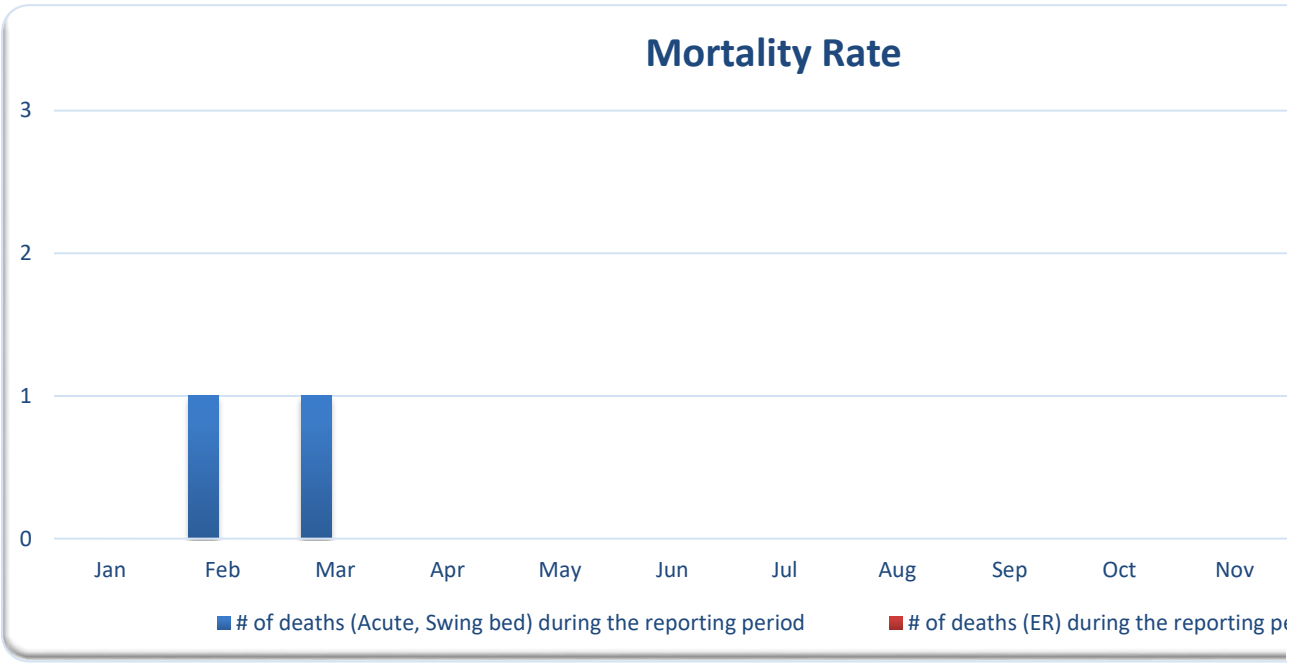


D. Patient Falls

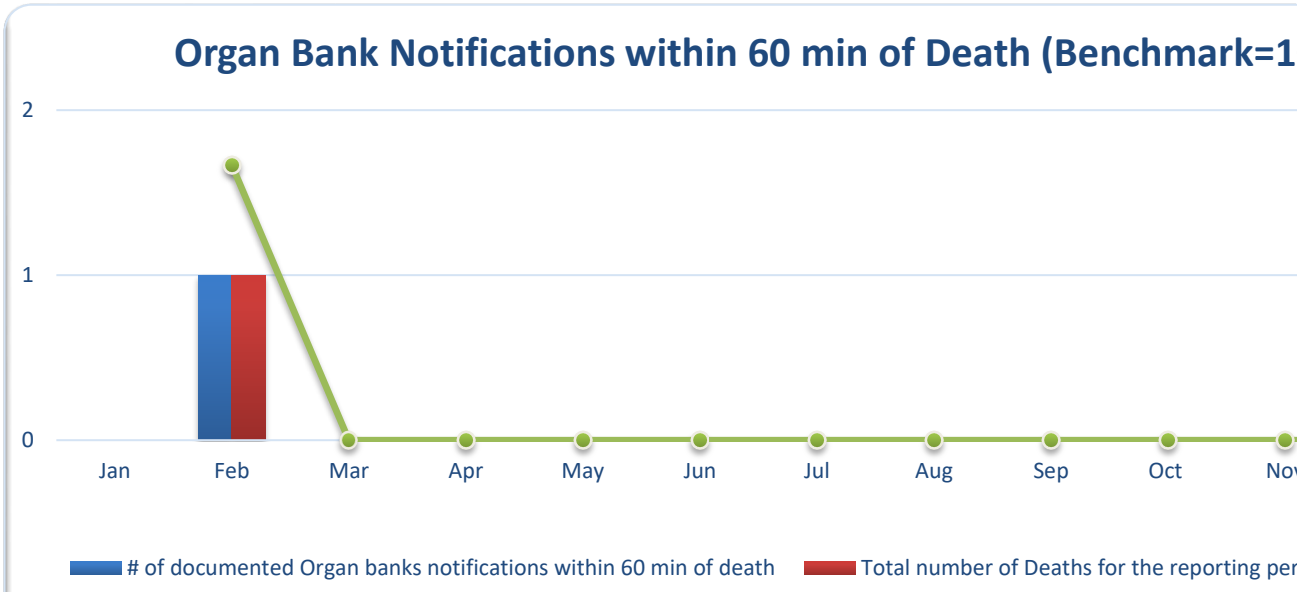




G. Mortality Rate

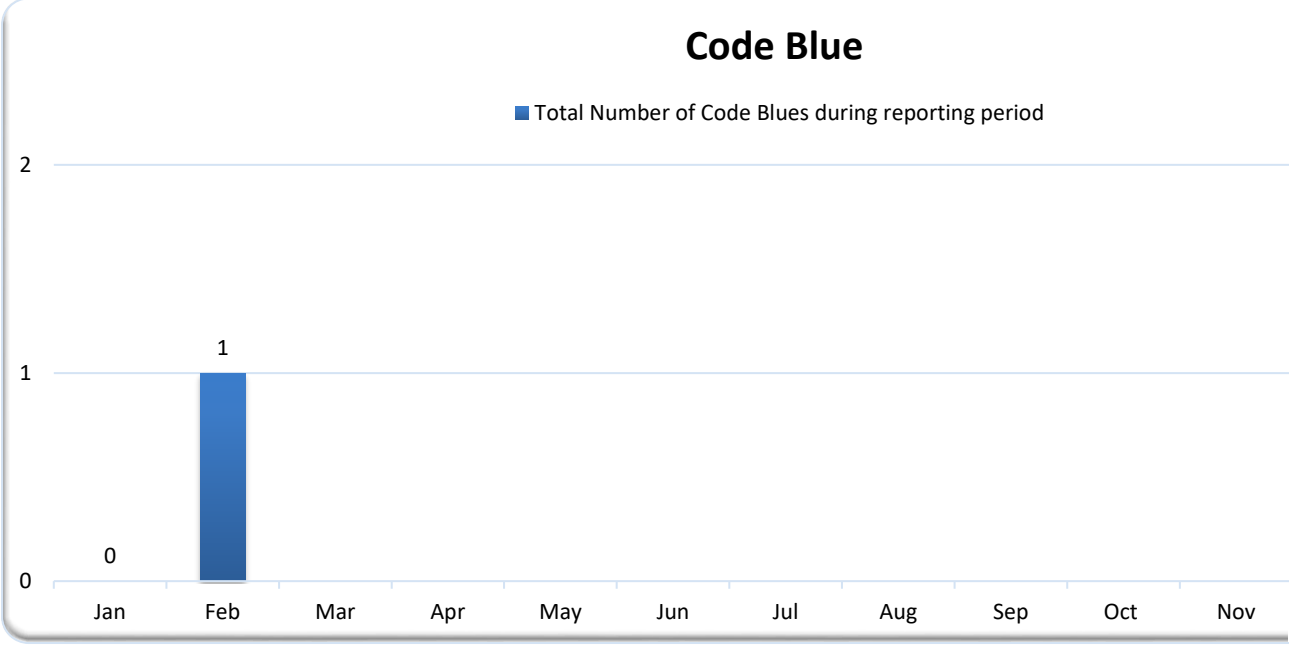


I. OPO

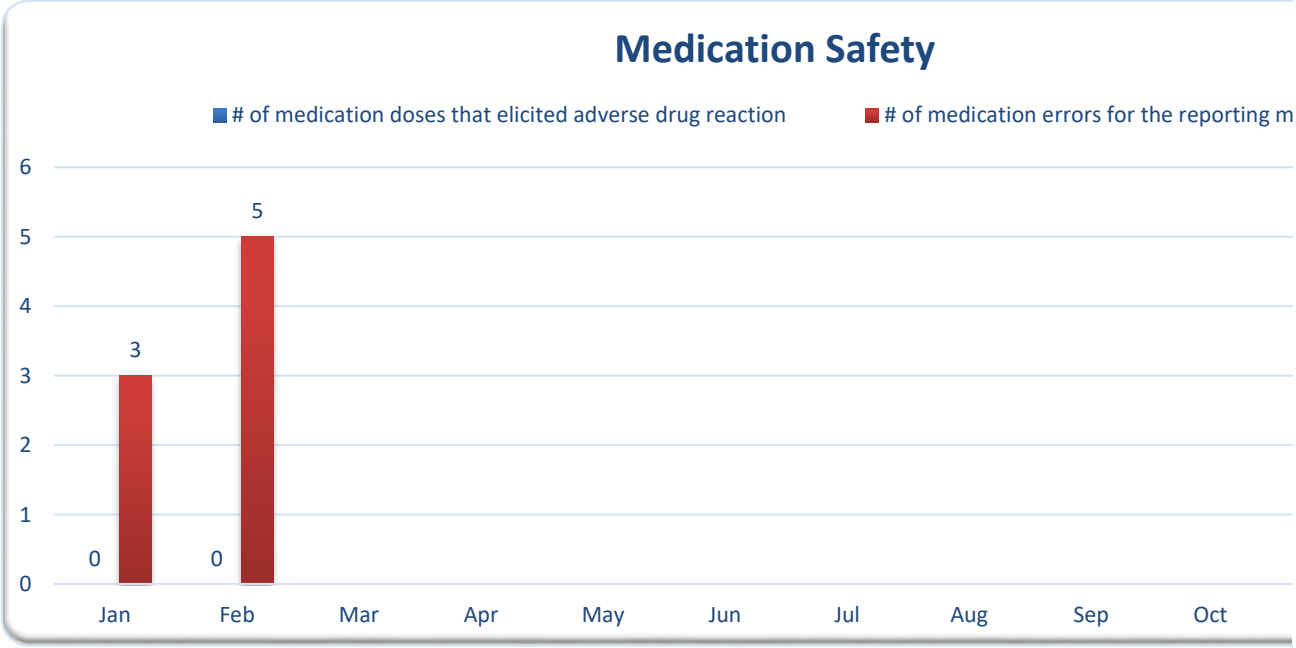


Percent of Deaths Reported (Benchmark = 100%)

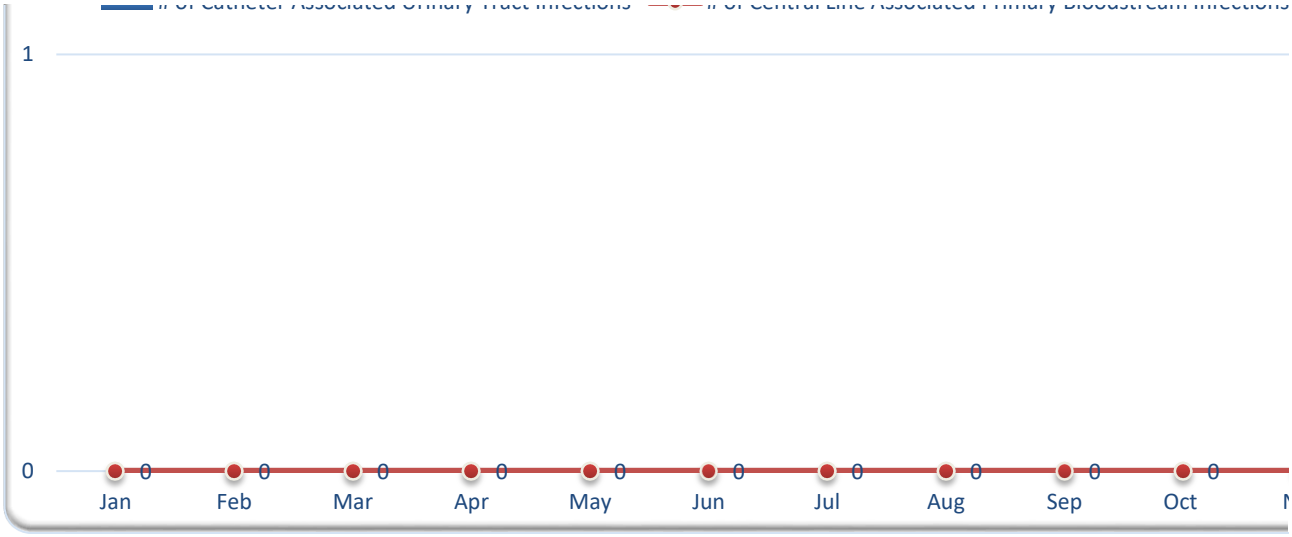
J. Code Blue Intervention



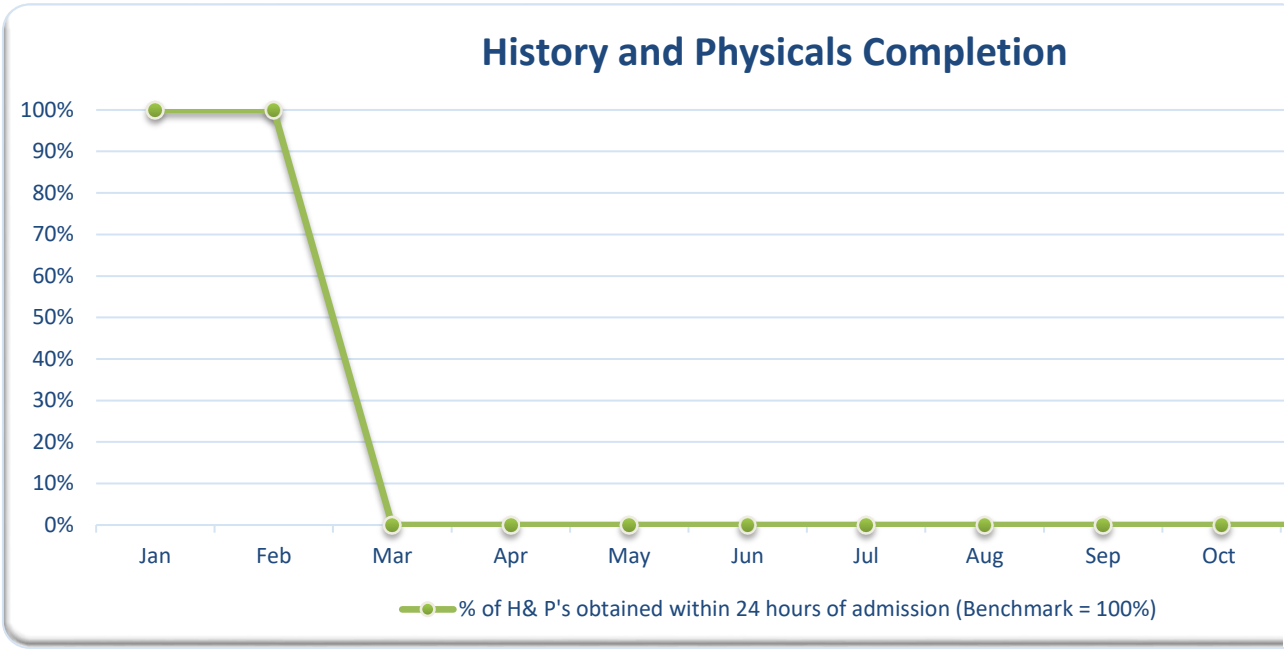
B. Med Errors

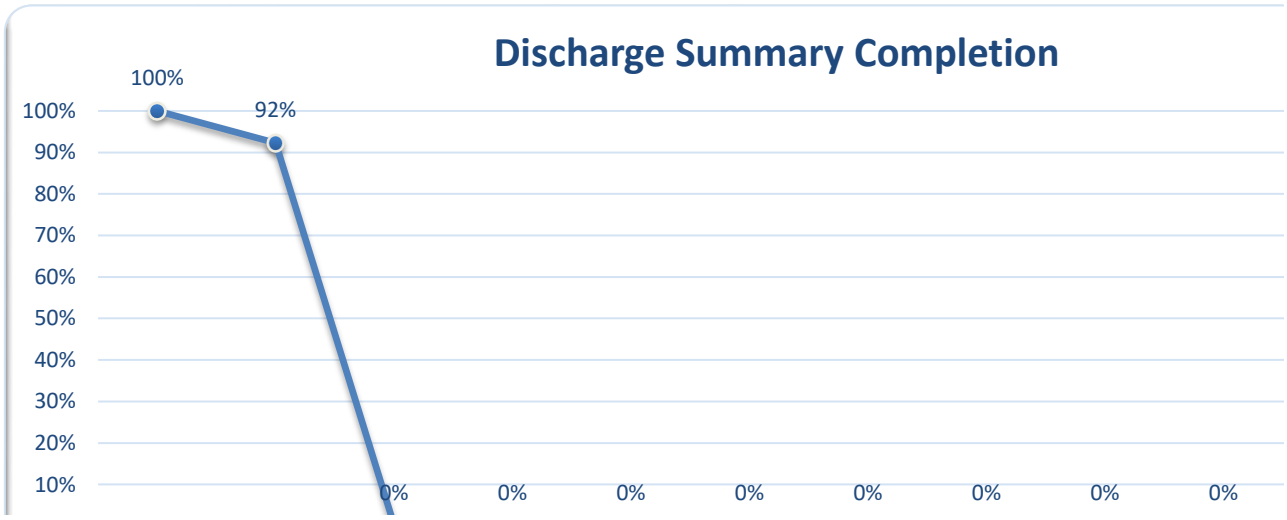


XIII. Infection Control & Prevention


1
0
0 0 0 0 0 0 0 0 0 0 0 0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct

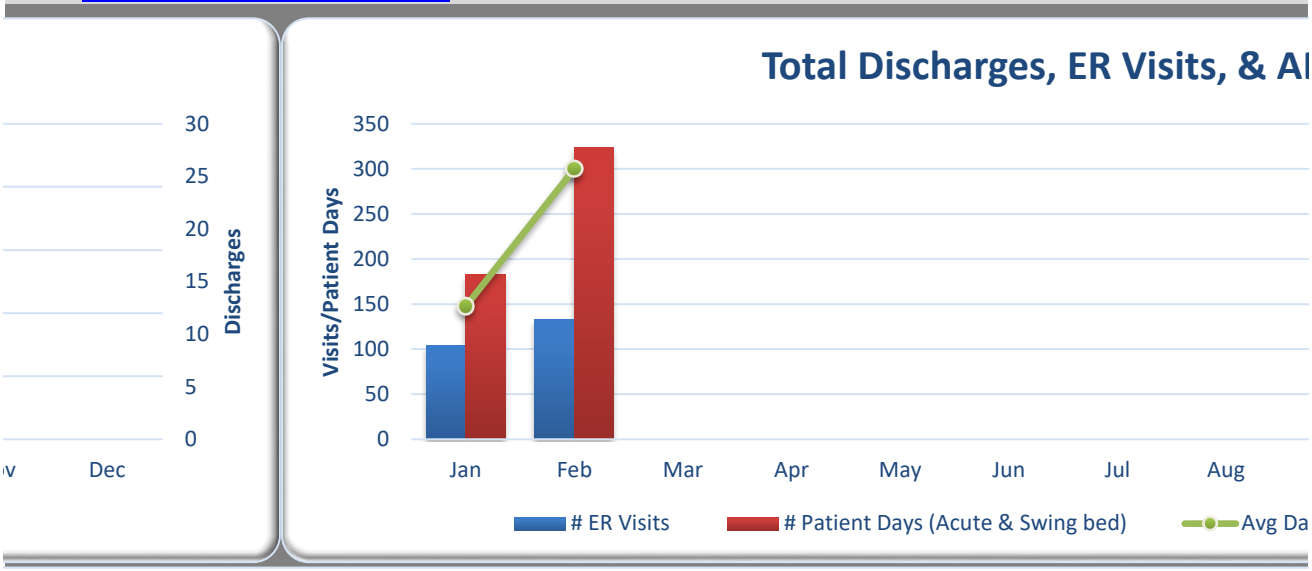
XIV. HIM

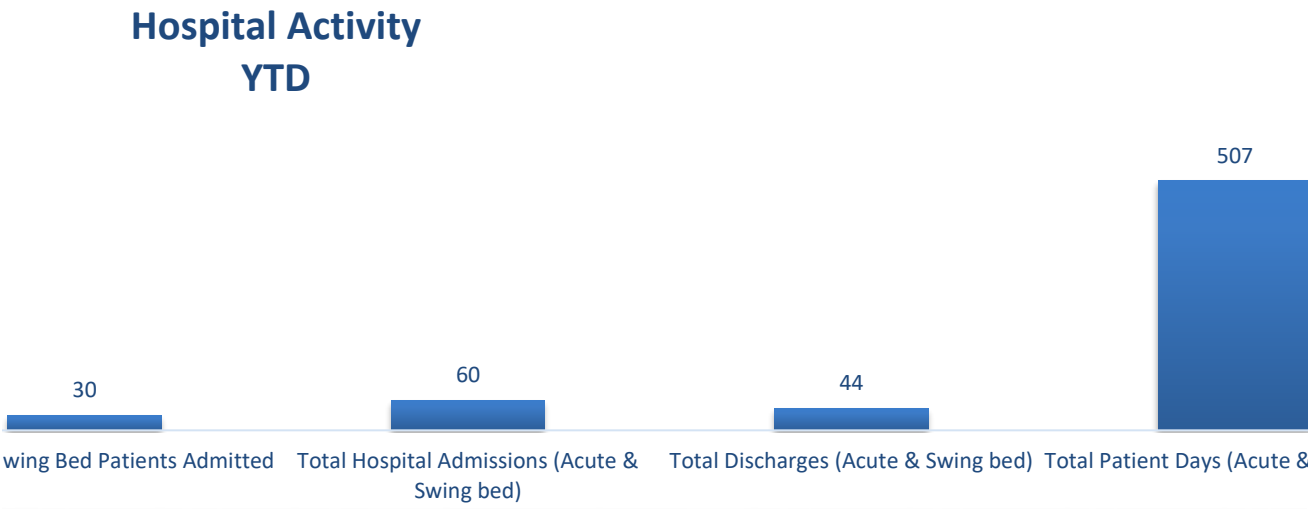

History and Physicals Completion
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
% of H& P's obtained within 24 hours of admission (Benchmark = 100%)


Discharge Summary Completion
100%
92%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0% 0% 0% 0% 0% 0% 0% 0%

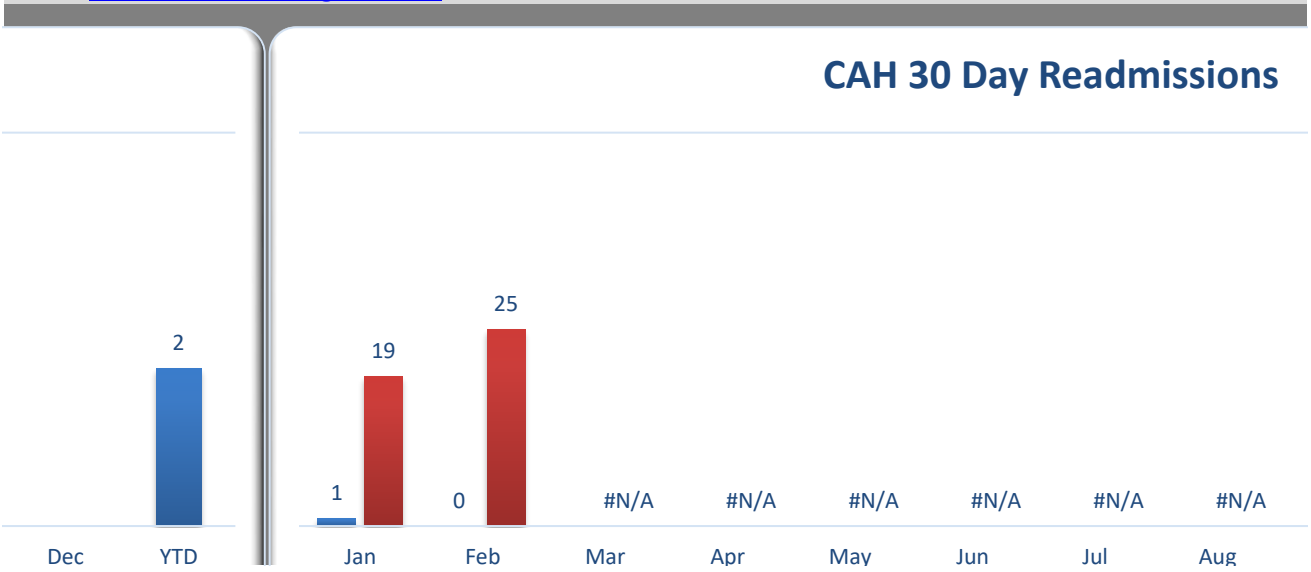

0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
% of Discharge Summaries completed within 48 hours of discharge (Benchmark=100%)

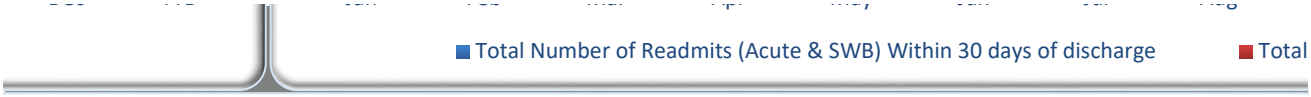
I. Volume & Utilization





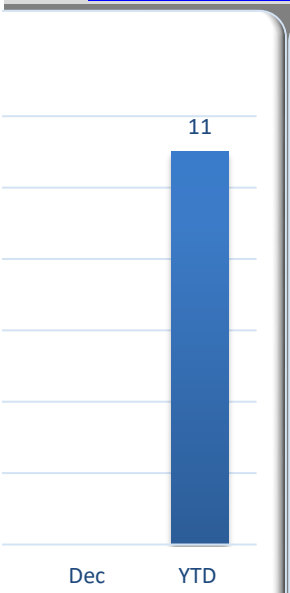
II. Care Management



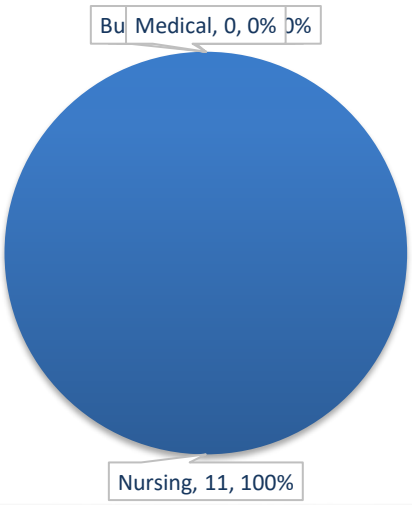


Hospital Activity
AMA/LWBS

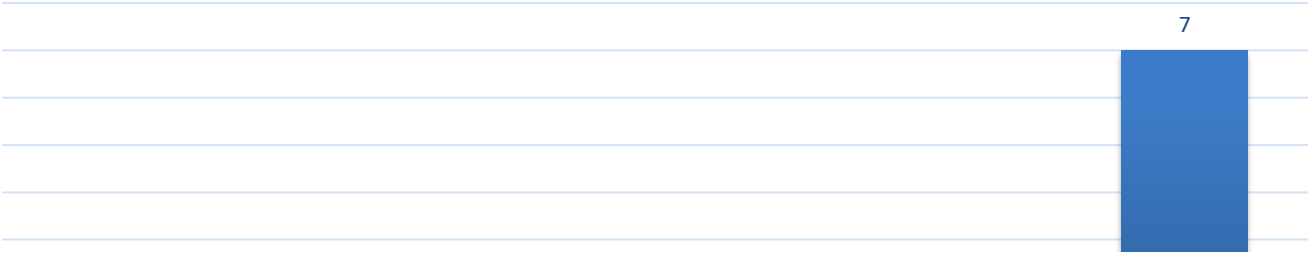
III. Risk Management

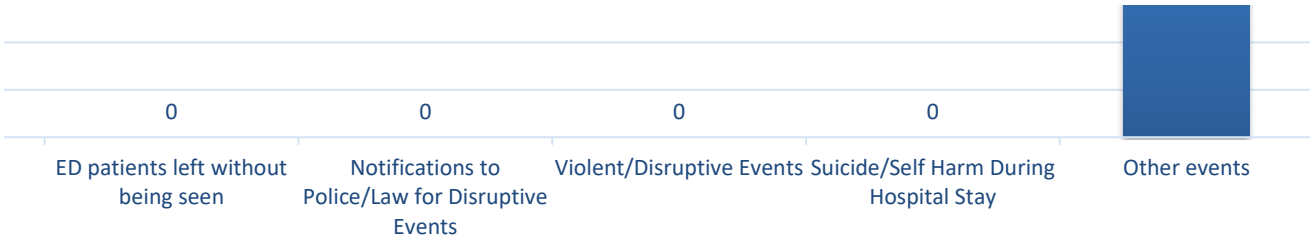


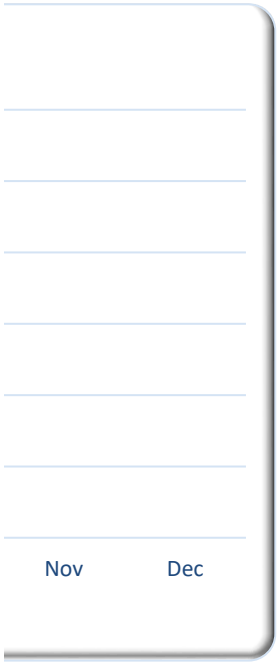
YTD
Incident by Department

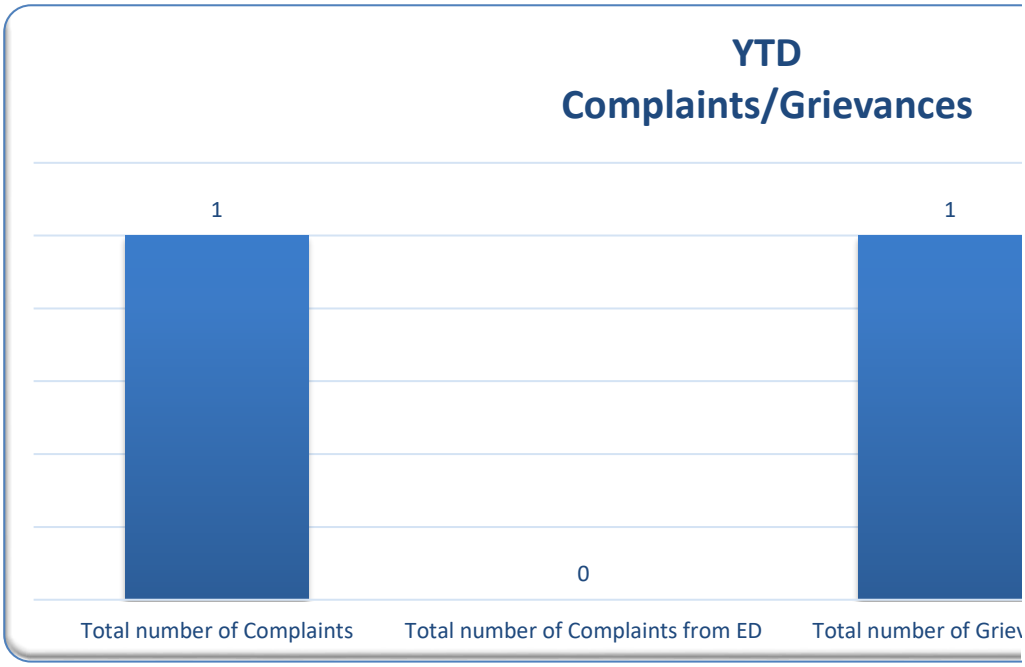


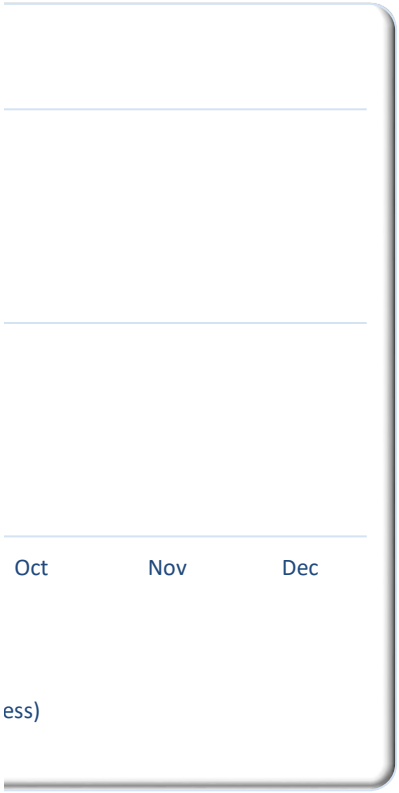
YTD
Incident Report Categories

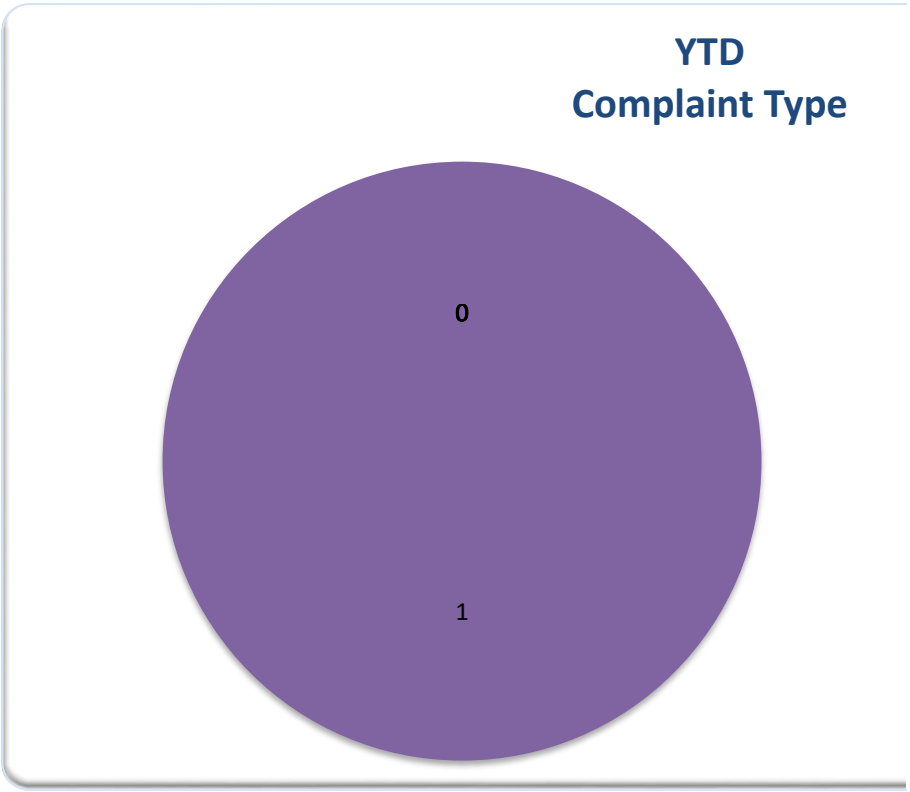


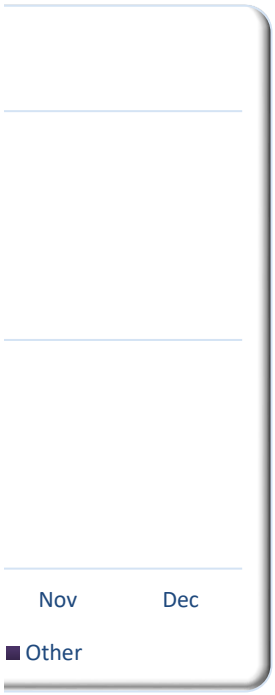

0
0
0
0
ED patients left without being seen
Notifications to Police/Law for Disruptive Events
Violent/Disruptive Events
Suicide/Self Harm During Hospital Stay
Other events

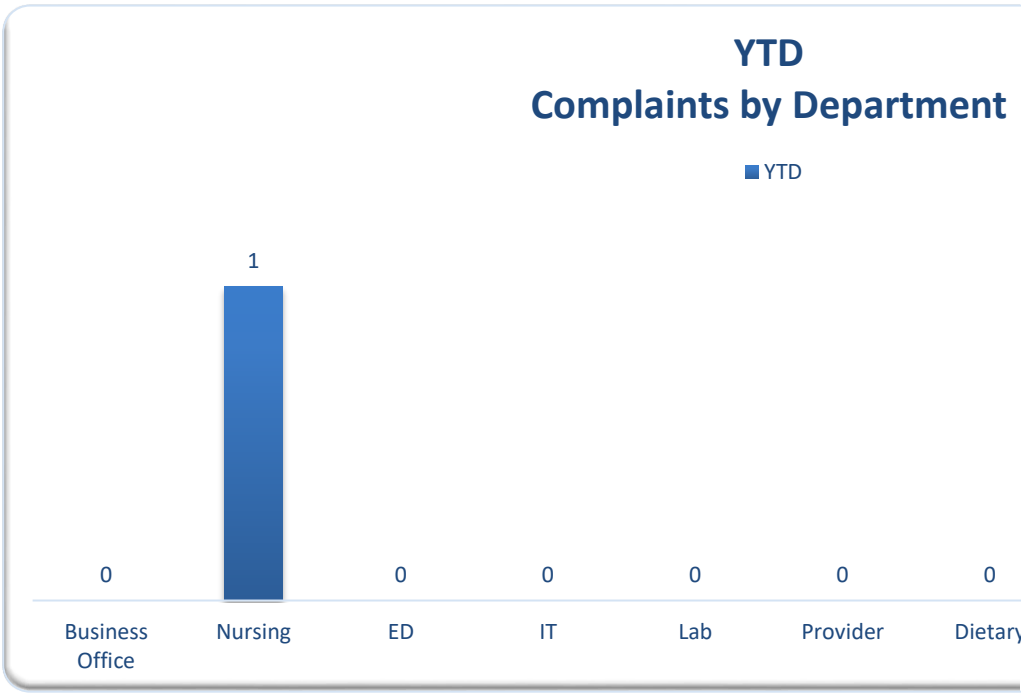

Nov
Dec

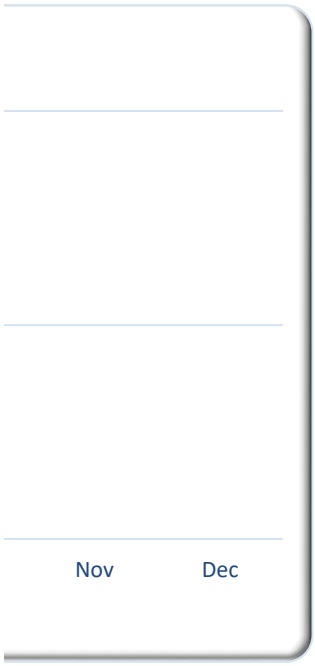

YTD
Complaints/Grievances
1
0
1
Total number of Complaints
Total number of Complaints from ED
Total number of Griev

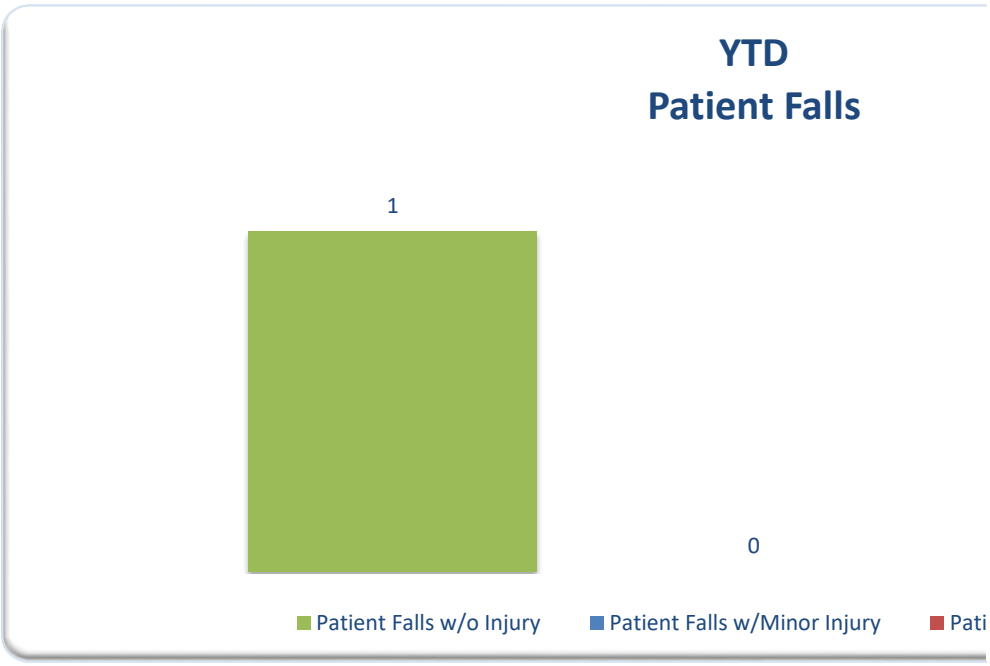

Oct
Nov
Dec
ess)

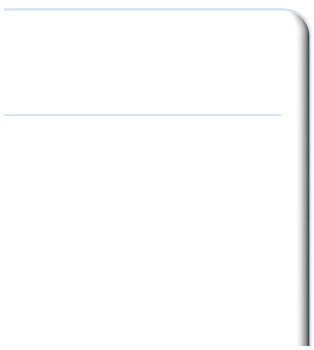

YTD
Complaint Type
0
1

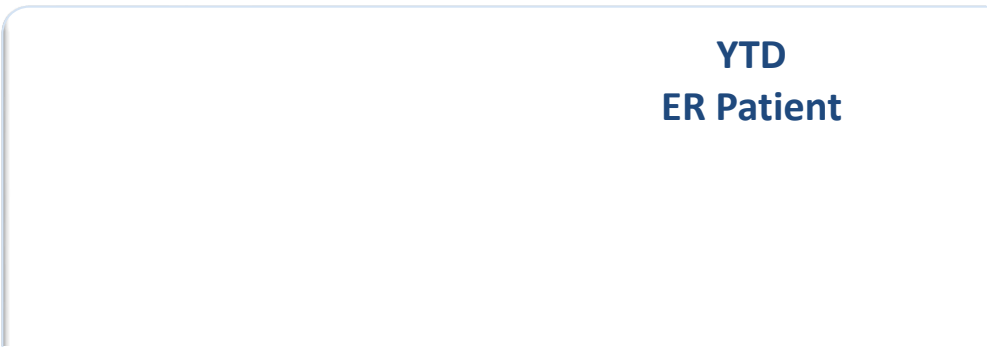

Nov
Dec
Other

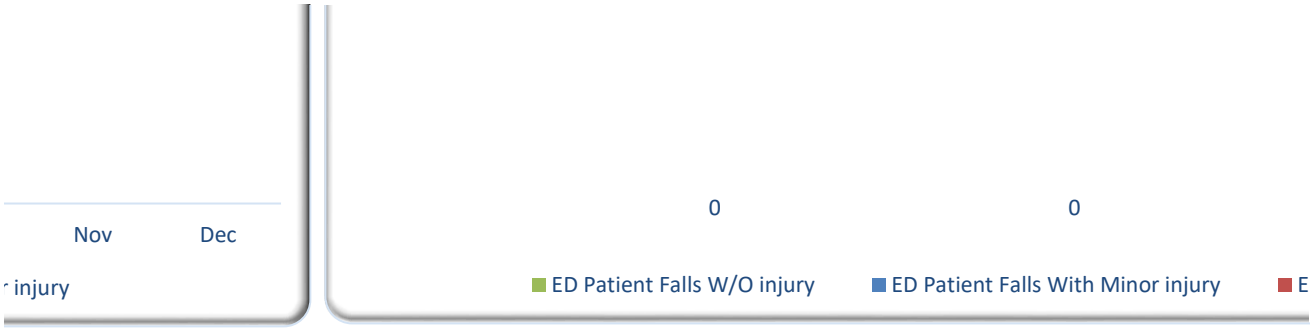

YTD
Complaints by Department
YTD
1
0
0
0
0
0
0
Business Office
Nursing
ED
IT
Lab
Provider
Dietary

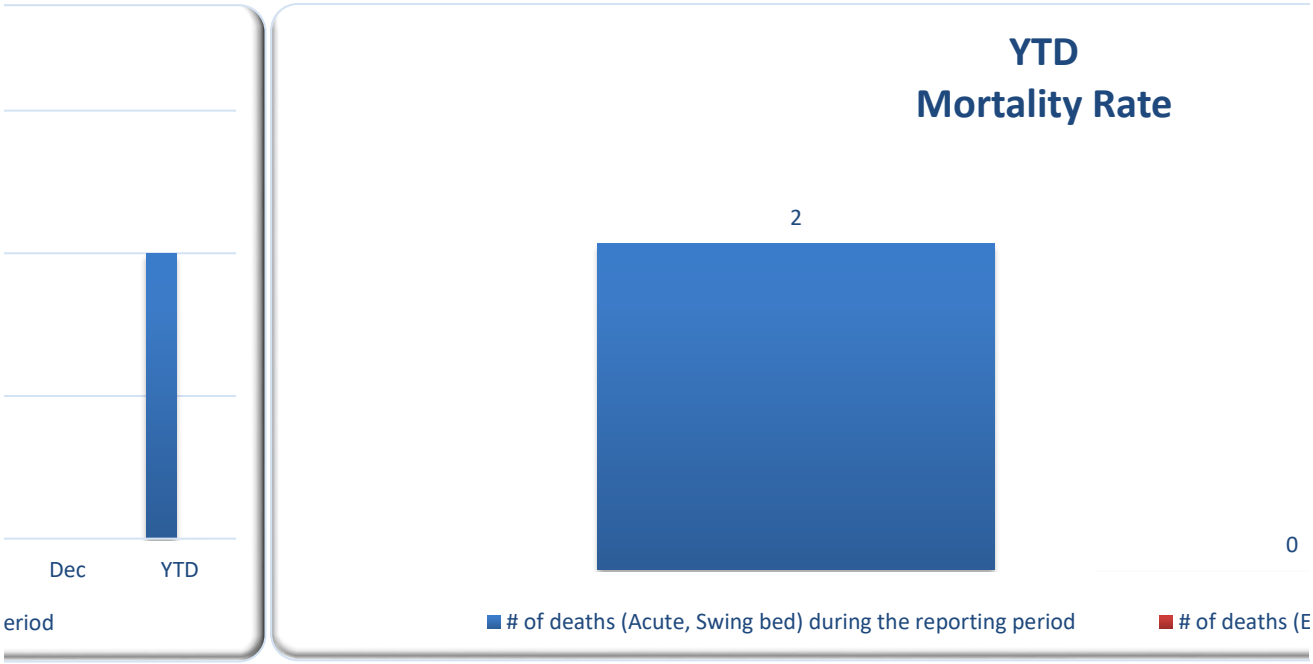

Nov
Dec

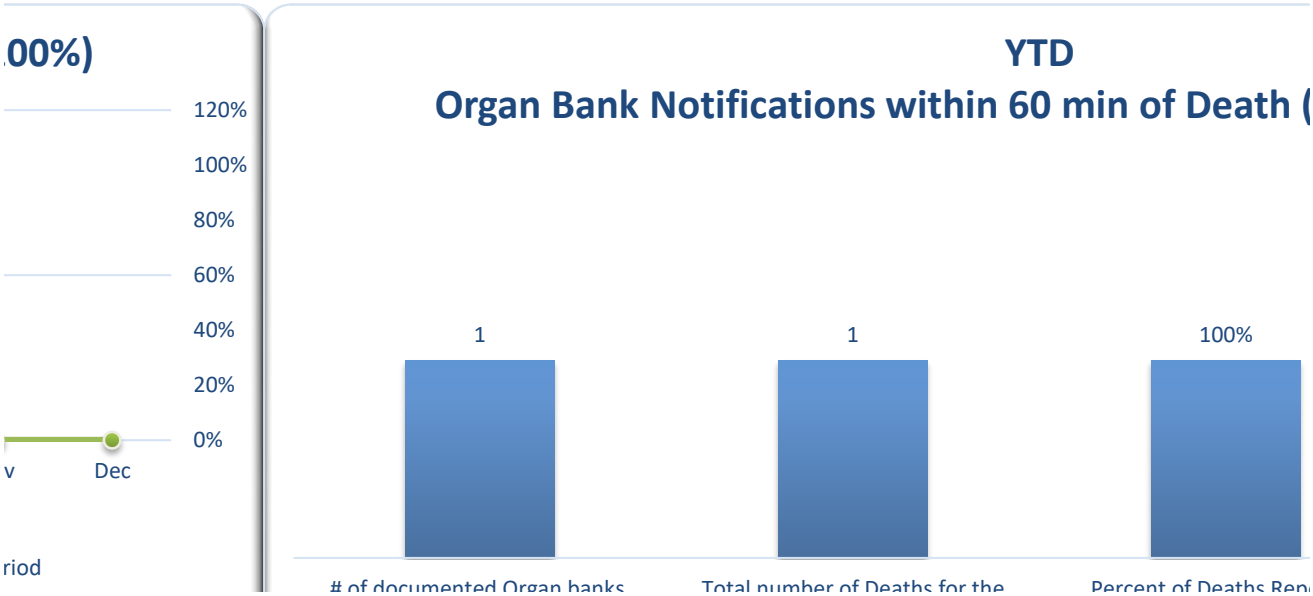

YTD
Patient Falls
1
0
Patient Falls w/o Injury
Patient Falls w/Minor Injury
Pati



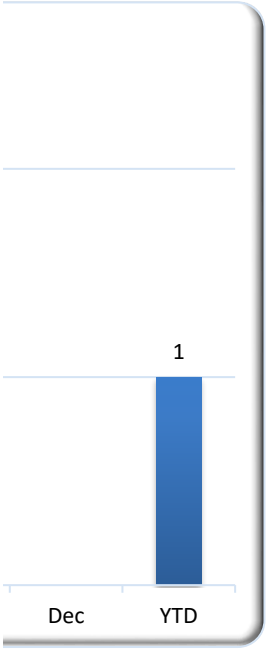

YTD
ER Patient

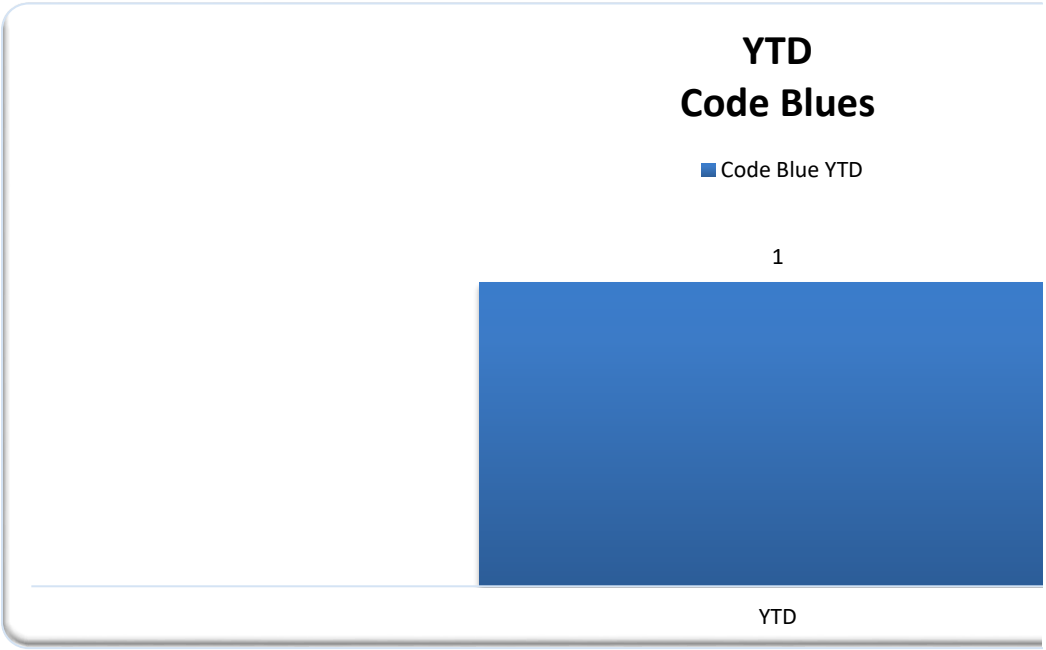

Nov
Dec
injury
0
0
ED Patient Falls W/O injury
ED Patient Falls With Minor injury
E

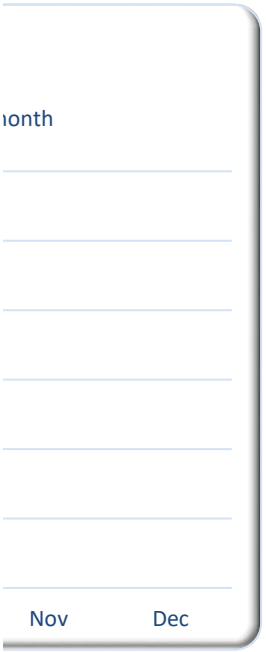

Dec
YTD
eriod
YTD
Mortality Rate
2
0
# of deaths (Acute, Swing bed) during the reporting period
# of deaths (E

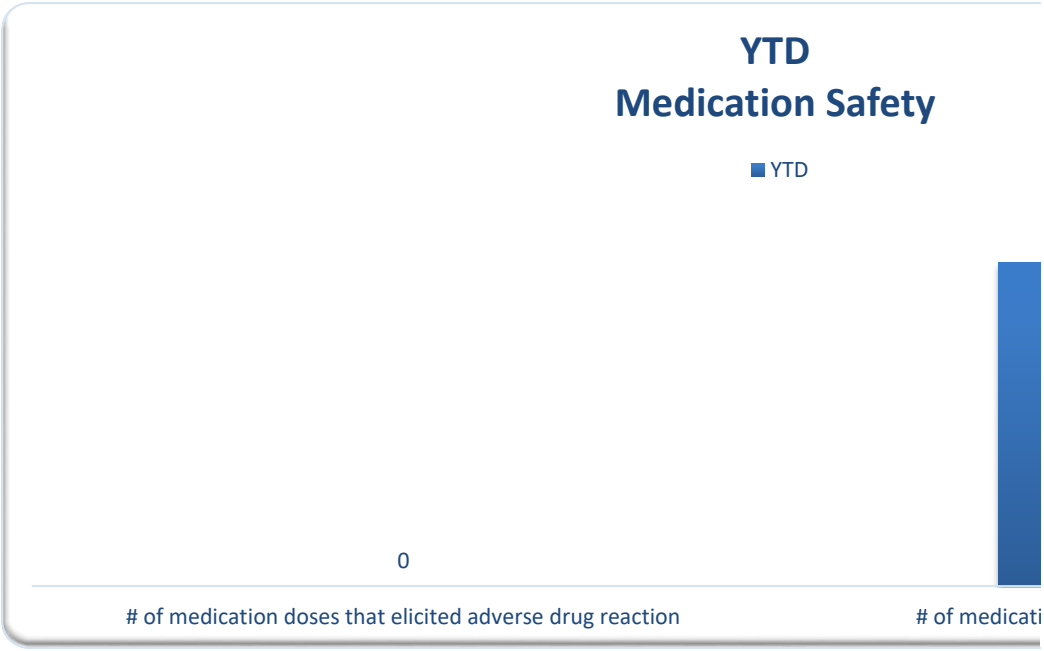

00%)
120%
100%
80%
60%
40%
20%
0%
v
Dec
riod
YTD
Organ Bank Notifications within 60 min of Death (
1
1
100%
# of documented Organ banks
Total number of Deaths for the
Percent of Deaths Rep

notifications within 60 min of death | reporting period | (Benchmark = 100%



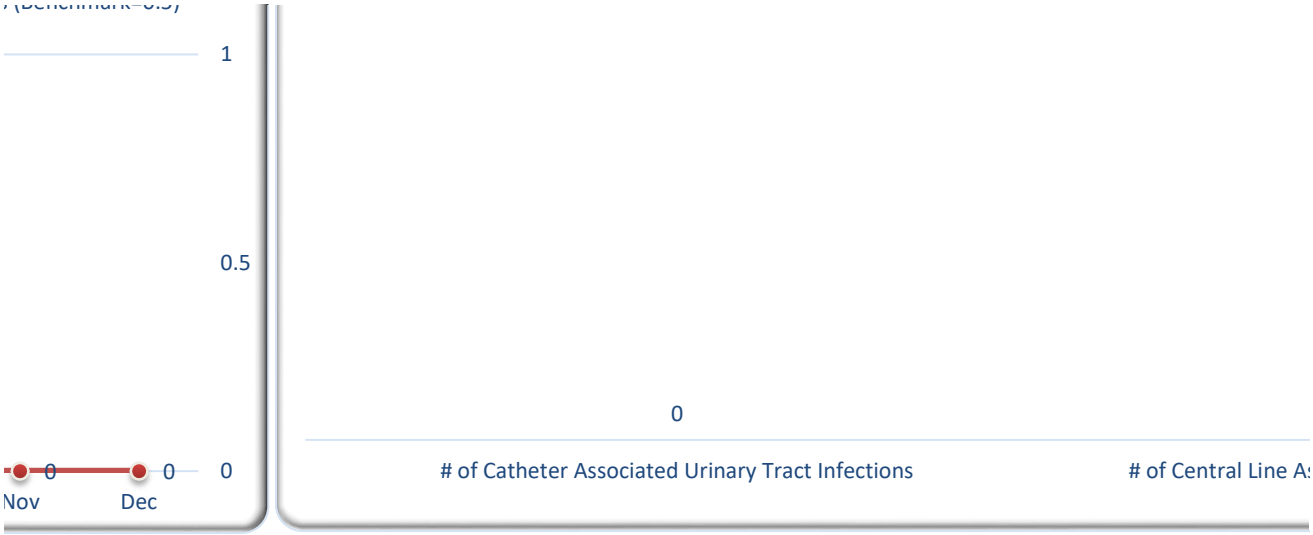


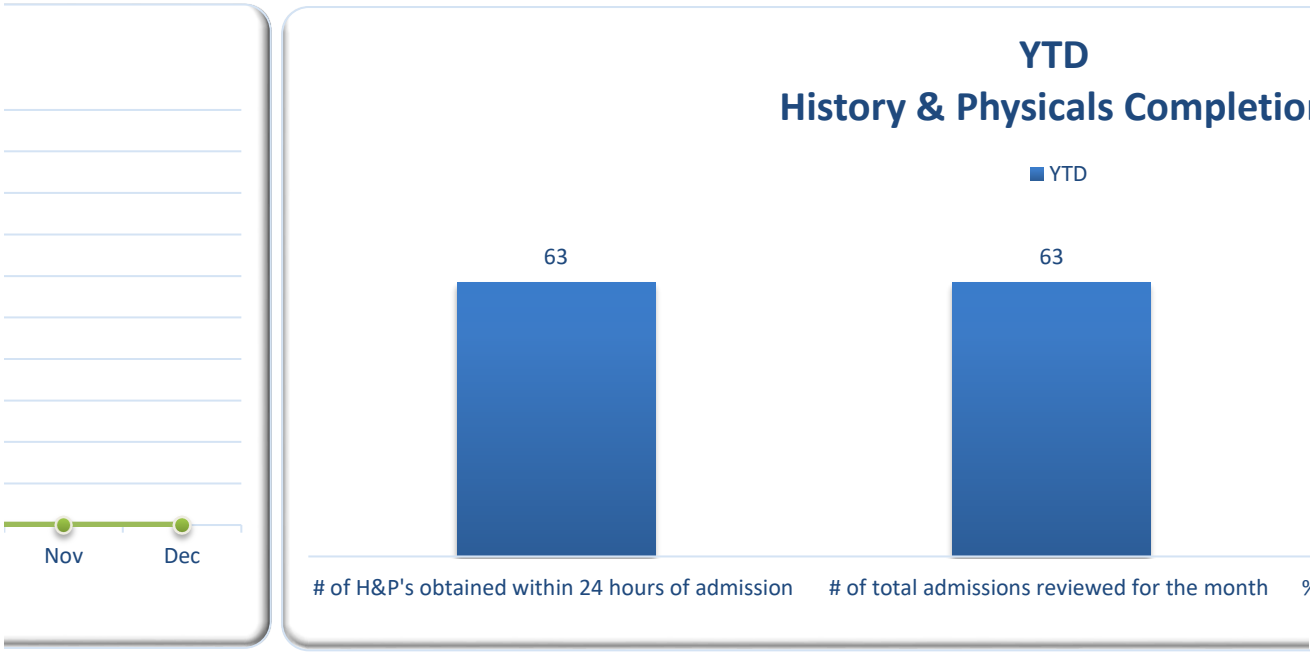


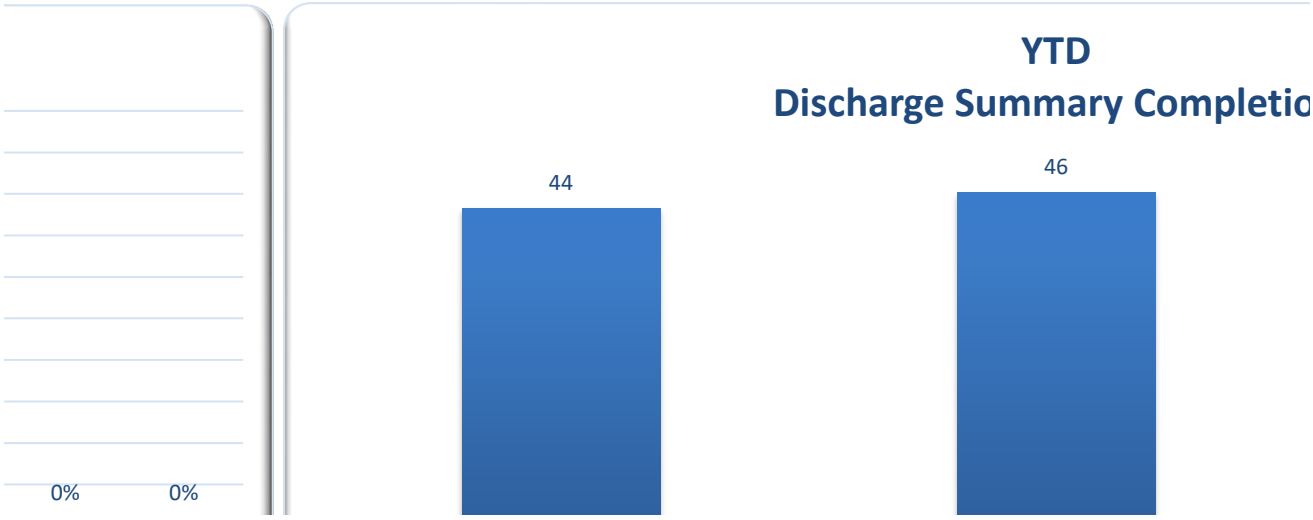


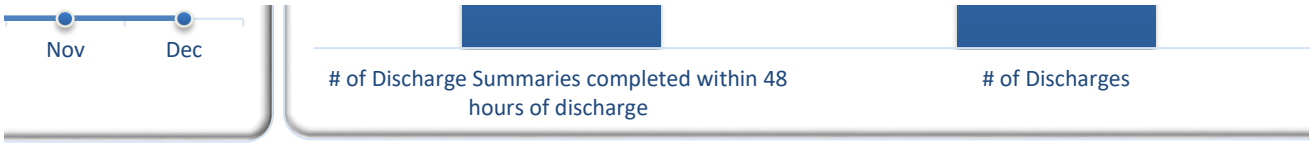
(Benchmark=0.5)

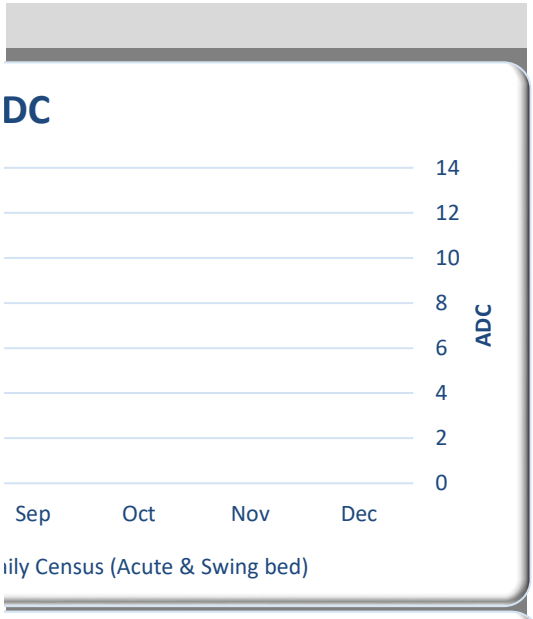
YTD
Infection Control and Preventio

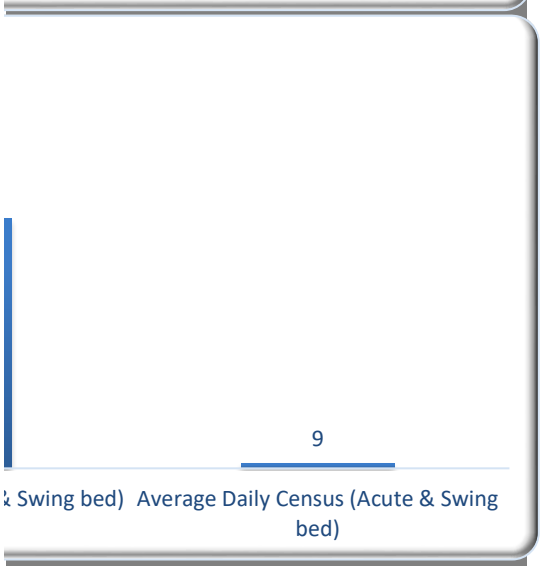

1
0.5
0
0
0
Nov
Dec
0
# of Catheter Associated Urinary Tract Infections
# of Central Line A

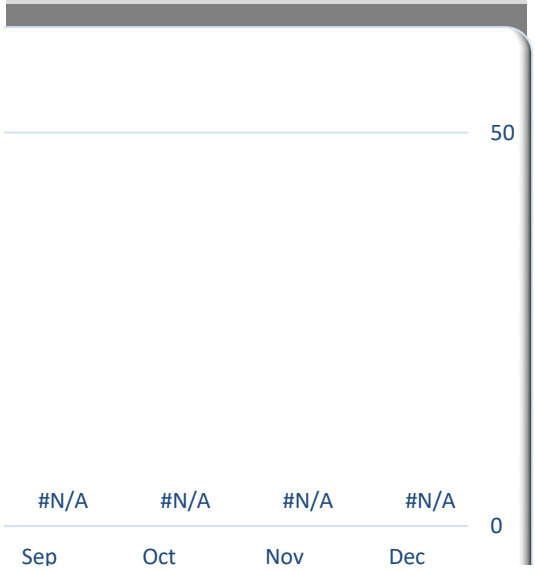

Nov
Dec
YTD
History & Physicals Completio
YTD
63
63
# of H&P's obtained within 24 hours of admission
# of total admissions reviewed for the month


0%
0%
YTD
Discharge Summary Completio
44
46

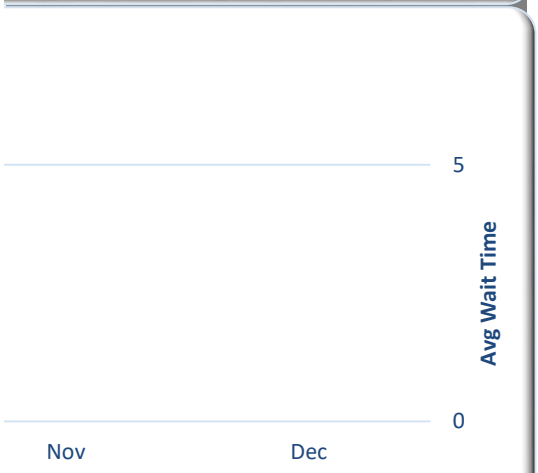

Nov
Dec
# of Discharge Summaries completed within 48 hours of discharge
# of Discharges

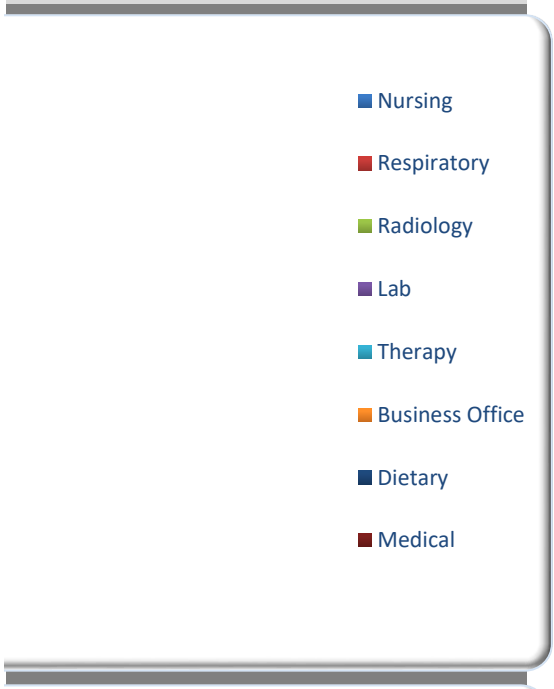

DC
14
12
10
8
6
4
2
0
ADC
Sep
Oct
Nov
Dec
ily Census (Acute & Swing bed)

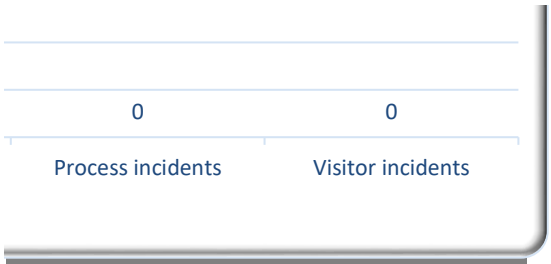

9
Swing bed)
Average Daily Census (Acute & Swing bed)


50
#N/A
#N/A
#N/A
#N/A
0
Sep
Oct
Nov
Dec

Discharges for the reporting month

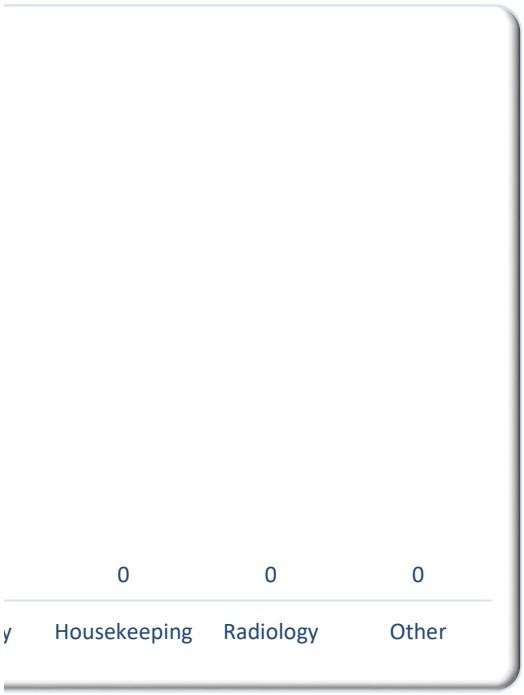


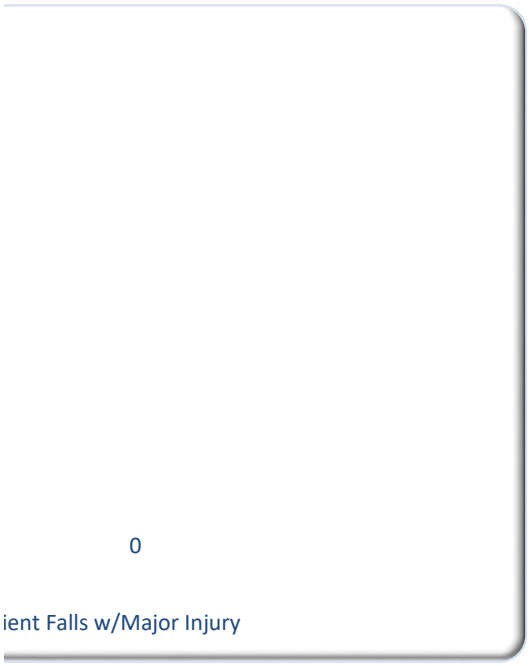



0
0
Process incidents
Visitor incidents


0
vances
Total number of Grievances from ED


Basic Care (daily hygiene, oral care, peri care, etc.)
Medication related
Communication (follow-through on concerns, etc.)
Attitude and Customer Service
Preventative measures (turning, activity)
Nutrition (assistance, quality, diets, timeliness)
Call light response


0
0
0
y
Housekeeping
Radiology
Other


0
ient Falls w/Major Injury

0

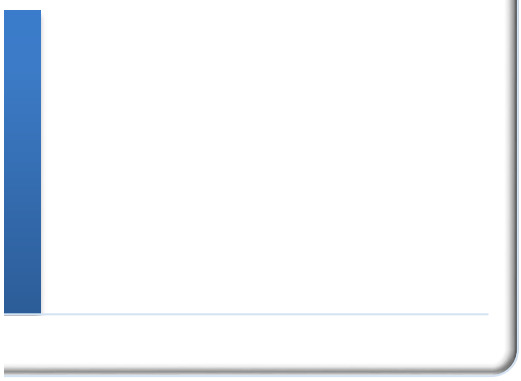
D Patient Falls With Major injury

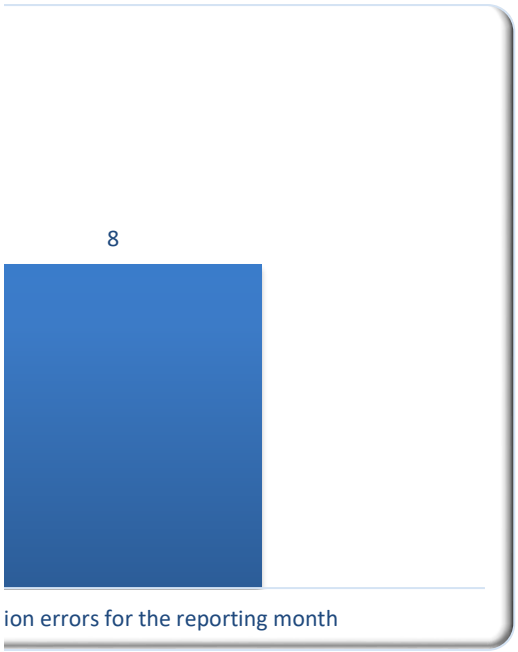
R) during the reporting period

(Benchmark=100%)

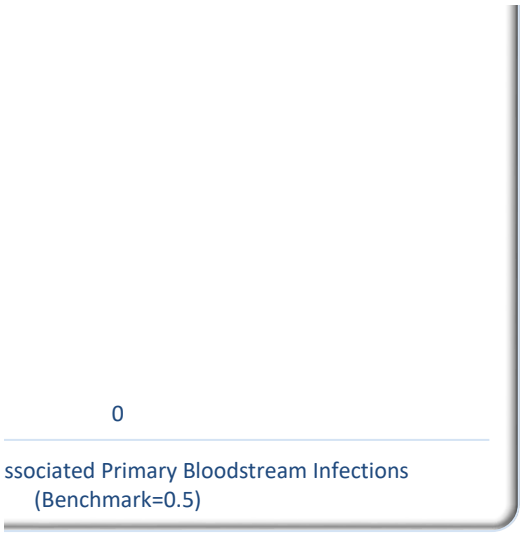
0

orted Tissue Donations



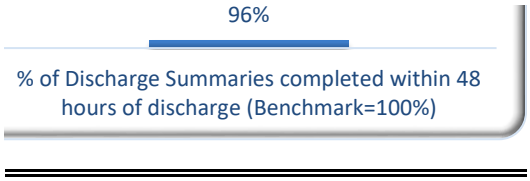


ion errors for the reporting month


0
ssociated Primary Bloodstream Infections
(Benchmark=0.5)


n
100%
% of H& P's obtained within 24 hours of admission
(Benchmark = 100%)


on

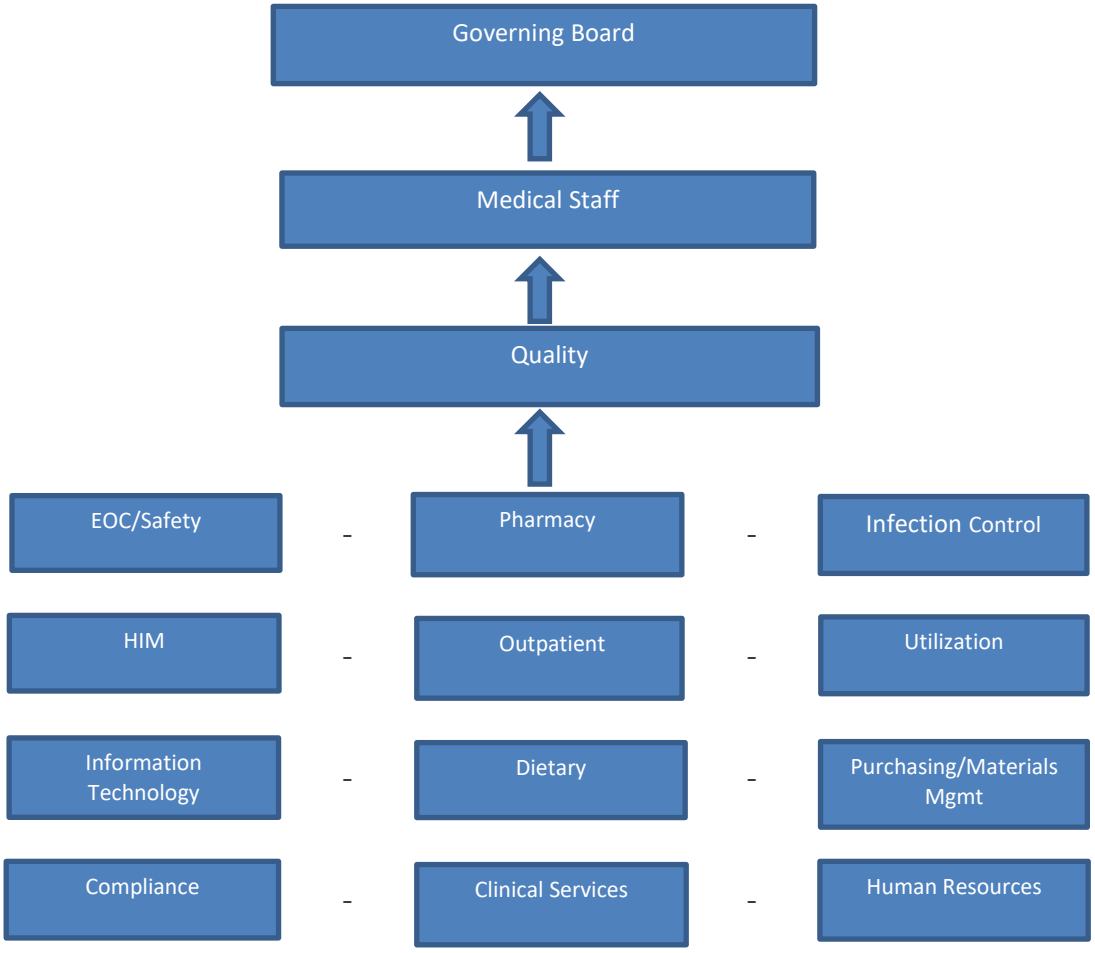

96%
% of Discharge Summaries completed within 48 hours of discharge (Benchmark=100%)

Overview

The Hospital Quality Assurance and Performance Improvement Committee is the central coordinating body for all performance improvement and patient safety activities within the hospital. The Quality Committee meets on a routine scheduled basis. The Quality Committee coordinates the performance improvement process by establishing a planned, systematic, organization-wide approach to performance measurement, analysis and improvement. Membership includes representation from both leadership and staff levels.

The hospital quality indicators are a set of measures that provide a perspective on hospital quality of care using hospital data. These indicators reflect quality of care inside the hospital. The quality indicators can be used to help the hospital identify potential problem areas that might need further study; provide the opportunity to assess quality of care inside the hospital using collected data and implement improvement processes.

Reporting Hierarchy



Name of Facility
Hospital Meeting Calendar/Meeting Frequency

Title of Meeting	***Frequency of Meeting***	***Attendees***
Quality Assurance & Performance Improvement Committee	Monthly	Administrator, CCO, QM/RM, IP, Dept. Leads
Environment of Care (EOC) & Safety Committee	Monthly	Administrator, CCO, QM/RM, IP, Dept. Leads
Infection Prevention & Control Committee	Monthly	Physician, Administrator, CCO, QM/RM, IP, Pharmacy, ES, EHN
Pharmacy & Therapeutics Committee	Monthly	Administrator, Pharmacist, DRN, CCO, QM, IP
Health Information Management (HIM) & Credentialing Committee	Monthly	HIM, CCO, QM, Registration Clerk, Credentialer
Utilization Review Committee	Monthly	Administrator, CCO, QM, IP, CM
Compliance Committee	Monthly	Administrator, CCO, QM, BOM, CO, Physician, HR, Nurse Managers, CM
Medical Executive Committee	Monthly	Medical Staff, Administrator, CCO, QM
Governing Board	Monthly	Administrator, CCO, Medical Staff, Governing Board Members

MANUGM REGIONAL MEDICAL CENTER
Quality Assurance & Performance Improvement
Agenda

Date: 7/15/2021

I. Call to Order

II. Review of Minutes

III. Review of Committee Meetings
- A. EOC/Patient Safety Committee
- B. Infection Control Committee
- C. Pharmacy & Therapeutics Committee
- D. HIM/Credentialing Committees
- E. Utilization Review Committee
- F. Compliance Committee

IV. Old Business

V. New Business

VI. Quality Assurance/Performance Improvement

I. Volume & Utilization
- A. Hospital Activity
- B. Blood Utilization

II. Care Management
- A. CAH Re-Admits
- B. Acute Transfers
- C. Transition of Care
- D. Discharge Follow-Up Phone Calls
- E. Patient Safety Discharge Checklist

III. Risk Management
- A. Incidents
- B. Reported Complaints
- C. Reported Grievances
- D. Patient Falls Without Injury
- E. Patient Falls With Minor Injury
- F. Patient Falls With Major Injury
- G. Mortality Rate
- H. Deaths Within 24 Hours of Admit
- I. OPO Notification/Tissue Donation
- J. Patient Identifiers

IV. Nursing
A. Critical Tests/Labs
B. Restraints
C. RN Assessments
D. Code

V. Emergency Department
A. ER Log & Visits
B. Medical Screeing Exam
C. Provider ER Response Time
D. ED RN Assessments (Initial)
E. ED Readmissions
F. EMTALA Transfer Form
G. ED Transfers
H. Stroke Care
I. Suicide Management
J. Triage
K. STEMI Care
L. ED Nursing Assessment (Dicharge/Transfer)

VI. Pharmacy & Med Safety
A. Pharmacy Utilization
B. After Hours Access
C. Adverse Drug Reaction
D. Medication Errors

VII. Respiratory Care Services
A. Ventilator Days
B. Ventilator Wean Rate
C. Patient Self-Decannulation Rate
D. Respiratory Care Equipment

VIII. Wound Care Services
A. Development of Pressure Ulcer
B. Wound Healing Improvement
C. Wound Care Documentation
D. Debridement/Wound Care Procedures
E. Wound VAC

IX. Radiology
A. Radiology Films
B. Imaging
C. Radiation Dosimeter Report
D. Physicist's Report

X. Lab
A. Lab Reports
B. Blood Culture Contaminants

XI. Infection Control & Employee Health
A. CAUTI Infections
B. CLABSI Infections

C. Hospital Acquired MDROs
D. Hospital Acquired C. diff
E. Hospital Acquired Infections By Source
F. Hand Hygiene/PPE & Isolation Surveillance
G. Public Health Reporting
H. Patient Vaccinations
I. Ventilator Associated Events
J. Employee Health Summary

XII. HIM

A. H&P's
B. Discharge Summaries
C. Progress Notes (Swingbed & Acute)
D. Consent to Treat
E. Swingbed Indicators
G. E-prescribing System
H. Legibility of Records

XIII. Dietary

A. Food Test Tray Evaluation
B. Dietary Checklist Audit

XIV. Therapy

A. Therapy Indicators
B. Therapy Visits
C. Standardized Assessment Outcomes

XV. Human Resources

A. Compliance

XVI. Resgistration Services

XVII. Environmental Services

A. Terminal Room Cleans

XVIII. Materials Management

A. Materials Management Indicators

XIX. Plant Ops

A. Fire Safety Management

XX. Information Technology (IT)

A. IT Indicators

XXI. Outpatient Services

A. Orders and Assessments
B. Outpatient Therapy Services
C. Outpatient Wound Services

XXII. Strong Mind Services

A. Record Compliance
B. Client Satisfaction Survey
C. Master Treatment Plan
D. Suicidal Ideation
E. Scheduled Appointments

VII. Contract Services

VIII. Regulatory & Compliance

A. OSDH & CMS updates
B. Surveys
C. Product Recalls
D. Failure Mode Effect Analysis (FMEA)
E. Root Cause Analysis (RCA)

IX. Policy & Procedure Review

X. Standing Agenda

A. Annual Approval of Strategic Quality Plan
B. Annual Appointment of Infection Preventionist
C. Annual Appointment of Risk Manager
D. Annual Appointment of Safety Officer
E. Annual Appointment of Security Officer
F. Annual Appointment of Compliance Officer
G. Annual Review of ICRA
H. Annual Review of HVA

XI. Credentialing/New Appointment Updates

Karli

XII. Chief Clinical Officer Report

XIII. Administrator Report

XIV. Education & Training

XV. Performance Improvement Project

XVI. Department Reports

XIX. Other

XX. Adjournment

Quality Workbook Contents

Topic	*Responsible Party*
I. Hospital Volume & Utilization	
A. Hospital Activity	
B. Blood Utilization	
II. Care Management	
A. CAH/ER Re-Admits	
B. Acute Transfers	
C. Transition of Care	
D. Discharge Follow-Up Phone Calls	
E. Patient Discharge Safety Checklist	
III. Risk Management	
A. Incidents	
B. Reported Complaints	
C. Reported Grievances	
D. Patient Falls Without Injury	
E. Patient Falls With Minor Injury	
F. Patient Falls With Major Injury	
G. Mortality Rate	
H. Deaths Within 24 Hours of Admission	
I. OPO/Tissue Donation	
J. Patient Identifiers	
IV. Nursing	
A. Critical Tests/Labs	
B. Restraints	
C. RN Assessments	
D. Code Blue	
V. Emergency Department	
A. ER Log & Visits	
B. Medical Screening Exam	
C. Provider Response Time	
D. ED RN Assessment (Initial)	
E. ED Readmissions	
F. EMTALA Transfer Form	
G. ED Transfers	
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B. Ventilator Wean Rate	
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B. Wound Healing Improvement	
C. Wound Care Documentation	
D. Debridement/Wound Care Procedure	
E. Wound Vac Application	
IX. Radiology	
A. Radiology Films	
B. Imaging	
C. Radiation Dosimeter Reports	
D. Physicist's Report	
X. Laboratory	
A. Lab Reports	
B. Blood Culture Contaminations	
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D. Hospital Acquired C.diff	
E. Hospital Acquired Infections By Source	
F. Hand Hygiene/PPE & Isolation Surveillance	
G. Public Health Reporting	

H. Patient Vaccinations
I. Ventilator Associated Events
J. Employee Health Summary

XII. Health Information Management (HIM)

A. History & Physical Completion
B. Discharge Summary Completion
C. Progress Notes (Swingbed & Acute)
D. Consent to Treat
E. Swingbed Indicators
G. E-prescribing System
H. Legibility of Records

XIII. Dietary

A. Food Test Tray Evaluation
B. Dietary Checklist Audit

XIV. Therapy Services

A. Therapy Swingbed Services
B. Therapy Visits
C. Standardized Assessment Outcomes

XV. Human Resources

A. Employee Compliance

XVI. Registration Services

XVII. Environmental Services

A. Terminal Room Cleans

XVIII. Materials Management/Purchasing Serviees

A. Materials Management Indicators

XIX. Plant Operations

A. Fire Safety Management

XX. Information Technology (IT)

A. IT Indicators

XXI. Outpatient Services

A. Outpatient Orders and Assessments
B. Outpatient Therapy Services
C. Outpatient Wound Services

XXII. Strong Mind Services

A. Record Compliance
B. Client Satisfaction Survey
C. Master Treatment Plan
D. Suicidal Ideation
E. Scheduled Appointments

Hospital Volume & Utilization Data

A. Hospital Activity

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total ER visits	104	133											**237**
Total # of Observation Patients Admitted	0	2											**2**
Total # of Acute Patients Admitted	15	15											**30**
Total # of Swing Bed Patients Admitted	10	20											**30**
Total Hospital Admissions (Acute & Swing bed)	25	35	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	60
Total Discharges (Acute & Swing bed)	19	25											**44**
Total Patient Days (Acute & Swing bed)	183	324											**507**
Average Daily Census (Acute & Swing bed)	6	12											**9**

January	
Summary of Findings	**Plan of Action**
N/A	N/A
February	
Summary of Findings	**Plan of Action**
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**

Hospital Volume & Utilization Data

October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Blood Utilization

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Medical Record/Lab Reports/Blood Log
. Sample Size: All episodes of blood/blood product administration
Methodology: Audit Log, PDSA
Inclusion Criteria: All patients receiving blood/blood products during reporting period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Units of Blood / Blood Products Administered	4	1											**5**
Total Number of Transfusion Episodes	2	1											**3**
Appropriateness for transfusion (per criteria)	4	1											**5**
Total number of transfusion reactions	0	0											**0**
Patient identification using 2 identifiers (total # of units with 2 patient identifiers/total units infused) (Benchmark=100%)	4	1											**5**
Signed Informed Consent (total # of episodes with signed Informed Consent/total episodes) (Benchmark=100%)	4	1											**5**
Vital signs monitor and document per protocol for each transfusion occurrence													**0**
Total # of transfusion occurrence													**0**

January	
Summary of Findings	**Plan of Action**
All blood products were administered without problems	no action needed
February	
Summary of Findings	**Plan of Action**

Hospital Volume & Utilization Data

All blood products were administered withoug problems All paperwork completed.	no action needed
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Hospital Volume & Utilization Data

Care Management

A. CAH Re-Admits

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All acute & SWB patients readmitted to CAH
Methodology: Medical records, Discharge reports, PDSA
Inclusion Criteria: All acute & SWB patients readmitted to CAH within 30 days of discharge
Exclusion Criteria: Patients who are transferred to a higher level of care and then readmitted back to CAH

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Readmits (Acute & SWB) Within 30 days of discharge	1	0											**1**
Total Discharges for the reporting month	19	25	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**44**
CAH Readmission Rate per 100 patient discharges	**5%**	---	---	---	---	---	---	---	---	---	---	---	**2%**

January	
Summary of Findings	**Plan of Action**
1 re-admit to acute within 30 days. Patient was admitted to acute care on 1-3-20 with CHF, COPD exacerbation and shortness of breath. She was started on IV Rocephin and Zithromax for CXR that showed mediastinal opacity. Neb treatments were ordered routinely. She received DVT and stress ulcer prophylaxis and has improved. She has no dyspnea with exertion and on room air is oxygenating at 95%. She insists she go home, though it was suggested a few more days of IV antibiotics would be beneficial, and sputum culture results would be available. She states she has family that will be staying with her and she 'really needs' to go home. CXR shows improving opacity. She was discharged on Nicotine patch, increase in Lasix to 40 mg BID for one week, then once daily, Metoprolol 50 mg BID and Prednisone 20 mg daily for 5 days, along with Levaquin 500 mg once daily. She has received order for outpatient ultrasound of LLE for mild, chronic edema, worse on left. F/U in one week with PCP. Patient readmitted next day for c/o DOE, for breathing treatments and supplemental O2 prn, Levaquin 750 mg IVPB daily, LLE venous US	

February	
Summary of Findings	**Plan of Action**
No re-admits for February	Will continue to monitor

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May

Care Management

Summary of Findings	Plan of Action
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

D. Discharge Follow-Up Phone Calls

Function: Outcome Measure
Rationale: Problem Prone
Data Source: Discharge List
Sample Size: All discharged acute & SWB patients to home during the reporting period
Methodology: PDSA, Patient Records

Inclusion Criteria: All discharged acute & SWB patients to home during the reporting period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD

Care Management

Total number of Discharge Follow-Up calls completed within 48 hours; excluding holidays & weekends)	19	25											**44**
# of Discharge Follow-Up calls required during the reporting	19	25											**44**
Percentage of Compliance	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
February	
Summary of Findings	**Plan of Action**
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**

Care Management

December	
Summary of Findings	**Plan of Action**

E. Patient Discharge Safety Checklist

Function: Outcome Measure

Rationale: Problem Prone

Data Source: Patient Records
Sample Size: All inpatients discharged to home during the reporting period

Methodology: PDSA, Patient Records

Risk Management

A. Incidents

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Incident Reports
Sample Size: All patients/visitors/facility with unplanned events/incidents
Methodology: Incident reports, patient records, PDSA
Inclusion Criteria: All patients/visitors/facility with unplanned events/incidents

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Intravenous Line events	0	0											**0**
Other line events (foley, enteral tubes, drains, etc.)	0	0											**0**
Patient falls without injury	0	1											**1**
Patient falls with injury	0	0											**0**
AMA events	2	1											**3**
ED patients left without being seen	0	0											**0**
Average Wait Time/Minutes (LWBS)	0	0											**0**
Notifications to Police/Law for Disruptive Events	0	0											**0**
Violent/Disruptive Events	0	0											**0**
Suicide/Self Harm During Hospital Stay	0	0											**0**
Other events	3	4											**7**
Process incidents	0	0											**0**
Visitor incidents	0	0											**0**
Total Number of Events	**5**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**11**
January													
Summary of Findings				**Plan of Action**									

Risk Management

OTHER EVENTS: 1. On 1/31/21 drug room tech identified FSBS ommission while doing QA checks of MARS. FSBS omitted by LPN. CCO interviewed LPN, LPN had inaccurate FSBS data. LPN given opportunity to correct the ommission. LPN entered inacurate data into EMR documented that she had completed a finger stick on a patient. **2.** On 1/8/21 CNA was assisting patient with shower when patient had inappropriate behavior towards CNA. CNA let the patient know that it is not acceptable. No findings of confusion, AMS or dementia. **3.** On 1/11 @ 1700 it was found by LPN that the RMS was in the vagina instead of the rectum. RMS was removed and cleaned and properly placed into the rectum. **AMA - 1.** Patient presented @ 20:30 by EMS with CP. Patient was triaged upon arrival. Provider notified, and EKG was done. Pt did not like that her S.O. could not come in ED. RN & lab at bedside for IV & blood draw. Pt is relaxed & calm, states " I am feeling better, and want to go home" Pt now denies CP or SHOB. RN discussed what tests are ordered & why – pt remains pleasant with staff & further declines any testing, and wants to go home. NP at bedside to discuss risks of leaving and benefits of staying. Pt comprehends again states she "wants to go home." Agrees to sign AMA form. Pt ambulated to car w/out difficulty. **2. AMA ED -** Patient presented to ED @ 11:50 with hyperglycemia and CP. Patient became angry about NPO order. He cursed at nursing staff. Patient stated "If I don't get a heater and more blankets and some food, I am leaving and I am not signing any paperwork" Provider notified of pt behavior. Provider advised pt to stay to receive further treatment, pt refused further treatment and refused to sign AMA form. Patient was informed that refusal of further treatment has serious consequences to his health, possibly even death. Patient dressed himself, got out of bed, and refused to sit. Patient stated "I don't like the way I'm being treated, and my stress levels are through the roof. I just need to go." Patient also stated "my health doesn't matter." Patient refused to wait for his sister to come and get him	**OTHER EVENTS: 1.** CCO met with LPN involved. LPN's agency contacted. Agency and CCO agree to cancel contract.LPN will not return to MRMC. **2.** Charge nurse notified. It was also noted in chart. Care plan was reviewed and updated which included, but was not limited to socially inappropriate behavior. CCO told staff to use "buddy system" for patient hygiene needs. **3.** CCL and QM interviewed all staff members one by one that take care of said patient. None of the staff members interviewed knew how it was misplaced. CCO reminded each staff member to take time and make sure of insertion. **AMA - 1.** RN involved counseled and reminded that an incident report is to be filled out on each AMA. Also, that CCO and QM must be notified about incident. **AMA -ED 2.** QM spoke with RN and several warm blankets were given to pt. Patient was NPO and could not have food or drink administered to him. Nursing staff walked with patient off the property and also called the Police Department to let them know the patient had left the hospital and asked if the PD would check on him.
February	
Summary of Findings	**Plan of Action**

Risk Management

FALL W/O INJ 1. On 2/24/21 At Patient was found on floor due to an unassisted fall while walking. Patient stated "I needed to use restroom" She then said she got out of bed w/out hitting call light. At 0153 call light went off and nursing staff found patient on the floor by bed in a sitting position. Patient stated"I fell on my bottom and crawled back toward bed to hit call light." Patient was assessed for injuries. No apparent injuries, and patient denies pain anywhere. Vitals taken and patient was assisted to commode and then back to bed. Bed alaarm was turned on. Patient was instructed to use call light if needing to get out of bed. Patient verbalized understanding. Patients socks were changed to grip socks. Patient had put her own personal socks on. patient call light was w/in reach, bed was in low position. Provider and patient's family was informed of the fall. AMA 2/8/21 Patient presented to the ED @ 15:15 with a PMH of Hep C, diabetes II, hypertension, chronic neck pain and chronic substance-abuse with complaint of lower extremity swelling for the last month that has not improved. She reports gradual increase in swelling to lower extremities that has continued to worsen and become painful. Patient was triaged and seen by Provider. Patient left prior to lab review. Patient left AMA because her house was getting broken into. Patient was informed of risks of leaving and the benefits of staying before signing AMA. OTHER EVENTS: 1. On 2/9/21 @ 0053 Patient was reaching for something on his bedside table. His hand slipped and the table went up under his fingernail and pulled it completely off. Patient stated "Oh, this happens all the time." 2. On 2/21/20 @ 1830 Staff noticed an odor of cigerettes in patients room. Patient admitted she was smoking cigarette in her room so she could get kicked out and go back to the Nursing home. Patient does not use oxygen and hasn't for several days. 3. On 2/22/20 @ 10:10 a.m. Nursing staff smelled cigerette smoke and went into patient room to find patient watching tv. Smoke smell was strong. Nurse made CCO aware of incident, then CCO went to patients room and with nurse. Patient approved CCO and nurse to look in her purse. Findings were 2 partially smoked cigerettes. Patient is requesting to go back to nursing home so she can smoke freely. 4. On 2/21/21 at 10:22 ED Patient presented from EMS nonresponsive, will open eyes but no other response. Provider assessed patient and patient was triaged immediately. Provider ordered a "stat" CT of the brain @ 10:22 RN failed to inform Radiology of the CT patient. At approximately 12:00 Provider noticed no CT was	FALL W/O INJ 1. On 2/24/21 Changed patients personal socks to non skid socks. Made sure appropriate railing up. Bed alarm was turned on. AMA 2/8/21 1. Staff did explain to patient the risks of leaving and the benefits of staying. Patient was being treated but had emergency. OTHER EVENTS: 2/9/21 1. RN assessed finger. Cleaned the wound, and applied 2X2 with medical tape. Provider was notified of patient injury. Also, CCO communicated with patient regarding safety with furniture during repositioning. Patient verbalized understanding. 2. Patient's lighter was confiscated by nursing staff and lighter was also educated on risks to herself, staff and other patients. It was explained to the patient that she could cause a fire/explosion from smoking around oxygen. 3. Patient gave CCO verbal consent to search purse. Removed cigerettes and lighter from purse and took it to the ward clerk to be stored for patient. CCO comunicated the risks associated with smoking in the hospital. CCO also visted with patient about going back to Nursing home. Patient wanted to be d/c'd back to nursing home. CCO spoke with CM and provider. CM approved the d/c back to Nursing home. 4. Immediate action taken, CCO informed CEO that he would remove the RN off the schedule in the ED unless shorthanded. 2nd QM reviewed the chart and interviewed staff involved. 3rd action is to educate RN and Provider individually. 4th CCO will get Dr. C involved and do an immediate read and sign. Also, CCO is doing a global response to nursing when he introduces new policies and procedures on 3/9/2021. Future education is also coming when Cohesive rolls out video training on new policies and procedures in near future. No exact date is set. 5th QM also spoke with the Radiology Director about the event. Director said she will remind her staff that all stroke patients are to be done first and immediately.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**

Risk Management

June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Incident Grouped by Department Involved													
Department	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Nursing	5	6											**11**
Respiratory	0	0											**0**
Radiology	0	0											**0**
Lab	0	0											**0**
Therapy	0	0											**0**
Business Office	0	0											**0**
Dietary	0	0											**0**
Medical	0	0											**0**

Risk Management

B. Reported Complaints

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient, Family, Visitor
Sample Size: All Complaints
Methodology: Report (Verbal), PDSA
Inclusion Criteria: All complaints

Documentation Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of Complaints	0	1											**1**
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**507**
Rate per 1000 patient days	---	**3.1**	---	---	---	---	---	---	---	---	---	---	**2.0**
Total number of Complaints from ED	0	0											**0**
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**237**
Percentage of ED Complaints	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No complaints for January	Will continue to monitor

February	
Summary of Findings	**Plan of Action**
On 2/4/21 Patient spoke with the charge nurse about staff member upsetting her when helping her to the bed side commode. She said the LPN that came in to help her said she needs to finish and empty her bladder this time. She also said that LPN used her hurt arm to help assist her. Patient said she stated "that is my hurt arm" LPN then let go of her arm. QM and CCO spoke with the patient the morning of 2/5 and patient felt nurse was irriated at how many times she goes to the bathroom. QM spoke with LPN about the matter. She said when the patient got off of the commode to quickly she was afraid the patient would fall so she grabbed her arm without thinking of her arm injury. She immediately let go when the patient said that is her hurt arm.	2/5/21 QM and CCO assured patient that we all love taking care of her. CCO asked patient if he made it where the LPN would not assist in her care anymore would that help her to feel more comfortable with her stay here at MRMC? Patient said "yes" Also, CCO asked if patient wanted any further action taken on this matter? Patient stated " no, I am fine with that" Further actions taken was CCO had LPN read and sign education on empathy and human connection. QM also reviewed chart. QM was approved by patient to call her sister and let her know what actions were taken and how her sister was doing. The sister was happy with the process.

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

Risk Management

June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

C. Reported Grievances

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient, Family, Visitor
Sample Size: All Complaints
Methodology: Report (Verbal, Written), PDSA
Inclusion Criteria: All grievances

Documentation Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of Grievances	1	0											**1**
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**507**
Rate per 1000 patient days	**5.5**	---	---	---	---	---	---	---	---	---	---	---	**2.0**
Total number of Grievances from ED	0	0											**0**
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**237**
Percentage of ED Grievances	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**

Risk Management

On 1/12/21 Patient's husband wanted video footage reviewed of his wife's room entrance 1/9/21 between 11:30 a.m. - 7:30 p.m. He wanted to make sure only the allowable staff was entering his wife's room. Patient's husband didn't want to file a grievance, but we followed policy.	1/13/21 QM reviewed video footage, interviewed staff and reviewed the chart. After review found only the allowed staff were entering room. Date issue was closed and letter sent 1/18/21.
February	
Summary of Findings	**Plan of Action**
No grievances for the monthe of February	Will continue to monitor
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Risk Management

Complaint Grouped by Type													
Complaint Type	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Basic Care (daily hygiene, oral care, peri care, etc.)	0	0											**0**
Medication related	0	0											**0**
Communication (follow-through on concerns, etc.)	0	0											**0**
Attitude and Customer Service	0	1											**1**
Preventative measures (turning, activity)	0	0											**0**
Nutrition (assistance, quality, diets, timeliness)	0	0											**0**
Call light response	0	0											**0**

Complaint Grouped by Department													
Department	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Business Office	0	0											**0**
Nursing	0	1											**1**
ED	0	0											**0**
IT	0	0											**0**
Lab	0	0											**0**
Provider	0	0											**0**
Dietary	0	0											**0**
Housekeeping	0	0											**0**
Radiology	0	0											**0**
Other	0	0											**0**

Risk Management

D. Patient Falls Without Injury

Function: Outcome and Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Incident Reports
Sample Size: All patients with falls
Methodology: Patient Records, Incident Reports, PDSA
Inclusion Criteria: All patients with falls

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Patient Falls W/O injury	0	1	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**1**
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**507**
Rate per 1000 patient days (Benchmark = 5 or less)	**---**	**3.1**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**#N/A**	**2.0**
Indicator	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
ED Patient Falls W/O injury	0												**0**
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**237**
Percent of Total ED Patient Falls (Benchmark = 5 or less)	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**

January	
Summary of Findings	**Plan of Action**
No falls w/o inj for Januray	Will continue to monitor
February	
Summary of Findings	**Plan of Action**
See summary of findings under Risk Management Incident tab	
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	

Risk Management

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

E. Patient Falls with Minor Injury

Function: Outcome and Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Incident Reports
Sample Size: All patients with falls (minor cuts, minor bleeding, skin abrasions/contusions/tears, swelling, pain)
Methodology: Patient Records, Incident Reports, PDSA
Inclusion Criteria: All patients with falls

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Patient Falls with Minor injury	0	0											**0**
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**507**
Rate per 1000 patient days (Benchmark = 5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---
Indicator	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
ED Patient Falls With Minor injury	0	0											**0**
Total number of ED Visits	104	133	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**237**
Percent of Total ED Patient Falls (Benchmark = 5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No falls for January	Will continue to monitor
February	
Summary of Findings	**Plan of Action**
No falls for February	Will continue to monitor
March	

Risk Management

Summary of Findings	Plan of Action
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

F. Falls with Major Injury

Function: Outcome and Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Incident Reports
Sample Size: All patients with falls (fractures, subdural hematomas, other major head trauma, cardiac arrest, excessive bleeding, lacerations requiring sutures, loss of consciousness)
Methodology: Patient Records, Incident Reports, PDSA
Inclusion Criteria: All patients with falls

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD

Risk Management

Patient Falls with Major Injury	0	0											**0**
Total number of Patient Days	183	324	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**507**
Rate per 1000 patient days (Benchmark = 0.5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---
Indicator	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
ED Patient Falls With Major injury	0	0											**0**
Total number of ED Visits	104	133	0	0	0	0	0	0	0	0	0	0	**237**
Percent of Total ED Patient Falls (Benchmark = 0.5 or less)	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No falls this month	Will continue to monitor
February	
Summary of Findings	**Plan of Action**
No falls with major injury for February	Will continue to monitor
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**

Risk Management

November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Risk Management

G. Mortality Rate

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Discharge Report
Sample Size: All patient expirations during reporting period
Methodology: Patient Records, Discharge Report, PDSA
Inclusion Criteria: All patient expirations during reporting period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of deaths (Acute, Swing bed) during the reporting period	0	1	1										**2**
Total number of patient discharges	19	25	0	0	0	0	0	0	0	0	0	0	**44**
Percent of Total Discharges (Benchmark=10%)	---	**4%**	**#DIV/0!**	---	---	---	---	---	---	---	---	---	**5%**
Indicator													
# of deaths (observation) during reporting period	0	**0**											**0**
Indicator													
# of deaths (ER) during the reporting period	0	0											**0**
Total number of ER patient discharges	104	133	0	0	0	0	0	0	0	0	0	0	**237**
Percent of Total Discharges	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No deaths for MRMC in January	Will continue to monitor
February	
Summary of Findings	**Plan of Action**
One patient death in reporting period. 1. Patient was admitted for CHF and AKI. During stay patient became unresponsive. ACLS protocols administered. No ROSC noted. Death called.	Continue operating capacities for this CAH.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**

Risk Management

July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

H. Deaths within 24 hours of Admit

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Discharge Report
Sample Size: All patient expirations during reporting period
Methodology: Patient Records, Discharge Report, PDSA
Inclusion Criteria: All patient expirations during reporting period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of deaths within 24 hours of admit	0	0											**0**
# of deaths during the reporting period	0	0											**0**
Percentage of deaths within 24 hours	**#N/A**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**

January	
Summary of Findings	**Plan of Action**
No deaths w/in 24 hours of admit	No action required at this time
February	
Summary of Findings	**Plan of Action**
No deaths w/in 24 hours of admit	No action required at this time
March	

Risk Management

Summary of Findings	Plan of Action
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

I. Organ Procurement Organization Notification/Tissue Donation

Function: Outcome & Process Measure **Rationale: High Risk, Problem Prone** **Data Source: Patient Records, Discharge Report** **Sample Size: All patient deaths** **Methodology: Patient Records, Discharge Report, PDSA** **Inclusion Criteria: All patient expirations during reporting period**

Risk Management

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of documented Organ banks notifications within 60 min of death	**0**	**1**											**1**
Total number of Deaths for the reporting period	**0**	**1**											**1**
Percent of Deaths Reported (Benchmark = 100%)	**#N/A**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Tissue Donations	0												0

January	
Summary of Findings	**Plan of Action**
No deaths	NO action required at this time
February	
Summary of Findings	**Plan of Action**
LifeShare notified within 60 minutes of death.	No action required at this time
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	

Risk Management

Summary of Findings	Plan of Action
December	
Summary of Findings	**Plan of Action**

J. Patient Identfiers

Function: Outcome & Process Measure **Rationale: High Risk, Problem Prone** **Data Source: Tracking Tool**

Nursing Services

A. Critical Tests / Labs

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Lab reports, Patient Records
Sample Size: All critical labs for Reporting Period
Methodology: Audit Tool, Patient Records, PDSA

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Critical results with documented MD/LIP contact within 1 hour (from RN notification to provider) (Benchmark=90%)	11	27											**38**
Total critical results logged during reporting period	16	27											**43**
Percentage of Critical Lab Results Completed (Benchmark = 90%	**69%**	**100%**	---	---	---	---	---	---	---	---	---	---	**88%**

January	
Summary of Findings	**Plan of Action**
31% below benchmark	CCO has instructed Lab staff to call critical results to nurse. Nurse will promptly log and report results to provider. Additionally, lab staff will accompany their call with a faxed reults and request signed acknowledgment from the receiving nursing. Staff were educated on the updated process via read and sign inservice by CCO.
February	
Summary of Findings	**Plan of Action**
no remarkable findings	no action required at thsi time
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	

Nursing Services

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**
December	

B. Restraint Use

Rationale: High Risk, Problem Prone
Data Source: Patient Records, Audit Log
Sample Size: All episodes of restraint Use During Reporting Period
Methodology: Patient Records, Audit Log, PDSA

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of restraint days during reporting period	0	0											**0**
Total patient days during reporting period	183	324	0	0	0	0	0	0	0	0	0	0	**507**
Rate per 1000 patient days	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No restraint use in January	No action required at thsi time
February	
Summary of Findings	**Plan of Action**
No restraint use in February	No action required at thsi time
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**

Nursing Services

May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**
December	

Nursing Services

Summary of Findings	Plan of Action

C. RN Assessments

Rational: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: Quarterly Random Sample (20 records) of Discharged Patients (Acute & SWB)
Methodology: Patient Records, PDSA
Inclusion Criteria: Discharged patients (Acute & Swing) during a quarterly period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of RN assessments completed q24 hours	19	20											**39**
Total Number of assessments reviewed	19	20											**39**
Percent of Compliance (Benchmark = 100%)		**1000**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**1000**

January

Summary of Findings	Plan of Action
	No action required at this time

February

Summary of Findings	Plan of Action
No remarkable findings	No action required at this time

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

May

Summary of Findings	Plan of Action

June

Summary of Findings	Plan of Action

July

Summary of Findings	Plan of Action

August

Summary of Findings	Plan of Action

Nursing Services

September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Emergency Department

A. ER Log & Visits

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, ER Log PDSA
Sample Size: All ER patients During Reporting Period
Methodology: Patient Records, Audit Tool, PDSA
Inclusion Criteria: All ER Patients During Reporting Period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ER Log Current & Complete (Each ER Visit)	104	133											**237**
Total number of ER Visits	104	133	0	0	0	0	0	0	0	0	0	0	**237**
Percent of Compliance (Benchmark = 100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
no remarkable findings	No action required at this time.
February	
Summary of Findings	**Plan of Action**
No remarkable findings	No action required at this time.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Medical Screening Exams

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records
Sample Size: Quarterly Random Sample of 20 Discharged Patients
Methodology: Patient Records, PDSA
Inclusion Criteria: ED Records

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of Medical Screening Exams Completed (Benchmark=100%)	20	20											**40**
Total # of Medical Exam Screenings Reviewed	20	20											**40**
Compliance Percentage (Benchmark = 100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

Summary of Findings	Plan of Action
January	
Summary of Findings	**Plan of Action**
No remarkable findings	No action required at this time.
February	
Summary of Findings	**Plan of Action**
no remarkable findings	No action required at this time.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

C. Provider ER Response Time

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records
Sample Size: Quarterly Random Sample of 20 Discharged Patients
Methodology: Patient Records, PDSA
Inclusion Criteria: ED Records

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of ER response times within 20 minutes (time of provider notification to provider arrival time)	20	20											**40**
Total number of ER visits reviewed	20	20											**40**
ER Provider Response Time (Benchmark=90%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January

Summary of Findings	Plan of Action
No remarkable findings	No action required at this time.
February	
Summary of Findings	**Plan of Action**
No remarkable findings	No action required at this time.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

D. ED RN Assessment (Initial)

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records

Sample Size: Quarterly Random Sample of 20 Discharged ED Patients
Methodology: Patient Records, PDSA
Inclusion Criteria: ED Records

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of ED RN assessments (Initial) completed	20	20											**40**
Total # of ED RN assessments reviewed	20	20											**40**
ED RN Assessment Percent of completion (Benchmark=100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
no remarkable findings	No action required at this time.

February	
Summary of Findings	**Plan of Action**
no remarkable findings	No action required at this time.

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**

September	
Summary of Findings	**Plan of Action**

October	
Summary of Findings	**Plan of Action**

November

Summary of Findings	Plan of Action
December	
Summary of Findings	**Plan of Action**

E. ED Readmissions

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All ED Readmissions within 72 hours of discharge
Methodology: Medical records, Discharge reports, PDSA
Inclusion Criteria: All ED Readmissions within 72 hours of discharge

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients readmitted to ED within 72 hours	1	3											**4**
Total # of ED discharges	104	133											**237**
ER Re-Admits Rate per 100 patient discharges (Benchmark=2.5%)	**1**	**2**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**2**

January	
Summary of Findings	**Plan of Action**
1 readmit to acute: Patient was admitted to acute care on 1-3-20 with CHF, COPD exacerbation and shortness of breath. She was started on IV Rocephin and Zithromax for CXR that showed mediastinal opacity. Neb treatments were ordered routinely. She received DVT and stress ulcer prophylaxis and has improved. She has no dyspnea with exertion and on room air is oxygenating at 95%. She insists she go home, though it was suggested a few more days of IV antibiotics would be beneficial, and sputum culture results would be available. She states she has family that will be staying with her and she 'really needs' to go home.	no action required at this time.
February	
Summary of Findings	**Plan of Action**

3 patients readmitted to ER within 72 hours. 1) First admission patient c/o n/v. NS bolus given in ER and phenergan given for home use. When patient came back within 24 hours was for c/o heart palpatations. Provider determined from phenergan use and patient was told to stop using the phenergan. 2) first admission was for laceration to left long finger and pinky. Laceration repair done with Dermabond and Steri-Strips. Patient came back within 24 hours due to a Steri-Strip falling off and then proceeding to remove the rest of the Steri-strips. Laceration repair done again with Dermabond and Steri-Strips and covered with bandage. 3) First admssion with c/o anxiety and out of medications until appointment in three days with PCP. Ativan given and patient discharged. Patient returned within 48 hours with same c/o. Ativan given. Patient stated had appointment with PCP the following day for medication refills.	No action required at this time.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**

December	
Summary of Findings	**Plan of Action**

F. EMTALA Transfer Form

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All ED Transfers
Methodology: Medical records, Discharge reports, PDSA
Inclusion Criteria: All patients transferred from ED

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients with EMTALA Transfer Form Completed	n/a	n/a											**0**
Total # of ED discharge reviews													**0**
ER Re-Admits Rate per 100 patient discharges (Benchmark = 100%)	#######	#######	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
Corporate is working towards getting us the correct EMTALA paperwork for	
February	
Summary of Findings	**Plan of Action**
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

G. ED Transfers

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: All acute transfers from ED to tertiary facility
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All ED transfers from ED to tertiary facility

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of ED patients transferred to tertiary facility	7	10											**17**

January	
Summary of Findings	**Plan of Action**
7 ER Transfers: 1) Patient had elevated troponin, obstructive uropathy, AKI vs CRF vs acute on chronic renal failure, severe bilateral hydronephrosis, metabolic acidosis, anemia, UTI, hyperphosphatemia. 2) Patient had dizziness, bradycardia, patient transferred for pacemaker placement per cardiologist Dr. Chanrda 3) 8 yr old with a dog bit to the face with avulsion injury, Transferred to OU Children's 4) Patient had hypovolemic shock with end0organ dysfunction, large abdominal wall hematoma s/p AAA surgery on 1/11/21, anemia. 5) Patient had hypoxia, CHF exacerbation, large right pleural effusion, A-fib 6) Patient had RLQ abdominal pain, RLQ abdominal Spigelian hernia with possible obstruction, probable incarcerated hernia 7) Patient has minimally displaced subcapital right femoral neck fracture s/p fall, syncope, bilateral pleural effusions and right basilar opacity	Continue operations at capacities appropriate for this CAH.
February	
Summary of Findings	**Plan of Action**

10 ER Transfers: 1. Patient presented with rhabdomyolysis and acute respiratory failure. 2. Presented with acute thrombolitic stroke and right hemiparesis. 3. Presented with left sided weakness and noted NSTEMI on EKG. 4. Presented with right subdural hematoma with midline shift secondary to head injury with LOC. 5. Presented with right hip fracture. 6. Presented with RLQ pain, Right ovarian cyst, possible intermittent Right ovarian Torsion. 7. Presented with left femoral neck fracture. 8. Presented with Covid + and Shortness of Breath. 9. Presented with UTI, Nephrolithiasis, and Sepsis. 10. Presented with Exacerbation of COPD and AKI.	1) Higher level of care needed. 2) Higher level of care needed. 3) Higher level of care needed. 4) Higher level of care needed. 5) Surgical repair needed. 6) Higher level of care needed. 7) Surgical repair needed. 8) Inability to keep at facility due to inablility to heat Covid rooms at time of presentation. 9) Higher level of care needed. 10) Inability to keep at facility due to inablility to heat Covid rooms at time of presentation. Continue operations at capacities appropriate for this CAH
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

H. Stroke Care

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: All stroke alerts during reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All stroke alerts during reporting period

	Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
1	Stroke Log Completed	0%	%											**0%**
2	Door to EMS/Air Evac Notification < 15 Minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
3	Door to Patient Transfer < 60 minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
4	Door to Provider Evaluation < 15 minutes	0	2											**2**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
5	Door to Stroke Center Notification < 20 minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
6	Vital Signs Documented Every 15 minutes	0	1											**1**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	**50%**	---	---	---	---	---	---	---	---	---	---	**50%**
7	Neurological Checks Documented Every 15 minutes	0	0											**0**
	Total # of Stroke Alerts	0	2											**2**
	Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
8	Total # of Stroke Patients	0	2											**2**
9	Total # of Acute Stroke Patients	0	2											**2**
10	Total # of Stroke Patients Eligible for Thrombolytics	0	1											**1**

January

Summary of Findings	Plan of Action
No strokes noted for January	No action required at this time.

February

Summary of Findings	Plan of Action
1. No TPA in building. Vital signs and neuro checks not done every 15 minutes until stable. Inclement weather and pandemic (lack of bed) delayed transport. 2. No clinical signs for TPA. No neuro checks noted every 15 minutes until stable. Inclement weather and pandemic (lack of beds) delayed transport. (Wasn't this patient admitted?) This patient was not admitted, but was tranfered to a higher level of care.	Continue operations at capacities for this CAH. No other action required at this time. ER RN's re-educated on stroke protocols for vital signs and neuro checks.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

I. Suicide Management

Function: Outcome & Process Measure

Rationale: High Risk, Problem Prone
Sample Size: All ED patients during reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All patients with suicidal/homicidal ideations, suicide attempt, self-harming behaviors, intentional overdose, etc.

	Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
1	Total # of Suicide Screenings Documented on Admission/Triage	2	2											**4**
	Total # of Suicide Screenings Required	2	2											**4**
	Percentage of Compliance (Benchmark = 80%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
2	Completion of Environmental Patient Safety Checklist	2	1											**3**
	Total # of Environmental Patient Safety Checklists Required	2	2											**4**
	Percentage of Compliance (Benchmark = 80%)	**100%**	**50%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**75%**

January

Summary of Findings	Plan of Action
1. Patient presented on 1/13 w/suicidal ideations. QM can not find Psych paperwork in the chart. Patient came in with thoughts of self harm, depression and anxiety. Patient was told by Red Rock to come in and get an eval. Patient was triaged and evaluated. Had virtual meeting with Red Rock. Patient was transferred from ED to Red Rock facility by MPD. 2. Patient presented on 1/12 w/chronic depression and auditory hallucinations. Patient wanted to be transfereed to Red Rock. Patient was triaged and evaluated. Had virtual meeting with Red Rock. Patient was transferred from ED to Red Rock facility by MPD	QM spoke with CCO and QA Nurse about not being able to find Psych paperwork. QA Nurse is reassessing the chart. CCO will re-educate the RN involved in the care of that patient about Psyc paperwork that is required to be done.

February

Summary of Findings	Plan of Action
1. Patient presented on 2/17 with thoughts of self harm. Patient was triaged and evaluated. Red Rock held virtual meeting with patient and safety plan was implemented. Patient allowed to discharge home with safety plan. No ED psych paper work noted. 2. Patient presented on 2/24 with suicidal ideations. Patient was triaged and evaluated. Patient had virtual meeting with Red Rock Crisis team and crisis plan/safety plan was implemented. Patient was allowed to discharge home with parents with crisis/safety plan.	ER RN re-educated on Psych paperwork that is required for such patients.

March

Summary of Findings	Plan of Action
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

J. Triage

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: Minimum of 20 records per reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All ED patients

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Door to Triage Level < 5 minutes	20	20											**40**
Total # of ED Patients Reviewed	20	20											**40**

Percentage of Compliance (Benchmark = 85%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
	No action required at this time
February	
Summary of Findings	**Plan of Action**
No remarkable findings	No action required at this time
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**
	No action required at this time

K. STEMI Care

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: All cardiac patients during reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All patients reporting chest pain, chest discomfort or other symptoms based on ECG screening criteria

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Door to ECG < 5 Minutes Met	0	1											**2**
Total # of Cardiac Patients	0	1											**2**
Percentage of Compliance (Benchmark = 80%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**
Door to Provider Evaluation < 15 minutes	0	1											**2**
Total # of Cardiac Patients	0	1											**2**
Percentage of Compliance (Benchmark = 80%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**
Door to Chest X-ray < 30 minutes	0	1											**0**
Total # of Cardiac Patients	0	1											**2**
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to EMS/Air Evacuation Notification < 20 minutes	0	0											**0**
Total # of Cardiac Patients	0	1											**2**
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to Patient Transfer < 60 minutes	0	0											**0**
Total # of Cardiac Patients	0	1											**2**
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---
Door to Fibrinolytic Therapy < 30 minutes	0	0											**0**
Total # of Cardiac Patients	0	1											**2**
Percentage of Compliance (Benchmark = 80%)	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No STEMI/NSTEMI noted for January	No action required at this time
February	
Summary of Findings	**Plan of Action**

One patient noted for reporting period. 1) Patient presented to ER with Stroke like symptoms. Upon evaluation during ER visit, it was noted patient had a NSTEMI per EKG. Patient was delayed transfer due to inclement weather and pandemic (lack of beds). Thrombolytic therapy was not indicated for patient.	CCO re-educated ED RN on cardiac protocols. DATE??? Continue operating capacities for this CAH. No action required at this time.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

l. ED Nursing Assessment (Discharge/Transfer)

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Sample Size: Minimum of 20 records per reporting period
Methodology: Medical records, Discharge reports, ED Log, PDSA
Inclusion Criteria: All ED patients

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
ED Nursing Assessment Completed Upon DC or Transfer	20	20											**40**
Total # of ED Patients Reviewed	20	20											**40**
Percentage of Compliance (Benchmark = 90%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
	No action required at this time
February	
Summary of Findings	**Plan of Action**
No remarkable findings	No action required at this time
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**

November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Pharmacy and Medication Safety

A. Pharmacy Utilization

Drug Costs	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Drug Costs for reporting month	$9,525	$18,552											**$28,078**
High Cost Medications (Medications that cost more than $100 per dose)	$709.92	4177.88											**4888**

January	
Summary of Findings	**Plan of Action**
High Cost Medications: $709.92 (Advair, Santyl, Cathflo); Antibiotics: $817.19; Radiology: $1383.87 (Optiray); Vaccines: $832.07 (Adacel, Tubersol); COVID-19 Meds: $131.24 (ProAir)	
February	
Summary of Findings	**Plan of Action**
High Cost Medications: $4177.88 (Symbicort, Lantus, Combivent); Antibiotics: $2057.90; Vaccines: $243.85 (Adacel); Nutrition/IV fluids: $2721.42; COVID-19 Medications: $2243.25 (Combivent inhalers)	
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	

Pharmacy and Medication Safety

Summary of Findings	Plan of Action
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. After Hours Access

Rationale: High Risk, Problem Prone
Data Source: Med Dispense & Patient Records
Sample Size: All After Access Hours Occurrences
Methodology: Pharmacy Logs, PDSA

Quality Control Monitoring	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of after hours access to pharmacy for narcotics	0	0											**0**
Total # of after hours access to pharmacy for narcotics (Benchmark = < 50)	104	133											**237**

January	
Summary of Findings	**Plan of Action**
DR accessed 104 times: 41 times for refrigerated medications; 11 times for ER patient medications; 3 times to restock RT box; 25 times for IV fluids not stocked in MedDispsense; 4 times for inhalers/topicals that are kept in DR to capture charges; 1 time for a vaccine; 1 time for Bamlanivimab therapy; 5 times to restock MedDispense; and 12 times for no need when medications were actually in MedDispense	Refrigerator and MedDispense locking sysstem has been purchased for nursing station. Awaiting installation. Will dramatically decrease the amount of times DR is accessed after hours. We still are looking at options for adding additional automated dispensing systems to increase storage capabilities at the nursing station.
February	
Summary of Findings	**Plan of Action**
Dr accessed 133 times: 3 times for refrigerated medications; 21 times for inhalers/topicals that are kept in DR to capture charges; 12 times for ER patient medications; 7 times for bulk medications; 5 times for vaccines; 31 times for IV fluids not stocked in MedDispense; 13 times to restock RT box; 5 times for Remdesivir or other COVID-19 medications; 9 times to restock MedDispense; and 22 times for no need when medications actually stocked in MedDispense.	Refrigerator and MedDispense locking system has been purchased for nursing station. Awaiting installation. Will dramatically decrease the amount of times DR is accessed after hours. We still are looking at options for adding additional automated dispensing systems to increase storage capabilities at the nursing station.
March	
Summary of Findings	**Plan of Action**

Pharmacy and Medication Safety

April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

C. Adverse Drug Reactions

Definition per The American Society of Health-System Pharmacists (ASHP): **"Any unexpected, unintended, undesired, or excessive response to a drug that: 1) requires discontinuing the drug (therapeutic or diagnostic) 2) requires changing the drug therapy 3) requires modifying the dose (except for minor dose adjustments) 4) necessitates hospital admission 5) prolongs stay in a health care facility 6) necessitates supportive 7) significantly complicates diagnosis 8) negatively affects prognosis 9) results in temporary or permanent harm, disability, or death 10) an allergic reaction (an immunologic hypersensitivity occurring as the result of unusual sensitivity to a drug) and idiosyncratic reaction (an abnormal susceptibility to a drug that is peculiar to the individual)"**
Function: Outcome & Process Measure **Rationale: High Risk, High Volume, Problem Prone** **Data Source, Patient Records, Incident Reports** **Sample Size: All Incidences with a Reported/Suspected ADR During Reporting Period** **Methodology: Patient Records, Incident Reports, PDSA**

Pharmacy and Medication Safety

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of medication doses that elicited adverse drug reaction	0	0											**0**
# of medication doses dispensed from pharmacy during reporting period	5,874	TBD											**5874**
ADR Rate per 1000 medications dispensed	---	---	---	---	---	---	---	---	---	---	---	---	---
January													

Respiratory Care Services

A. Ventilator Days

Function: Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All Inhouse Ventilator Patients During Reporting Period
Methodology: Patient Records, PDSA
Inclusion Criteria: All Inhouse Ventilator Patients During Reporting Period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Ventilator Days	0	10											**10**

January	
Summary of Findings	**Plan of Action**
Benchmark met	No action required

February	
Summary of Findings	**Plan of Action**
Benchmark met	No action required

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**

September	
Summary of Findings	**Plan of Action**

October	
Summary of Findings	**Plan of Action**

Respiratory Care Services

November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Ventilator Wean

Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All Inhouse Ventilator Patients On Weaning Program
Methodology: Patient Records, PDSA
Inclusion Criteria: All Inhouse Ventilator Patients On Weaning Program

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients on a ventilator at least 7 days, in the weaning program and weaned from the ventilator at least 2 days prior to discharge and at time of discharge	0	0											**0**
# of ventilator patients discharged during the reporting month that had a physician order to wean, were on a vent > 7 days, and were NOT a terminal wean.	0	0											**0**
Percent of discharged patients successfully weaned from the ventilator prior to discharge	---	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
Benchmark met	No action required
February	
Summary of Findings	**Plan of Action**
Benchmark met	No action required
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**

Respiratory Care Services

May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

C. Unplanned Trach Decannulations

Rationale: High Risk, Problem Prone
Data Source: Patient Records, Incident Reports
Sample Size: All Patients with Unplanned Trach Decannulations
Methodology: Patient Records, Incident Reports, PDSA
Inclusion Criteria: All Patients with Unplanned Trach Decannulations

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Unplanned Patient Decannulations	0	0											**0**
Total Trach Days	0	10											**10**
Self Decannulation Rate per 1000 Trach Days	**#DIV/0!**	**0**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**0.0**

January	
Summary of Findings	**Plan of Action**

Respiratory Care Services

Benchmark met	No action required
February	
Summary of Findings	**Plan of Action**
Benchmark met	No action required
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

D. Respiratory Care Equipment

Rationale: High Risk, Problem Prone **Data Source: Patient Records, Log**

Respiratory Care Services

Sample Size: All Patients with Respiratory Care Equipment
Methodology: Patient Records, Log, PDSA
(Benchmark = 100%)
Inclusion Criteria: All Patients with Respiratory Care Equipment

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
HME's Changed Every Shift & PRN	0	3											**3**
Total Due To Change	0	3											**3**
Percentage of Compliance	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Inner Cannulas Changed Every Shift & PRN	0	19											**19**
Total Due To Change	0	19											**19**
Percentage of Compliance	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Suction Set-Ups Changed Every 7 Days & PRN	0	1											**1**
Total Due To Change	0	1											**1**
Percentage of Compliance	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Nebulizer & Masks Changed Every 7 Days & PRN	10	21											**31**
Total Due To Change	10	21											**31**
Percentage of Compliance	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Trach Collars & Tubing Changed Every 7 Days & PRN	0	2											**2**
Total Due To Change	0	2											**2**
Percentage of Compliance	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Vent Circuits Changed Every 30 Days & PRN	0	0											**0**
Total Due To Change	0	0											**0**
Percentage of Compliance	---	---	---	---	---	---	---	---	---	---	---	---	---
Trach Changed Every 30 Days & PRN	0	0											**0**
Total Due To Change	0	0											**0**
Percentage of Compliance	---	---	---	---	---	---	---	---	---	---	---	---	---
Closed Suction Kits Changed Every 3 Days & PRN	0	3											**3**
Total Due To Change	0	3											**3**
Percentage of Compliance	---	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**

January	
Summary of Findings	**Plan of Action**
Benchmark met	No action required
February	
Summary of Findings	**Plan of Action**
Benchmark met	No action required
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**

Respiratory Care Services

May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Wound Care

A. Development of Pressure Ulcers

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All Patients who Develop a Stage II PU or >
Methodology: Patient Records, Incident Reports, PDSA
Inclusion Criteria: All Patients who Develop a Stage II PU or > Exclusion Criteria: Kennedy Ulcers
Formula: All patients who develop Stage II PU or > (Count on Discharge)/Total # of Discharges for the Month

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients that develop hospital acquired pressure ulcers during the stay: Stage II or higher, including eschar	0	0											**0**
Total number of patients discharged during the reporting period	19	10											**29**
Percent of patients developing 1 or more pressure ulcers during reporting period (Benchmark = 2% or less)	**0%**	**0%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**0%**

January	
Summary of Findings	**Plan of Action**
N/A	N/A
February	
Summary of Findings	**Plan of Action**
N/A	N/A
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	

Wound Care

Summary of Findings	Plan of Action
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Wound Healing Rate

Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All Discharged Patients Receiving Wound Care for PU During Reporting Period
Methodology: Patient Records, PDSA
Formula: Total sum of admission wound scores minus total sum of discharged wound scores

# of wounds that showed improvement	1	0											**1**
# of total wounds	1	0											**1**
Wound Healing Rate	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100.0%**

January	
Summary of Findings	**Plan of Action**
1 patient discharged with a PU and her wound showed improvement	N/A
February	
Summary of Findings	**Plan of Action**
No patient discharged with PU's for the month of February	N/A
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**

Wound Care

August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

C. Wound Care Documentation

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Initial wound patients with assessment/pictures completed within 24 hours of admission	2	3											**5**
# of wound care patients admitted during the reporting period	2	3											**5**
Total of Completed Wound Care Admission Assessments/Pictures (Benchmark=95%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
# of discharged wound patients with assessment/pictures completed at discharge	3	1											**4**
# of wound care patients discharged during the reporting period	3	1											**4**
Total of Completed Wound Care Discharge Assessments/Pictures (Benchmark-=95%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
N/A	N/A
February	
Summary of Findings	**Plan of Action**
N/A	N/A
March	
Summary of Findings	**Plan of Action**

Wound Care

April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

D. Wound Debridement/Wound Procedures

Medical Wound Debridement/Wound Procedures	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of patients with consents completed prior to the procedure	1	3											**4**
# of patients with wound debridement's/wound procedures performed during reporting period	1	3											**4**
Percent of patients receiving documented informed consent (Benchmark=100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Total number of debridements	3	8											**11**

January	
Summary of Findings	**Plan of Action**

Wound Care

N/A	None
February	
Summary of Findings	**Plan of Action**
N/A	N/A
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

E. Wound Vac Application

Function: Outcome & Process Measure

Rationale: High Risk, Problem Prone

Data Source: Patient Records

Sample Size: All Discharged Patients Receiving Wound Vac Treatment During Reporting Period

Methodology: Patient Records, PDSA

Wound Care

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of consents completed prior to application of first wound vac	1	0											**1**
# of patients initiating wound vac therapy during the reporting period	1	0											**1**
Percent of patients receiving consent for wound vac intervention prior to first treatment (Benchmark=100%)	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
Only 1 patient had a wound vac for January and consent was signed	N/A
February	
Summary of Findings	**Plan of Action**
N/A	N/A
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	

Wound Care

Summary of Findings	Plan of Action

Radiology/Imaging Services

A. Radiology Films

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Patient Records
Sample Size: All Radiology Performed During Reporting Period
Methodology: Patient Records, PDSA
Inclusion Criteria: All Radiology Reports Performed During Reporting Period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of films repeated	5	9											**14**
Total Number of films completed	103	149											**252**
Percentage of films repeated	**5%**	**6%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**6%**
Poor preparation	1	0											**1**
Technical Error	4	9											**13**
Equipment Failure	0	0											**0**

January	
Summary of Findings	**Plan of Action**
Did not make sure the bucky and tube were lined up, There was patient motion. The tech	No action needed.
February	
Summary of Findings	**Plan of Action**
Clipped anatomy in some, the technique was incorrect in the others.	no action needed.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**

Radiology/Imaging Services

September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Radiology/Imaging Services

B. Imaging

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Patient Records
Sample Size: All CT Imaging Performed During Reporting Period
Methodology: Patient Records, PDSA
Inclusion Criteria: All CT Imaging Performed During Reporting Period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Contrast CT scans completed ***with reaction***	0	0											**0**
Total Number of Contrast CT scans completed	19	10											**29**
Percentage of CT scan reactions	**0%**	**0%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**
Contrast CT scans with completed and signed consents	19	10											**29**
Total Number of Contrast CT scans	19	10											**29**
Percentage of Contrast CT scan consents	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
No Reactions. All exams completed with signed consents.	no action needed.

February	
Summary of Findings	**Plan of Action**
No Reactions. All exams completed with signed consents.	No action needed.

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July

Radiology/Imaging Services

Summary of Findings	Plan of Action
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Radiology/Imaging Services

C. Radiation Dosimeter Report

Function: Outcome Measure
Rationale: Safety & Compliance
Data Source: Dosimeter Reports (Quarterly Report)
Sample Size: All Radiology Personnel
Methodology: Dosimeter Reports, PDSA
Inclusion Criteria: All Radiology Personnel

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Radiology Personnel Monitored	6	6											**12**
Total Number of Radiology Personnel	6	6											**12**
Percentage of Compliant Personnel	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Total Number of Radiology Personnel with out of range results	0	0											**0**
Total Number of Radiology Personnel	6	6											**12**
Percentage of out of range Personnel	**0%**	**0%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**

January	
Summary of Findings	**Plan of Action**
Reports come in quarterly. All techs within range.	No action needed.

February	
Summary of Findings	**Plan of Action**
Reports were received this month. All techs within range.	No action needed.

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July	
Summary of Findings	**Plan of Action**

August

Radiology/Imaging Services

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

D. Physicist's Report

Function: Outcome Measure
Rationale: Safety & Compliance
Data Source: Physicist Report
Methodology: Physicist Report, PDSA

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Physicist Report Completed	X	X	X	X	X	X							**0**

Laboratory

A. Lab Reports

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Lab Reports
Sample Size: All Lab Reports Performed During Reporting Period
Methodology: Lab Reports, PDSA
Inclusion Criteria: All Lab Reports Performed During Reporting Period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Number of labs repeated or rejected	2	1											**3**
Total Number of labs completed	2140	2286											**4426**
Percentage of labs repeated	**0%**	**0%**	---	---	---	---	---	---	---	---	---	---	**0%**
Processing Specimen Error	2	1											**3**
Specimen Collection Procedure/Technique Error	0	0											**0**
Equipment Failure	0	0											**0**
Specimen Identification Error	0	1											**1**

January

Summary of Findings	Plan of Action
2 specimens from the nursing home was misplaced when brought in from the nursing home	Lab tech contacted the nursing home and had the patients specimens resent and the correction for the problem had been established, when the specimens are checked in at the laboratory the specimens are ran by the tech that is in that department that day. Instead of several different techs handling the specimens.

February

Summary of Findings	Plan of Action
Sputum specimen recieved in laboratory with wrong label and the laboratory notified Respiratory Therapy about the mistake and Respiratory came to lab and labeled the specimen with the correct label the resspiratory therapist was the person that had collected the specimen and was certain that the specimen was collected from the patient	The respiratory stated that they would make sure the correct label would be applied before the specimen was collected.

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

May

Summary of Findings	Plan of Action

June

Summary of Findings	Plan of Action

July

Summary of Findings	Plan of Action

Laboratory

August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Blood Culture Contaminations

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Lab Reports
Sample Size: All Blood Culture Lab Reports Performed During Reporting Period
Methodology: Lab Reports, PDSA
Inclusion Criteria: All Blood Culture Lab Reports Performed During Reporting Period

Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Number of contaminated blood cultures	0	0											**0**
Total number of blood cultures obtained	18	34											**52**
Percentage of contaminated blood cultures	**0%**	---	---	---	---	---	---	---	---	---	---	---	---

January	
Summary of Findings	**Plan of Action**
No contaminated blood cultures	no action needed
February	
Summary of Findings	**Plan of Action**
No contaminated blood cultures	no action needed
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**

Laboratory

June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

A. Catheter Associated Urinary Tract Infections (CAUTI's)

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Lab Reports
Sample Size: All Patients with Indwelling Urinary Catheters During Reporting Period
Methodology: Patient Records, Lab Reports, PDSA
Inclusion Criteria: All Patients with Indwelling Urinary Catheters During Reporting Period

Catheter Associated Urinary Tract Infections (CAUTI's)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Catheter Associated Urinary Tract Infections	0	0											**0**
Total # of Urinary Catheter Days During the Reporting Period	71	100											**171**
Infection Rate per 1000 foley catheter days (Benchmark=1)	**0.0**	**0.0**	---	---	---	---	---	---	---	---	---	---	---
CAUTI Bundle Compliance (Benchmark=90%)	100%	100%											**100%**

January	
Summary of Findings	**Plan of Action**
0 CAUTI'S for the month of January. 71 total catheter days between 7 patients.	IP will continue to monitor CAUTI bundles and maintain surveillance of Foley catheter usage for appropriate usage, intitiation, and maintenace.
February	
Summary of Findings	**Plan of Action**
0 CAUTI'S for the month of February. 100 total catheter days between 11 patients.	IP will continue to monitor CAUTI bundles and maintain surveillance of Foley catheter usage for appropriate usage, intitiation, and maintenace.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Central Line Associated Bloodstream Infections (CLABSI's)

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Lab Reports
Sample Size: All Patients with Indwelling Central Venous Catheters During Reporting Period
Methodology: Patient Records, Lab Reports, PDSA
Inclusion Criteria: All Patients with Indwelling Central Venous Catheters During Reporting Period

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Central Line Associated Primary Bloodstream Infections	0	0											**0**
# of Total Central Line Days During the Reporting Period	58	127											**185**
Infection Rate per 1000 central line days (Benchmark = 0.5)	**0.0**	**0.0**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**
CLABSI Bundle Compliance (Benchmark=90%)	100%	100%											**100%**

January	
Summary of Findings	**Plan of Action**
0 CLABSI's for the month of January. 58 total CVL days between 6 patients.	Nursing and IP will reinforce rationale for placement and maintenance of central lines. IP will reinforce hand hygiene and sterile technique to nursing staff when performing dressing changes and proper technique for utilization when administering medications.
February	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

0 CLABSI's for the month of February. 127 total CVL days between 11 patients.	Nursing and IP will reinforce rationale for placement and maintenance of central lines. IP will reinforce hand hygiene and sterile technique to nursing staff when performing dressing changes and proper technique for utilization when administering medications.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

C. Hospital Acquired MDRO

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Lab Reports
Sample Size: All Patients who Develop HA MDRO
Methodology: Patient Records, Lab Reports, PDSA
Inclusion Criteria: All Patients who Develop HA MDRO

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of MDRO identified >24 hours after admission	0	0											**0**
Total # of Patient Admissions	25	35	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**60**
Hospital Acquired MDRO Rate per 1000 patient admissions	**0.0**	---	---	---	---	---	---	---	---	---	---	---	---

January

Summary of Findings	Plan of Action
0 Hospital-acquired MDRO's for the month of January.	IP will continue to reinforce prompt recognition of need and collection for cultures within 3 days of admission through ongoing training and upon orientation of new nursing staff.

February

Summary of Findings	Plan of Action
0 Hospital-acquired MDRO's for the month of February	IP will continue to reinforce prompt recognition of need and collection for cultures within 3 days of admission through ongoing training and upon orientation of new nursing staff.

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

May

Summary of Findings	Plan of Action

June

Summary of Findings	Plan of Action

July

Summary of Findings	Plan of Action

Infection Control and Prevention

August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

D. Hospital Acquired C-diff

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Lab Reports
Sample Size: All Patients who Develop C. diff > days After Admission
Methodology: Patient Records, Lab Reports, PDSA
Inclusion Criteria: All Patients who Develop C. diff > days After Admission

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of LAB ID EVENT C. diff (Hospital Onset identified > 3 days after admission	0	0											**0**
Total # of Patient Days (Excludes observation patients)	183	324											**507**
LAB ID EVENT C. Diff Rate	**0.0**	---	---	---	---	---	---	---	---	---	---	---	---
Total number of admissions	25	35	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	**60**
Total # of LAB ID EVENT C. diff (Community Onset identified within 3 days of admission)	0	0											**0**

January	
Summary of Findings	**Plan of Action**
No C-Diff findings for the month of January	Continue to monitor for C-Diff with ABX surveillance and stewardship.
February	
Summary of Findings	**Plan of Action**
No C-Diff findings for the month of February.	Continue to monitor for C-Diff with ABX surveillance and stewardship.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Correction**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

E. Hospital Acquired Infections by Source

Source	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Blood with CVC (central venous catheter)	0	0											**0**
Blood without CVC	0	0											**0**
Urine with indwelling catheter	0	0											**0**
Urine without indwelling catheter	0	0											**0**
HAI with artificial airway device	0	0											**0**
HAI without artificial airway device	0	0											**0**
Stool	0	0											**0**
Wound	0	0											**0**
Total Acquired Infection Sources	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

January	
Summary of Findings	**Plan of Action**
0 HAI for January	IP will continue infection control surveillance, increase education and emphasize importance of hand hygiene and PPE usage. Prompt recognition and collection of cultures within 3 days of admission, or less than 24 hrs if possible, will be initiated by nursing and IP.
February	
Summary of Findings	**Plan of Action**
0 HAI for February	IP will continue infection control surveillance, increase education and emphasize importance of hand hygiene and PPE usage. Prompt recognition and collection of cultures within 3 days of admission, or less than 24 hrs if possible, will be initiated by nursing and IP.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	

Infection Control and Prevention

Summary of Findings	Plan of Action
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

F. Hand Hygiene/PPE & Isolation Surveillance

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Observation
Sample Size: 20 observations/month
Methodology: All Staff, PDSA
Inclusion Criteria: All Staff

% of Hand Hygiene Compliance (Benchmark=80%)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Nursing (RN, LPN, Tech)	100%	100%											**100%**
Radiology/Imaging Staff	100%	100%											**100%**
Lab	100%	100%											**100%**
Respiratory	100%	100%											**100%**
Therapy	100%	100%											**100%**
Housekeeping/Dietary	100%	100%											**100%**
Medical Staff (MD/DO, NP, PA)	100%	100%											**100%**
% of PPE Compliance (Benchmark=80%)	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Nursing (RN, LPN, Tech)	100%	100%											**100%**
Radiology/Imaging Staff	100%	100%											**100%**
Lab	100%	100%											**100%**

Infection Control and Prevention

Respiratory	100%	100%											**100%**
Therapy	100%	100%											**100%**
Housekeeping/Dietary	100%	100%											**100%**
Medical Staff (MD/DO, NP, PA)	100%	100%											**100%**
Isolation	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of patients in isolation	20	22											**42**
Total number of isolation patient days	122	92											**214**

January	
Summary of Findings	**Plan of Action**
100% compliance with hand hygiene and PPE measures monitored for the month of January. A total of 122 isolation days between 20 patients in January. Each PUI in airborne/contact/droplet isolation pending COVID-19 swab results and screening history. 18 PUI patients for a total of 70 isolation days. 1 on contact and 1 on airborne/droplet, outside of the PUI isolation, for a total of 52 days.	IP will continue to promote and survey hand hygiene and PPE techniques and usage with all staff. Nursing will have continued diligence with COVID-19 PUI status, unless and until swab results with screening history indicate patient can be transferred to "regular" room. IP will continue monitoring appropriate PPE donning & doffing and supply count to be able to protect patients and staff and educate as needed.
February	
Summary of Findings	**Plan of Action**
100% compliance with hand hygiene and PPE measures monitored for the month of February. A total of 92 isolation days between 22 patients in February. Each PUI in airborne/contact/droplet isolation pending COVID-19 swab results and screening history. 18 PUI patients for a total of 49 isolation days. 4 on contact, outside of the PUI isolation, for a total of 43 days.	IP will continue to promote and survey hand hygiene and PPE techniques and usage with all staff. Nursing will have continued diligence with COVID-19 PUI status, unless and until swab results with screening history indicate patient can be transferred to "regular" room. IP will continue monitoring appropriate PPE donning & doffing and supply count to be able to protect patients and staff and educate as needed.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	

Infection Control and Prevention

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

G. Public Health Reporting

Function: Outcome Measure
Rationale: Regulatory Compliance
Data Source: Patient Records, Lab Records
Sample Size: All Inhouse Patients with A Reportable Disease Condition
Methodology: Patient Records, Lab Records, PDSA
Inclusion Criteria: All Inhouse Patients with A Reportable Disease Condition

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Reports to the Health Department	0	9											**9**

January	
Summary of Findings	**Plan of Action**
114 COVID-19 swabs obtained for month of January. 115 results negative, 3 positive. 4 IGG/IGM Serological Antibody tests performed with 2 negative results. Guidance on reporting indicated not to report unless In-House tests were completed and positive. No other issues reported for the month of January.	IP will continue to survey results of all COVID-19 swabs and antibody testing completed by MRMC. No In-House testing to be completed and utilized for official results at this time. Nursing will continue with isolation measures for each patient admitted regarding PUI status.
February	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

132 COVID-19 PCR swabs obtained for month of February. 118 results negative, 14 positive. 12 IGG/IGM Serological Antibody tests performed with 3 negative results, 9 positive. 8 resulted Positive Rapid Swabs. Guidance on reporting indicated not to report unless In-House tests were completed and positive. 1 Chlamydia STI reported.	IP will continue to survey results of all COVID-19 swabs and antibody testing completed by MRMC. In-House Covid-19 Rapid Tests to be completed by lab and reported by lab to PHIDDO within 24 hours of results. Ordering physicians to give the results to the patients or a resulted paper with result disclosure by lab tech. Nursing will continue with isolation measures for each patient admitted regarding PUI status. All other indicated positive results reported by IP to PHIDDO.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Infection Control and Prevention

H. Patient Vaccinations

Function: Process Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All Inhouse Patients (Swing bed)
Methodology: Patient Records, PDSA

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of eligible patients receiving influenza vaccination	3	0											**3**
Total number of eligible patients inhouse and/or admitted during reporting period that meet criteria for vaccination	3	0											**3**
Percentage of Compliance	**100%**	**100%%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Total number of eligible patients receiving pneumococcal	4	0											**4**
Total number of eligible patients inhouse and/or admitted during reporting period that meet criteria for vaccination	4	0											**4**
Percentage of Compliance	**100%**	**100%%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January

Summary of Findings	Plan of Action
3 patient influenza vaccines given in January. We had 4 patients receive pneumococcal vaccine. All vaccination assessments completed for the month of January except one who was transferred.	IP will continue to monitor patient assessments and documentation regarding vaccination status. Each admission gets a review of any immunizations logged into OSIIS and reported to charge nurse. IP will continue to educate and reinforce policy regarding Flu/Pneumo assessments with nursing staff and to document vaccinations under Immunizations in CPSI. IP will record vaccinations given into OSIIS database. At each IDT, IP will review upcoming discharges with primary nurse for review and administration of vaccines if appropriate.

February

Summary of Findings	Plan of Action
0 patient influenza vaccines given in February. We had 0 patients receive pneumococcal vaccine. 9 vaccination assessments via "blue sheet" completed for the month of February out of 13, two transfers, 2 missed.	IP will continue to monitor patient assessments and documentation regarding vaccination status. Each admission gets a review of any immunizations logged into OSIIS and reported to charge nurse. IP will continue to educate and reinforce policy regarding Flu/Pneumo assessments with nursing staff and to document vaccinations under Immunizations in CPSI. IP will record vaccinations given into OSIIS database. At each IDT, IP will review upcoming discharges with primary nurse for review and administration of vaccines if appropriate.

March

Summary of Findings	Plan of Action

Infection Control and Prevention

April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

I. Ventilator Associated Event

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records, Lab Reports
Sample Size: All Patients with Ventilators During Reporting Period

Health Information Management (HIM)

A. History and Physicals Completion

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone Compliance
Data Source: Patient Records
Sample Size: All patient admissions for reporting month if less than 20
Methodology: Patient Records, PDSA
Inclusion Criteria: All Patient Admissions

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of H&P's obtained within 24 hours of admission	25	38											**63**
# of total admissions reviewed for the month	25	38											**63**
% of H& P's obtained within 24 hours of admission (Benchmark = 100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
Met benchmark	Will continue to monitor
Summary of Findings	**Plan of Action**
Met benchmark	Will continue to monitor

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**

September	
Summary of Findings	**Plan of Action**

October	
Summary of Findings	**Plan of Action**

November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Discharge Summary Completion

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records
Sample Size: All discharged patients for reporting month if less than 20
Methodology: Patient Records, PDSA
Inclusion Criteria: Patient Discharges (Acute, SWB patients) Exclusion Criteria: Observation Patient Discharges

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
# of Discharge Summaries completed within 48 hours of discharge	20	24											**44**
# of Discharges	20	26	0	0	0	0	0	0	0	0	0	0	**46**
% of Discharge Summaries completed within 48 hours of discharge (Benchmark=100%)	**100%**	**92%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**96%**

January	
Summary of Findings	**Plan of Action**
Met benchmark	Will continue to monitor
February	
Summary of Findings	**Plan of Action**
Missing one d/c from swingbed and one for an acute chart.	HIM put these in the dr.'s boxes to be done. HIM sent out an email to both physicians letting them know that these are missing on 3/5/21. 3/9/21 Sent out an email to Marie-CEO and Kaye-Credentialing and they are going to send the message along to get these matters completed.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Correction**

August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

C. Progress Notes (Swing bed & Acute)

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records
Sample Size: All discharged patients for reporting month if less than 20
Methodology: Patient Records, PDSA
Inclusion Criteria: All Swing bed Patients

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of complete weekly SWB progress notes	32	23											**55**
Total # of progress notes audited	32	23											**55**
Weekly Progress Note Percent of completion (Benchmark=100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Indicator	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total # of complete daily acute progress notes	40	46											**86**
Total # of progress notes audited	40	46											**86**
Daily Progress Note Percent of completion (Benchmark=100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
Met benchmark.	Will continue to monitor
February	
Summary of Findings	**Plan of Action**
Met benchmark	Will continue to monitor
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

D. Consent to Treat

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records
Sample Size: All discharged patients for reporting month if less than 20
Methodology: Patient Records, PDSA
Inclusion Criteria: Patient Records

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of consent to treat completed	128	165											**293**
Total number of records reviewed	129	172											**301**
Consent To Treat Percent of completion (Benchmark=100%)	**99%**	**96%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**97%**

January	
Summary of Findings	**Plan of Action**
One swingbed is missing the consent.	Jessica with registration checks on them and sends out emails for them to get done when she comes across them. I will run a daily report for the charts to check the consents. if the consents are not scanned in, I will let Daniel in. We will have a sheet that the ward clerks will have to
February	
Summary of Findings	**Plan of Action**

There is 1 er, 1 obs, 3 acute and 2 swb that are missing consents.	HIM sent out emails to RCM-Kasi, CCO-Daniel, Ward Clerks-Desiree & Krystle letting them know about some of the charts that were missing consents on 2/11/21. Kasi followed up with me and i let her know that four of them had gotten done, but the other 7 had not. Kasi-RCM manager also followed up with HIM via emial on 2/25/21 about consents and they still were not
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

E. Swing bed

Function: Outcome & Process Measure
Rationale: High Risk, Problem Prone, Compliance
Data Source: Patient Records
Sample Size: All patient admissions for reporting month if less than 20
Methodology: Patient Records, PDSA
Inclusion Criteria: Swing bed Records

Indicator	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Transition of Care to Swing bed Completed	10	20											**30**
Total number of swing bed admissions	10	20	0	0	0	0	0	0	0	0	0	0	**30**
Percent of completion (Benchmark=95%)	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
Social History completed within 24 hours or first business day post admission	10	20											**30**
Total number of swing bed admissions	10	20	0	0	0	0	0	0	0	0	0	0	**30**
Percent of completion (Benchmark=95%)	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**

January

Summary of Findings	Plan of Action
There are two swingbeds missing the Social History.	2/08/21 HIM Manager sent SWB Director an email about the 2 missing. I am waiting on her response. Candy emailed me back and stated that she would get them done. 2/10/21 i checked and they are complete.

February

Summary of Findings	Plan of Action
Met benchmark	Will continue to monitor

March

Summary of Findings	Plan of Action

April

Summary of Findings	Plan of Action

May

Summary of Findings	Plan of Action

June

Summary of Findings	Plan of Action

July

Summary of Findings	Plan of Action

August

Summary of Findings	Plan of Action

September

Summary of Findings	Plan of Action

October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

F. Electronic Prescribing

Dietary Department

A.

Function: Outcome & Process Measure
Rationale: High Risk, High Volume, Problem Prone
Data Source: Patient Food Trays
Sample Size: 3 Trays/Month
Methodology: Food Trays, PDSA
Formula: # of Food Trays Meeting Goal/# of Food Trays Evaluated

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Food Test Tray Evaluation (Composite Score)	100	100											**200**
Total Score Possible (Composite Score)	100	100											**200**
Percentage of Compliance	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
February	
Summary of Findings	**Plan of Action**
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	

Dietary Department

Summary of Findings	Plan of Action
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Quality Checks

Function: Outcome & Process Measure

Therapy

A. Therapy Indicators

Function: Process, Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All patients on therapy services
Methodology: Patient records; PDSA
Inclusions: Swing bed patients receiving rehab services during reporting period

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Physician Signature on Evaluation Within 7 Days of Initial Evaluation	7	13											**20**
Total Number of Evaluations (Benchmark = 95%)	7	13											**20**
Percentage of Compliance	**100%**	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**100%**
Physician Signature & Date on Recertification Within 7 Days of Completion	2	1											**3**
Total Number of Recertifications (Benchmark = 95%)	2	1											**3**
Percentage of Compliance	**100%**	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**100%**
30-Day Progress Notes Present & On Time	2	1											**3**
Total Progress Notes Due (Benchmark = 80%)	2	1											**3**
Percentage of Compliance	**100%**	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**100%**
Discharge Note Present Within 72 Hours of Discharge (PT/OT/ST) (exclude weekends & holidays)	5	7											**12**
Total Number of Discharge Patients With Therapy Services (Benchmark = 75%)	5	7											**12**
Percentage of Compliance	**100%**	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**100%**
Number of Patients With Assistive Equipment Needs (Evaluation & Recommendations By Therapy)	5	13											**18**
Total Number of Discharge Patients With Identified Assistive Equipment Needs (Benchmark = 95%)	5	13											**18**
Percentage of Compliance	**100%**	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**100%**

January	
Summary of Findings	**Plan of Action**
All paperwork completed on time.	No changes needed.
February	
Summary of Findings	**Plan of Action**
All paperwork completed on time.	No changes needed.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Therapy Visits

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: All patients receiving therapy services
Methodology: Patient records; PDSA
Inclusions: Swing bed patients receiving rehab services during reporting period
Formula: # of treatments sessions completed/# of planned treatment sessions

Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of PT treatment sessions performed	79	117											**196**
Total # of planned treatment sessions	0	4											**4**
Treatment Compliance (Benchmark = 85%)	**#DIV/0!**	**2925%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**4900%**
Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of OT treatment sessions performed	72	130											**202**
Total # of planned treatment sessions	3	144											**147**

Treatment Compliance (Benchmark = 85%)	2400%	90%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	137%
Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of ST treatment sessions performed	5	0											**5**
Total # of planned treatment sessions	5	0											**5**
Treatment Compliance (Benchmark = 85%)	**100%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**100%**

January	
Summary of Findings	**Plan of Action**
Good particiation from patients this month.	Continue seeing patients that are well enough to participate.

February	
Summary of Findings	**Plan of Action**
Good particiation from patients this month.	Continue seeing patients that are well enough to participate and offer those refusing treatment alternative options for therapy.

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**

September	
Summary of Findings	**Plan of Action**

October	
Summary of Findings	**Plan of Action**

November	
Summary of Findings	**Plan of Action**

December

Summary of Findings	Plan of Action

C. Standardized Assessment Improvement Outcomes

Function: Outcome Measure
Rationale: Problem Prone
Data Source: Patient Records
Sample Size: All discharged patients in the therapy program for reporting month
Methodology: Patient records; PDCA
Inclusions: All swing bed patients admitted to therapy services to improve functional mobility
Exclusions: Deaths, patients who cannot tolerate therapy & unplanned facility discharges
Formula: total number of patients discharged with improved standardized assessment score/ total number of patients with documented standardized assessment score on admission

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total # of patients discharged with improved standardized assessment scores (Benchmark=80%)	5	4											**9**
Total # patients with documented standardized assessment score on admission	5	4											**9**
% of Functional Improvement	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Total # of discharges with full return to documented PLOF	3	4											**7**
Total # therapy patient discharges for the month	5	4											**9**
% of Home Discharges	**60%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**78%**

January	
Summary of Findings	**Plan of Action**
2 patient's were discharged below PLOF. 1 Patient had increased debility from stroke suffered prior to admission, and the other patient was given the OK from ortho to discharge home, although it was not recommended by Therapy staff.	Continue providing quality care suitable to each patient's needs.
February	
Summary of Findings	**Plan of Action**
All patients discharged at PLOF.	No changes needed.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	

Summary of Findings	Plan of Action
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
February	
Summary of Findings	**Plan of Action**

Human Resources

A. Compliance

Function: Process & Outcome Measure
Rationale: High Risk, Problem Prone, Regulatory Compliance
Data Source: Employee Records
Sample Size: All Employees as Applicable
Methodology: Employee Records, PDSA
Inclusion Criteria: All Employees

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
90-Day Staff Competency Check-Off Completed	100%	100%											**100%**
New Hire Orientation Compliance	100%	100%											**100%**
Background Check Completed	100%	100%											**100%**
Annual Licensure Check for Governing Board Action	100%	100%											**100%**
CPR Certification Compliance	100%	100%											**100%**
ACLS Certification Compliance	100%	100%											**100%**
PALS Certification Compliance	100%	100%											**100%**
Annual Education Compliance	100%	100%											**100%**

January	
Summary of Findings	**Plan of Action**
Monitored closley	Continue to monitor
Summary of Findings	**Plan of Action**
Monitored closley	Continue to monitor
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

A. Registration Services

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Correct Insurance Plan (COB)	300	340											**640**
Primary Doctor	340	365											**705**
Insurance Verified	340	360											**700**
Correct Guarantor	315	350											**665**
HIPAA	340	367											**707**
Emergency Contact	340	340											**680**
Signed Documents	300	340											**640**
Total Number of Documents Completed	340	367											**707**
Total Number of Documents Audited	340	367											**707**
Percentage of Compliance (Benchmark = 90%)	**100%**	**100%**	######	######	######	######	######	######	######	######	######	######	**100%**

January	
Summary of Findings	**Plan of Action**
HAVE FOUND THAT HOSPITAL STAFF ARE STILL NOT PUTTING IN CORRECT INS INFO,CORRECT GUARANTOR, SIGNED DOCUMENTS	RCM MANAGER, CEO, RCM DIRECTOR ARE PUTTING AN AUDIT PROCESS IN PLACE TO MAKE SURE THESE THINGS ARE CAUGHT AND WILL BE AUDITED BY RCM MANGER, WILL CONTINUE TO MONITOR AND EDUCATE IN THE MEANTIME.
February	
Summary of Findings	**Plan of Action**
HAVE FOUND THAT HOSPITAL STAFF ARE STILL NOT PUTTING IN CORRECT INS INFO,CORRECT GUARANTOR, SIGNED DOCUMENTS	RCM MANAGER, CEO, RCM DIRECTOR ARE PUTTING AN AUDIT PROCESS IN PLACE TO MAKE SURE THESE THINGS ARE CAUGHT AND WILL BE AUDITED BY RCM MANGER, WILL CONTINUE TO MONITOR AND EDUCATE IN THE MEANTIME.
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Environmental Services

A. Terminal Room Cleans

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Observation, EOC rounds report, incident reports
Sample Size: Ten per month or all whichever is greater
Methodology: Observation, EOC rounds report, incident reports, PDSA

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Terminal Room Cleans Meeting Inspection Standards	8	8											**16**
Total Number of Rooms Inspected	8	8											**16**
Percent of Compliance (Benchmark=100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
Compliant	No action needed
February	
Summary of Findings	**Plan of Action**
Compliant	No action needed
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**

October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Materials Management

A. Materials Management Indicators

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Order Sheets, Invoices, Audits
Methodology: Order Sheets, Invoices, Audits PDSA
Sample Size: All Orders and All Recalls

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Number of Back Orders by Vendors	1	3											**4**
Total Number of Orders Placed to Vendors by Hospital	30	32											**62**
Percentage of Back Orders	**3%**	**9%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**6%**
Total Number of Late Orders due to Vendor(s) Issues	0	1											**1**
Total Number of Orders Placed to Vendors by Hospital	30	32											**62**
Percentage of Late Orders	**---**	**3%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**2%**
Total Number of Recalls (Items utilized by the hospital)	2	1											**3**
Total Number of Items Checked Out Properly	712	981											**1693**
Total Number of Items Checked Out	721	984											**1705**
Percentage of Compliance	**99%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**99%**

January	
Summary of Findings	**Plan of Action**
recalls feb particulate respirator and surgical mask	
RECALLS: (1) Dermabond Advanced™ Topical Skin Adhesive, (2) Strata II™, Delta™, and CSF-Flow Control™ Valves and Shunts	Materials Manager checked stock, did not have affected product. No action needed.

February	
Summary of Findings	**Plan of Action**
RECALLS: 3M PARTICULATE RESPIRATOR AND SURGICAL MASK	**This is an update to a safety notice posted on 2/3/2021 to include additional lot numbers. Due to increasing reports of fraud. This is a counterfeit notification not a product recal. No action needed.**

Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

B. Materials Management Indicators

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Order Sheets, Invoices, Audits
Methodology: Order Sheets, Invoices, Audits PDSA
Sample Size: Ten Items Per Month with a sampling of 20 "eaches" or all if less than 20 "eaches" for each item
Inclusion Criteria: Chargeable Items Exclusion Criteria: Non-Chargeable Criteria
Process: For each reporting month a total of 10 separate "chargeable items" are reviewed for correct labeling, expiration date/within use date, & correct inventory information. Utilize the Audit Tool to gather and compile data. At the end of the month when the data is entered for all 10 items, a value will be autocalculated for a composite score. These are the values that will be entered into the Quality Report.

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Percentage of Chargeable Items Correctly Labeled	100%	100%											**100%**
Percentage of Items Within Use Date (Benchmark = 90%)	100%	98%											**99%**
Percentage of Inventory Information Correct (Benchmark = 90%)	100%	100%											**100%**

January	
Summary of Findings	**Plan of Action**
Met benchmark.	Continue to monitor

February	
Summary of Findings	**Plan of Action**
Found 2 expired products. Still within benchmark.	Continue to monitor
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Plant Operations

A. Fire Safety Management

Function: Process & Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Fire Drill Reports, Audit
Methodology: Fire Drill Reports, Audits
Note: Fire drills must be conducted at least quarterly but may be conducted more frequently.
Note: Fire extinguisher checks must be performed monthly

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
	Q1			Q2			Q3			Q4			
Total Number of Fire Drills Completed													**0**
Total Number of Fire Drills													**0**
Percentage of Compliance		---			---			---			---		---
Monthly Fire Extinguisher Checks Completed	24	24											**48**
Total Number of Fire Extinguishers	24	24											**48**
Percentage of Compliance	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**

January	
Summary of Findings	**Plan of Action**
Compliant	No action needed

February	
Summary of Findings	**Plan of Action**
Compliant	No action needed

March	
Summary of Findings	**Plan of Action**

April	
Summary of Findings	**Plan of Action**

May	
Summary of Findings	**Plan of Action**

June	
Summary of Findings	**Plan of Action**

July	
Summary of Findings	**Plan of Action**

August	
Summary of Findings	**Plan of Action**

September	
Summary of Findings	**Plan of Action**

October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Information Technology

A. IT Incidents

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Work Reports
Methodology: Work Reports, PDSA

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Equipment Malfunction/Issue	2	0											**2**
EHR System Shutdown	0	0											**0**
Power/Electrical Failure	0	0											**0**
Internet Outage	0	0											**0**
Interface Issue	0	0											**0**
Server Outage	0	0											**0**
Planned Changes	0	0											**0**
Other (Include in findings)	58	68											**126**

January	
Summary of Findings	**Plan of Action**
this month was quiet, usual password resets and such. we do have 2 COW units down on the floor that need new pc's istalled in them	IT will replace the PCs in the COW units and deliver back to the floor. WHEN? when i got the parts, at the time i did not know when the new units would arrive, and so instead of guessing, i chose not to make mention of a date.
February	
Summary of Findings	**Plan of Action**
it was a pretty quiet month again, only 68 tickets, mostly tv remotes and	
March	
Summary of Findings	**Plan of Action**
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	

Summary of Findings	Plan of Action
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Outpatient Services

A. Outpatient Orders & Assessments

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Patient Records
Sample Size: 10 randomized records per month
Methodology: Patient Records, PDSA
Inclusion Criteria: All patients receiving outpatient services

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Scheduled Appointment for Outpatient Services	10	0											**10**
Correct Order On Chart	10	0											**10**
Total number of orders	10	0											**10**
Percentage of correct orders (Benchmark=100%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**
RN assessments completed	4	0											**4**
Total number of RN assessments required & completed	4	0											**4**
Percentage of RN assessments required & completed (Benchmark=100%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**

January

Summary of Findings	Plan of Action
No OP noted for the month of February	No plan of action needed.

B. Outpatient Therapy Services

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Patient Records, Patient Reports
Methodology: Patient Records, PDSA
Inclusion Criteria: All patients receiving outpatient therapy services
Exclusion Criteria: death, unplanned/unexpected discharge

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Physician Signature on Initial Evaluations	1	0											**1**
Total # of Evaluations	1	0											**1**
Percentage of Compliance (Benchmark = 75%)	**100%**	---	---	---	---	---	---	---	---	---	---	---	**100%**
Total # Treatments Performed	12	9											**21**
Total # of Planned Patient Treatments	12	9											**21**
Percentage of Compliance (Benchmark = 70%)	**100%**	**100%**	---	---	---	---	---	---	---	---	---	---	**100%**
30-Day Progress Notes (performed on or before 30 days from initial evaluation)	0	0											**0**

Total Number of Progress Notes (all patients with therapy services greater than 30 days)	0	0											**0**
Percentage of Compliance (Benchmark = 95%)	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**
Discharge Note Performed Within 72 Hours By PT (exclude weekends & holidays)	2	0											**2**
Total Number of Discharged Patients	2	0											**2**
Percentage of Compliance (Benchmark = 95%)	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Total # of patients discharged with improved standardized assessment scores	2	0											**2**
Total # patients with documented standardized assessment score on admission	2	0											**2**
% of Functional Improvement (Benchmark=80%)	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
All paperwork written and received back in timely manner.	No changes needed at this time.

C. Outpatient Wound Services

Function: Process & Outcome Measure
Rational: High Risk, Problem Prone
Data Source: Patient Records, Patient Reports
Methodology: Patient Records, PDSA
Inclusion Criteria: All patients receiving outpatient therapy services

Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total Number of Wound Debridements	4	4											**8**
Total Number of Consents Completed	2	2											**4**
Total Number of Consents Required	2	2											**4**
Percentage of Compliance (Benchmark = 100%)	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**
Total Number of Wounds Showing Improvement	2	2											**4**
Total Number of Wounds	2	2											**4**
Percentage of Compliance	**100%**	**100%**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**100%**

January	
Summary of Findings	**Plan of Action**
N/A	N/A
February	
Summary of Findings	**Plan of Action**
N/A	N/A
March	

Summary of Findings	Plan of Action
April	
Summary of Findings	**Plan of Action**
May	
Summary of Findings	**Plan of Action**
June	
Summary of Findings	**Plan of Action**
July	
Summary of Findings	**Plan of Action**
August	
Summary of Findings	**Plan of Action**
September	
Summary of Findings	**Plan of Action**
October	
Summary of Findings	**Plan of Action**
November	
Summary of Findings	**Plan of Action**
December	
Summary of Findings	**Plan of Action**

Strong Mind Services

A. Record Compliance

Function: Compliance Measure
Rationale: High Risk, Problem Prone
Data Source: Client Records
Sample Size: All clients in program
Methodology: Client records; PDCA
Inclusions: All clients in program during reporting month
Formula: # of complete charts/# of charts audited

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of records meeting compliance													**0**
Total number of records audited													**0**
Percentage of Compliance (Benchmark=95%)	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**	**#DIV/0!**

January	
Summary of Findings	**Plan of Action**

B. Client Satisfaction Surveys

Function: Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Client Surveys
Sample Size: All discharged clients in program
Methodology: Client Surveys; PDCA
Inclusions: All clients in program discharged during reporting month
Formula: # of surveys completed/# of surveys returned

Indicators (Active Clients)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number surveys returned													**0**
Total number of surveys distributed (active clients)													**0**
Return Rate (Benchmark=80%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Satisfaction Score Results (composite score/active clients)													**0**
Total Score													**0**
Percentage of satisfaction (Benchmark=80%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Indicators (Discharged Clients)	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number surveys returned													**0**

Total number of surveys distributed (discharged clients)													**0**
Return Rate (Benchmark=80%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Satisfaction Score Results (composite score/discharged clients)													**0**
Total Score													**0**
Percentage of satisfaction (Benchmark=80%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
January													
Summary of Findings						**Plan of Action**							

C. Master Treatment Plans

Function: Process & Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Client Files
Sample Size: All clients in program
Methodology: Client records; PDCA
Inclusions: All clients in program during reporting month
Formula: # of master treatment plans completed within 5 days/# of master treatment plans

Indicators	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total number of master treatment plans completed													**0**
Total number of master treatment plans required													**0**
Master Treatment Plans Completed (Benchmark=100%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
January													
Summary of Findings						**Plan of Action**							

D. Suicidal Ideation

Function: Process & Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Client Files
Sample Size: All clients in program
Methodology: Client records; PDCA
Inclusions: All clients in program during reporting month
Formula: # of clients with suicidal ideation/# of clients with treatment plan

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of clients with suicidal ideation													**0**
Total number of clients with treatment plan													**0**
Treatment Plans Completed (Benchmark=100%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
January													
Summary of Findings				**Plan of Action**									

E. Scheduled Appointments

Function: Process & Outcome Measure
Rationale: High Risk, Problem Prone
Data Source: Client Files
Sample Size: All clients in program
Methodology: Client records; PDCA
Inclusions: All clients in program during reporting month
Formula: # of missed appointments/total number of scheduled appointments

Indicators	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total number of missed appointments													**0**
Total number of scheduled appointments													**0**
Percentage of Missed Appointments (Benchmark=less than 10%)	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
January													
Summary of Findings				**Plan of Action**									

Contract Services

Date	Name	Service	Date of Review	Renewed	Discontinued
01/14/21	Life Share Conctract/Log	Tissue donation	02/23/21	Yes	
01/14/21	OGA Business	Insurance for Strong Minds	02/23/21	Yes	
01/14/21	Press Ganey Contract	HCAHPS	02/23/21		
01/14/21	Space Labs	Telemetry system	02/23/21	Yes	
01/14/21	Press Ganey Contract	HCAHPS	02/23/21	Yes	
02/10/21	Wolters Kluwer Health,	Education/training/resources	3/1/2021 - 03/02/2022	Yes	
02/10/21	OFMQ Agreement	Peer review	2/23/2021 -	Yes	

MEC/GB Approval
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Education & Training

Date	Main Objectives	Audience	Compliance
01/25/21	Provider time study 2/15-2/28	Providers	
03/04/21	ACLS		
03/18/21	BLS	All Staff	

Performance Improvement Projects

Date	Title	Goals	Status	Progress
01/25/21				

Surveys

Date	Type of Survey	Results of Survey	Actions Taken
01/25/21			

Product Recalls

Date	Product/Equipment	Action Taken
01/01/21	Derma bond	Did not have product
01/01/21	Strata	Did not have product
02/01/21	No Recalls for MRMC	

FMEA

Date	Project Title	Actions Taken
01/25/21		

RCA

Date	Type of Event	Outcome of Event	Actions Taken
01/25/21			

Blood Utilization

Date	# of Transfusion Episodes	# of Blood Products	Transfusion Reaction
01/25/21	4	18	No
02/01/21	1		No

HIPAA Breaches

Date	Event	Action Taken
01/01/21	None for Janu	No action needed
02/01/21	None for Febr	No action needed

Facility/Equipment Issues/Concerns/PM Reports

Date	Brief Description of Issue	Actions Taken	PM Report Summary
01/25/21			

Emergency Preparedness

Date	Type of Drill	Emergency Disaster Event	After Action Summary
01/01/21		No drills for January	No summary needed
02/27/21	Water Supply	No water to the facility	Maintenance is doing summary

Mandatory or Routine Inspections

Date	Inspection Type	Inspection Date	Results
01/25/21			

Policy & Procedure Review and Approval

Date	Name of Policy	MEC/GB Approval
02/23/21	Respiratory P & P	Yes
02/23/21	Drug Room P & P	Yes
02/23/21	Emergency Department	Yes
02/23/21	Clinical P & P	Yes
02/23/21	Wound Care P & P	Yes
02/23/21	Hospital Rehab P & P	Yes
02/23/21	(Form) Patient Discharge Sa	Yes
02/23/21	(Form) HR Performance Eva	Yes
02/23/21	(Form) Blood Transfusion O	Yes

Staffing

Date	New Employee	Voluntary Separations	Involuntary Separations
01/31/21	3	2	
2/28/2021	0	1	

Open Positions

Credentialing & New Appointments

Date	Credential Update	New Appointments
02/23/21	John Chiaffitell, DO	Active Privileges-Re-Credentialing
02/23/21	Terrie Gibson, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Pathologists w/Heartland	Courtesy Privileges
02/23/21	Dr. Steven Snail	Voluntary removal
02/23/21	Dr. Riley Winham	Voluntary removal
02/23/21	OSU Telehealth removed as contract termed 1/1/21	
02/23/21	Sara McDade, APRN	Couresty Privileges
02/23/21	Dave Spear, MD	Courtesy Privileges
02/23/21	Mary Barnes, APRN	Courtesy Privileges-Re-Credentialing
02/23/21	Mary Homboe, MD	Courtesy Privileges-Re-Credentailing
02/23/21	Ruth Oneson, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Ricky Reaves, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Barry Rockler, MD	Courtesy Privileges-Re-Credentialing
02/23/21	Sherrita Wilson, MD	Courtesy Privileges-Re-Credentialing

Mangum Regional Medical Center
Quality Committee Meeting Minutes

Date: 7/15/2021	**Time: 11: 56**	**Recorder: Denise Jackson**	**Reporting Period Discussed: June 2021**

Members Present via Teams Meeting

Chairperson:		**CEO: Dale Clayton**		**Medical Representative: Dr. Chiaffitelli**			
Name	**Title**	**Name**	**Title**	**Name**	**Title**	**Name**	**Title**
Jennifer Waxell	Respiratory	Josey Kenmore	Materials Management	Chasity Howell	Case Manager		Lab Manager
Sarah Dillahunty	Dietary	Daniel Coffin	CCO	Kaye Hamilton	Credentialing	Karli Bowles	Infection
Linda James	Pharmacy			Jennifer Dreyer	HIM	Kasi HIlley	Business/RCM Director
Matt Moran	IT						

TOPIC	**FINDINGS/CONCLUSIONS**	**ACTIONS/RECOMMENDATIONS**	**FOLLOW-UP**
Call to Order	Sarah Dillahunty/Chasity Howell		
Review of Minutes	June QAPI mintues	approved - Daniel Coffin/Karli Bowles	
Review of Committee Meetings			
A. EOC/Patient Safety Committee	policies to board this month - ceiling tiles and flooring repaired, nurse/med room flooring rescheduled, outlets in hall scheduled for this month, waiting on head wall 02, glass fro pegboards. Started on replacing receptacles throughout the hospital. needing to work on ceiling in ultrasound/or2/lab, cafeteria walls		
B. Infection Control Committee	3 positive covid in june, follow up call to covid patients this week for 14 day quarantine, updated tx for covid discussed, no in house infections.	limited visitation due to rising number, n95 use in direct patient care areas	
C. Pharmacy & Therapeutics Committee	numbers discussed per qapi entries, T&P scheduled for 7/22/21		
D. HIM/Credentials Committee	100%, working on credentialing for the board approval this month for Jeff Brand PA and Jillian Lowell APRN	.	
E. Utilization Review Committee	167 er visits/11 admissions/27 discharges , 0 re-admits, 1 acute transfer to higher level of care		
F. Compliance Committee	stroke policy time discussed with patient cases reported		
Old Business	none		

New Business	OBI contract renewal/Policies revised: sepsis, hourly rounding, ED TOC, Nursing TOC, photo/multimedia policy,fire management plan,equipment management plan, electric wiring, elevator, hazardous materails management, secureity management, utility stsyems,		
Quality Assurance/Performance Improvement			
Volume & Utilization			
A. Hospital Activity	167 er visits/11 admissions/27 discharges		
B. Blood Utilization	5 units - Product was administered without problems	Will continue to monitor	
Care Management			
A. CAH/ER Re-Admits	0		
B. Acute Transfers	1		
C. Transition of Care			
D. Discharge Follow-Up Phone Calls	12		
E. Patient Discharge Safety Checklist	12 (12)		
Risk Management			
A. Incidents	1 pt fall w/o injury, 3 ama	no f/u required for fall, provider education on documentation to be provided	
B. Reported Complaints	1 complaint	resolved at bedside	no futher f/u required
C. Reported Grievances	no grievances		
D. Patient Falls Without Injury	1 fall w/o injury	no f/u required for fall	
E. Patient Falls With Minor Injury	no reported falls		
F. Patient Falls With Major Injury	no reported falls		
G. Mortality Rate	1 in-pt / 3 ER deaths - in-pt expected due to age/condition, 2 pt to er with cpr in progress/unsuccessful/family declined futher tx, 1 to er/family declined aggressive tx	no f/u required	
H. Deaths Within 24 Hours of Admit	0	0	
I. OPO Notification/Tissue Donation	Lifeshare was called within the 60 minute time frame.	Lifeshare declined	

Nursing			
A. Critical Tests/Labs	160(160)		
B. Restraints	0		
C. RN Assessments	20		
D. Code Blue	2		
E. Acute Transfers	ACUTE/SWING 2 Transfers - 2 patients for reporting period transfered to tertiary facilities. 1. one patient to higher level of care for respiratory distress 2. one patient to teriary facility er for urology placement of indwelling urinary catheter		
Emergency Department			
A. ER Log & Visits	167		
B. MSE			
C. Provider ER Response Time	w/i 20 minutes		
D. ED RN Assessment (Initial)	20		
E. ED Readmissions			
F. EMTALA Transfer Form	7		
G. ED Transfers	7 - were transferred due to higher level of care needed.	no f/u required	
H. Stroke Care	2	education on transfer time/stroke policy	
I. Suicide Management	3	no f/u needed	
J. Triage	167		

K. Stemi Care	0		
L. ED Nursing Assessment (Discharge/Transfer)	100%		
Pharmacy & Medication Safety			
A. Pharmacy Utilization	52,117		
B. After Hours Access	107	meddispensing machine to be purchased next month	
C. Adverse Drug Reactions	0		
D. Medication Errors	0		
Respiratory Care Services			
A. Ventilator Days	7		
B. Ventilator Wean Rate	0		
C. Patient Self-Decannulation Rate	0		
D. Respiratory Care Equipment	100%		
Wound Care Services			
A. Development of Pressure Ulcer	0		
B. Wound Healing Improvement	9		
C. Wound Care Documentation	8		
D. Debridement/Wound Care Procedures	4		

E. Wound Vac Application	0		
Radiology			
A. Radiology Films	113		
B. Imaging	20		
C. Radiation Dosimeter Report	6		
D. Physicist's Report	n/a	Due in July 2021	
Lab			
A. Lab Reports	0		
B. Blood Culture Contaminants	0		
Infection Control & Employee Health			
A. CAUTI's	0		
B. CLABSI'S	0		
C. HA MDROs	0		
D. HA C. diff	0		
E. Hospital Acquired Infections By Source	0		
F. Hand Hygiene/PPE & Isolation Surveillance	100%		
G. Public Health Reporting	3	3 positive COVID	
H. Patient Vaccinations	1		
I. Ventilator Associated Events	0		

J. Employee Health Summary	1. 1 light duty case continued untill 6/15/2021 2. 6 TB screenings on new employees 3. 7 Lost Work days due to illness 4. 1 reported fall duing working hours with no missed work days		
HIM			
A. H&P's	33		
B. Discharge Summaries	97% - 1 acute H&P missing		
C. Progress Notes (Swing bed & Acute)	43		
D. Consent to Treat	99%		
E. Swing bed Indicators			
F. E-prescribing System	843		
G. Legibility of Records	100%		
Dietary			
A. Food Test Tray Eval	100%		
B. Dietary Checklist Audit	100%		
Therapy			
A. Therapy Indicators	9		
B. Therapy Visits	157		
C. Standardized Assessment Outcomes	100%		
Human Resources			
A. Compliance	100%		
Registration Services			
Registration Services	100%		

Environmental Services			
A. Terminal Room Cleans	8		
Materials Management			
A. Materials Management Indicators	100%		
Plant Operations			
A. Fire Safety Management	100%		
Information Technology			
A. IT Indicators	1 power outage/1 server outage	plan routine updates/reboot checks	
Outpatient Services			
A. Outpatient Orders and Assessments	2		
B. Outpatient Therapy Services	8 evaluations		
C. Outpatient Wound Services	20 debridments		
Contract Services			
Contract Services	OBI contract renewal, BKD engagement for this months approval	approved in quality	to Med Staff and Board
A. OSDH & CMS Updates			
B. Surveys			
C. Product Recalls	none		
D. FMEA			
E. RCA			
Policy & Procedure Review			
Policy & Procedure	Policy Revisions; 1. Critical Lab policy update 2. Alcohol policy update 3. Suicide policy update		
Standing Agenda			

A. Annual Approval of Strategic Quality Plan	Approved 06/22/21		
B. Annual Appointment of Infection Preventionist	n/a		
C. Annual Appointment of Risk Manager	Denise Jackson	Approved 06/22/21	
D. Annual Appointment of Safety Officer			
E. Annual Appointment of Security Officer	Matt Moran	Approved 06/22/21	
F. Annual Appointment of Compliance Officer	Denise Jackson	Approved 06/22/21	
G. Annual Review of Infection Control Risk Assessment (ICRA)	n/a		
H. Annual Review of Hazard Vulnerability Analysis (HVA)	n/a		
Credentialing/New Appointments			
A. Credentialing/New Appointment Updates	1.) Randy Benish PA 2.) Surech Chandrasekaran MD	re-credentialing approved by board on 06/22/2021	
Education & Training			
A. Education & Training	BLS/ACLS/PALS		
Performance Improvement Projects			
A. Performance Improvement Projects	Stroke door to transfer time decrease. ROADI.		

Department Reports			
A. Department			
Other			
A. Other	Karli Bowles - Respiratory Prevention Program administrator	approved in quality	to Med staff and board
Adjournment			
A. Adjournment	12:07 - Daniel Coffin/Sarah Dillahunty		

Mangum Regional Medical Center
Medical Staff Meeting
June 17, 2021

MEMBERS PRESENT:

John Chiaffitelli, DO, Medical Director
William Gregory Morgan, III, MD
Absent:
Guest:

ALLIED HEALTH PROVIDER PRESENT:

David Arles, APRN
Mary Barnes, APRN
Randy Benish, PA

NON-MEMBERS PRESENT:
Chelsea Church, PhD
Dale Clayton, CEO
Daniel Coffin, CCO
Denise Jackson, Quality Director
Chasity Howell, RN, Utilization Review
Lynda James, LPN, Drug Room Tech.
Kaye Hamilton, Medical Staff Coordinator

1. Call to order
    a. The meeting was called to order at 11:53 am by Dr. John Chiaffitelli, Medical Director.

2. Acceptance of minutes
    a. The minutes of the May 20, 2021, Medical Staff Meeting were reviewed.
        i.Action: Dr. Chiaffitelli, Medical Director, made a motion to approve the minutes.

3. Unfinished Business
    a. None

4. Report from the Chief Executive Officer
    a. CEO report – Dale Clayton, CEO

We continue to participate in daily Region 3 Merc Briefings.

- Cohesive and hospital leadership continue to ensure the staff and providers are kept up to date regarding any changes or new policies pertaining to COVID-19.

Hospital Staff and Operations Overview:

- Open positions include (1) Accounts Payable, (1) LPN and (2) RNs.
    - We have hired several new employees for the following positions. Matt Moran, IT Tech; Denise Jackson, RN, Quality Director; Chasity Howell, RN, Case Manager; Narmeen Vegdani, Full Time Contract PT; Kristen York, Dietary, Brooke Rodriquez, RN and Stella O'Neal, MLT, Lab Tech.
    - Our census has remained good throughout May with an average daily census of 11.23.
    - The hospital is partnering with the 4H kids to plant flowers in the flower beds around the hospital.

  Written report remains in the minutes.

5. Committee / Departmental Reports
    a. Medical Records
        i. No report was given.

    b. Nursing

Excellent Patient Care

- Monthly Education topics included: Catheter Securement devices and uses, Peripherally Inserted Central Catheter Management.
- Non-Clinical staff initiated Rapid Response Code due to patient presentation including diaphoresis, facial flushing and substernal chest pain. On duty staff responded, assessed and transported the patient to Emergency Department within seconds.
- Emergency Department provided rapid treatment and transfer to a STEMI patient. Patient returned to work within just a few days.
- Respiratory, Nursing and Provider teams collaborated to wean and graduate a 2-year ventilator patient to Nasal Canula and C-Pap. Patient is looking forward to discharging home.

Excellent Client Service

- Patient days increased from 281 in April to 345 in May. This represents an average daily census of 11.13. ER volumes continue to trend upward.
- May COVID-19 State at MRMC: 82 Swabs (39-PCR & 43-Antigen) 82 Negative.
- Greer County April COVID-19 Statistics: 584 Positive Cases and 22 Deaths (3.77% death rate).

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN and CNA.
- Open Director positions include Rehabilitation.

- For the clinical team MRM has hired the following core positions: Monitor Tech/Registration Clerk and LPN.
- Recruiting efforts included positing of positions on mangumregional.net and Facebook.
- Hospital Week was a huge success. Staff received delicious meals and awesome gifts.

Written report remains in minutes.

c. Infection Control

- New Business:
  a. Annual N95 testing to be completed in June 202 by Karli Bowles, RN
- Data:
  a, No CAUTIs or CLABSI, and no MDRO. 100% hand hygiene and PPE compliance.
- Policy & Procedures: N/A
- Education/In Services
  a. 5/4/2020 – On spot education to nursing staff over catheter securement devices. IP observed x3 being placed.
  b. 5/7/2021 – PICC line education via read and sign power point.
- Updates:
  a. IP goals are improving. Blue vaccine sheets are being filled out via nurse/ward clerk prior to discharge/transfer from facility.
- Annual Items:
  a. IP will visit linen company for yearly review on 6/16/2021
- Any additional recommendations from committee:
  a. N/A

Written report remains in minutes.

d. Environment of Care and Safety Report

i. Evaluation and Approval of Annual Plans –

i.i. Old Business - -

a. Evaluation and approval of Annual Plans-Plans will be presented in June meeting.
Continuing to work on the building. Working on flooring in Nurses break room and Med Prep room, installing additional outlets, new oxygen/suction headwall in ER1, new covered pegboard needed, roof over OR2 area damaged/needs repair and addressing the visible cracks in the Cafeteria walls.

b. Stretcher in ER1 needs supports under head replaced.

i.i.i. New Business

a. None

Written report remains in minutes.

e. Laboratory
   i. Tissue Report – Approved – May, 2021
   i.i. Transfusion Report – Approved – May, 2021

f. Radiology
   i. There was a total of – 200 X-Rays/CT/US
   i.i. Nothing up for approval
   i.i.i. Updates: There are no updates to report at this time. Written report remains in minutes.

g. Pharmacy
   i. Verbal Report by Pharmacist.
   i.i. 10 doses of Regeneron in Pharmacy
   i.i.i. P & T Meeting will be held next Thursday.

h. Physical Therapy
   i. No report.

i. Emergency Department
   i. No report

j. Quality Assessment Performance Improvement

- Risk
  - Risk Management
    1. Complaints – None
    2. No reported fall for the month
    3. 2 In-patient deaths
    4. AMA - 0
    5. Wrong medication administered to patient, no harm to patient. Nurse education provided.
- Quality
  - Quality Minutes from previous month included as attachment.
  - Policy Revisions:
    1. Critical Test Reporting
    2. Management of the Alcohol Intoxication and Withdrawal
    3. Care of Patient with SI/HI Ideations Attempt and Self Harming Behaviors

- Standing Agenda
  1. Annual Appointment of Quality Manager/Risk Manager/Compliance Officer – Denise Jackson

2. Annual Appointment of Security Officer – Matthew Moran

- HIM – Discharge summaries are at 97% due to Provider out for vacation/completed on return. Consent to treat at 99%
- Med event – 1
- Afterhours access increased this month.
- 6 Readmissions to ED

- Compliance
    - Contracts that were approved in Quality on 6/10/2021
        1. Blue Stream Contract
        2. Medgas Contract
        3. Renewal – Greer County Health Dept and MRMC Radiology Contract

- Workman's Comp
    - There are currently not any Workman's Comp cases currently open.

Written report remains in minutes.

k. Utilization Review
   i. Total Patient days for May: 345
   i.i. Total Medicare days for May: 293
   i.i.i. Total Medicaid days for May: 15
   i.v. Total Swing Bed days for May: 300
   v. Total Medicare SB days for May: 269

Written reports remain in minutes.

Motion made by Dr. John Chiaffitelli, Medical Director to approve Committee Reports.

6. New Business
   a. Approval of Policy Revision: Critical Test Reporting
      i.Motion: made by Dr. Chiaffitelli to approve Critical Test Reporting.
   b. Approval of Policy Revision: Management of the Alcohol Intoxication and Withdrawal
      i.Motion: made by Dr. Chiaffitelli to approve Management of the Alcohol Intoxication and Withdrawal
   c. Approval of Policy Revision: Care of Patient with SI/HI Ideations Attempt and Self Harming Behaviors
      i.Motion: made by Dr. Chiaffitelli to approve Care of Patient with SI/HI Ideations Attempt and Self Harming Behaviors
   d. Annual Appointment of Quality Manager/Risk Manager/Compliance Officer – Denise Jackson
      i,Motion: made by Dr. Chiaffitelli to approve Annual Appointment of Quality Manager/Risk Manager/ Compliance Officer – Denise Jackson.
   e. Annual Appointment of Security Officer – Matthew Moran
      i.Motion: made by Dr. Chiaffitelli to approve Annual Appointment of

Security Officer – Matthew Moran.

f. Approval of Contract: Blue Stream Contract
   i.Motion: made by Dr. Chiaffitelli to approve Blue Stream Contract.
g. Approval of Contract: Medgas Contract
   i.Motion: made by Dr. Chiaffitelli to approve Medgas Contract.
h. Approval of Renewal – Greer County Health Department and MRMC Radiology Contract
   i.Motion: made by Dr. Chiaffitelli to approve Renewal – Greer County Health Department and MRMC Radiology Contract
i. Mangum Annual Review & Evaluation 2020 Quality Program and 2021 Quality Plan
   i.Motion: made by Dr. Chiaffitelli to approve Mangum Annual Review & Evaluation 2020 Quality Program and 2021 Quality Plan.
j. Approval of Contracts: Contracts for Approval - 1 through 14
   i.Motion: made by Dr. Chiaffitelli to approve Contracts for Approval 1 through 14.
k. Approval of Contracts: COVID Grant List For Approval 1 through 44
   i.Motion: made by Dr. Chiaffitelli to approve COVID Grant List For Approval 1 through 44.

7. Adjourn
   a. Dr. Chiaffitelli made a motion to adjourn the meeting at 12:13 pm.

_____ _____

Medical Director/Chief of Staff Date

Mangum Regional Medical Center
Claims List
June 2021

Check#	Ck Date	Amount	Paid To	Expense Description
15799	6/3/2021	2,025.00	ABC BIOMEDICAL	IV Pumps Rental
15852	6/17/2021	3,089.00	ADVANCE ALARMS INC	Monitoring system
15853	6/17/2021	19.00	AMBS CALL CENTER	Hotline
15800	6/3/2021	776.19	ANESTHESIA SERVICE INC	Telemetry sensors
15801	6/3/2021	3,493.30	ARAMARK	Linens - purch svs
15867	6/22/2021	1,868.04	ARAMARK	Linens - purch svs
15889	6/30/2021	5,380.11	ARAMARK	Linens - purch svs
15854	6/17/2021	3,079.13	AT&T	Fax lines
15868	6/22/2021	2,990.44	AT&T	Fax lines
15855	6/17/2021	6,405.23	BAXTER HEALTHCARE	Pharmacy Supplies
15890	6/30/2021	457.94	BAXTER HEALTHCARE	Pharmacy Supplies
15891	6/30/2021	16,000.00	BENISH AND ASSOCIATES	1099 Provider
15826	6/11/2021	1,102.35	BIO-RAD LABORATORIES INC	Lab supplies
15856	6/17/2021	2,881.34	BIO-RAD LABORATORIES INC	Lab supplies
15802	6/3/2021	1,950.00	BLUTH FAMILY MEDICINE, LLC	RHC provider
15806	6/3/2021	14,654.55	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
15857	6/17/2021	45,964.64	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
15894	6/30/2021	15,022.59	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
901058	6/18/2021	1,384.36	CENTERPOINT ENERGY ARKLA	Gas
15807	6/3/2021	831.90	CINTAS CORPORATION #628	Linen Service
15827	6/11/2021	2,649.25	CINTAS CORPORATION #628	Linen Service
15828	6/11/2021	4,629.31	CITY OF MANGUM	Utilities
15895	6/30/2021	250.00	CITY OF MANGUM	Utilities
15829	6/11/2021	30,000.00	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15869	6/22/2021	2,312.05	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15896	6/30/2021	48,036.06	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15830	6/11/2021	202,445.40	COHESIVE HEALTHCARE RESOURCES	Payroll Staffing
15870	6/22/2021	174,741.30	COHESIVE HEALTHCARE RESOURCES	Payroll Staffing
15897	6/30/2021	1,838.50	COHESIVE MEDIRYDE LLC	Swing bed purchase service
15871	6/22/2021	42,476.43	COHESIVE REVOPS INTEGRATION	Billing purch svs
15872	6/22/2021	68,165.59	COHESIVE STAFFING SOLUTIONS	Agency staffing
15898	6/30/2021	26,334.57	COHESIVE STAFFING SOLUTIONS	Agency staffing
15880	6/22/2021	256,625.27	CONEXUS SOLUTIONS LLC	Agency staffing
15831	6/11/2021	9,600.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
15881	6/22/2021	9,200.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
15882	6/22/2021	38,226.50	CPSI	EHR monthly support
15899	6/30/2021	23,596.00	CPSI	EHR monthly support
15900	6/30/2021	31.00	CULLIGAN WATER CONDITIONING	RHC purch svs
15883	6/22/2021	91,891.93	DELL INC	COVID Capital
15901	6/30/2021	1,809.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
15858	6/17/2021	16,016.78	DOERNER SAUNDERS DANIEL ANDERS	Legal Fees
15808	6/3/2021	4,766.67	DR W. GREGORY MORGAN III	1099 Provider
15832	6/11/2021	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider

Check#	Ck Date	Amount	Paid To	Expense Description
15884	6/22/2021	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15809	6/3/2021	2,928.00	F1 INFORMATION TECHNOLOGIES IN	Software license
15902	6/30/2021	66.23	FEDEX	Postage
15925	6/30/2021	250.00	GEORGE BROS TERMITE & PEST CON	plant ops purch svs
15885	6/22/2021	4,320.00	GERAINT HARRIS	1099 Provider
901048	6/30/2021	995.09	GLOBAL PAYMENTS INTEGRATED	CC processing
901053	6/10/2021	759.33	GLOBAL PAYMENTS INTEGRATED	CC processing
901034	6/30/2021	583.35	GLOBAL PAYMENTS INTEGRATED	CC processing
15903	6/30/2021	368.43	GRAINGER	Supplies
15833	6/11/2021	20.00	GRAYSTONE MEDIA GROUP	advertising
15810	6/3/2021	329.25	HAC INC	Dietary food
15812	6/3/2021	4,136.04	HENRY SCHEIN	Lab supplies
15905	6/30/2021	2,830.96	HILL-ROM COMPANY, INC	COVID equipment
15834	6/11/2021	3,053.75	HOLEMAN MEDIATION	Legal Fees
901050	6/2/2021	9,805.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease
15835	6/11/2021	83.85	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
15836	6/11/2021	1,290.82	JANUS SUPPLY CO	Cleaning Supplies
15906	6/30/2021	84.00	KITTY JEANENE LEWIS	Employee reimbursement
15813	6/3/2021	9,684.55	LABCORP	Lab purch svs
15907	6/30/2021	5,800.48	LABCORP	Lab purch svs
15908	6/30/2021	909.80	LAMPTON WELDING SUPPLY	Patient Supplies
15814	6/3/2021	94.73	LOCKE SUPPLY	Supplies
15815	6/3/2021	67.84	LYNDA JAMES	Employee reimbursement
15816	6/3/2021	1,716.79	MARK CHAPMAN	Employee reimbursement
15859	6/17/2021	320.00	MARY BARNES, APRN	Training clinical
15838	6/11/2021	16,393.17	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901061	6/23/2021	15,651.99	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901065	6/28/2021	19,608.52	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
15821	6/3/2021	13,633.77	MEDLINE INDUSTRIES	Patient Care Supplies
901032	6/30/2021	6.00	NATIONAL DATA BANK	Credentialing
901033	6/30/2021	12.00	NATIONAL DATA BANK	Credentialing
901041	6/30/2021	6.00	NATIONAL DATA BANK	Credentialing
901051	6/2/2021	28.00	NATIONAL DATA BANK	Credentialing
901054	6/10/2021	4.00	NATIONAL DATA BANK	Credentialing
901030	6/30/2021	54.00	NATIONAL DATA BANK	Credentialing
901038	6/30/2021	8.00	NATIONAL DATA BANK	Credentialing
901042	6/30/2021	6.00	NATIONAL DATA BANK	Credentialing
15909	6/30/2021	1,190.00	NATIONAL RECALL ALERT CENTER	Central Supply purch svs
15839	6/11/2021	1,892.23	NEXTIVA, INC.	Phone svs
15910	6/30/2021	1,903.34	NEXTIVA, INC.	Phone svs
15861	6/17/2021	1,722.00	NUANCE COMMUNICATIONS INC	RHC purch svs
901056	6/14/2021	60.00	OK STATE BOARD OF MED LICENSUR	Credentialing
15841	6/11/2021	40.00	OK STATE BOARD OF PHARMACY	Licensure
15911	6/30/2021	125.00	OK STATE DEPT OF HEALTH	Licensure
15842	6/11/2021	3,955.80	OKLAHOMA BLOOD INSTITUTE	blood bank
15912	6/30/2021	505.20	OKLAHOMA BLOOD INSTITUTE	blood bank

Check#	Ck Date	Amount	Paid To	Expense Description
15886	6/22/2021	75.00	OKLAHOMA DEPARTMENT OF LABOR	Licensure
901055	6/11/2021	6,186.67	PHILADELPHIA INSURANCE COMPANY	Property Insurance
15844	6/11/2021	2,048.28	PRESS GANEY ASSOCIATES, INC	Quality purch svs
15862	6/17/2021	12,420.00	RAMSEY AND GRAY, PC	Legal Fees
15822	6/3/2021	8,750.00	REYES ELECTRIC LLC	Emergency repair COVID
15845	6/11/2021	9,667.00	SBM MOBILE PRACTICE, INC	1099 Provider
15887	6/22/2021	10,800.00	SBM MOBILE PRACTICE, INC	1099 Provider
15846	6/11/2021	436.14	SHRED-IT USA LLC	Secure Doc disposal svs
15823	6/3/2021	735.84	SIZEWISE	Equipment rentals
15847	6/11/2021	1,735.00	SMAART MEDICAL SYSTEMS INC	smaart pac rental
15913	6/30/2021	1,735.00	SMAART MEDICAL SYSTEMS INC	smaart pac rental
15914	6/30/2021	300.00	SOUTHWEST HOT STEAM CLEANING	Dietary purch service
15824	6/3/2021	278.63	SPARKLIGHT BUSINESS	Cable Service
15888	6/22/2021	412.33	SPARKLIGHT BUSINESS	Cable Service
901059	6/18/2021	7,222.11	STANDLEY SYSTEMS LLC	printer lease
15825	6/3/2021	706.90	STAPLES ADVANTAGE	Office Supplies
15864	6/17/2021	1,497.04	STAPLES ADVANTAGE	Office Supplies
15915	6/30/2021	808.09	STAPLES ADVANTAGE	Office Supplies
15918	6/30/2021	7,639.94	STERICYCLE INC	Waste Disposal Service
15865	6/17/2021	1,800.00	TECUMSEH OXYGEN & MEDICAL SUPP	Patient purch svs
15848	6/11/2021	2,898.39	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15919	6/30/2021	8,532.92	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15920	6/30/2021	345.62	ULINE	Supplies
15921	6/30/2021	335.87	ULTRA-CHEM INC	Housekeeping supplies
15849	6/11/2021	4,722.39	UMPQUA BANK VENDOR FINANCE	Note Payable Lab Equipment
15922	6/30/2021	4,722.39	UMPQUA BANK VENDOR FINANCE	Note Payable Lab Equipment
901049	6/30/2021	6,653.59	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
15850	6/11/2021	6,840.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
15923	6/30/2021	1,710.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
901052	6/7/2021	7,102.92	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
901057	6/15/2021	357.05	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
15851	6/11/2021	4,866.00	WOLTERS KLUWER HEALTH	Clinical education
	TOTAL	**1,455,891.90**		

Mangum Regional Medical Center
August 2021 Estimated Claims

Vendor	Description	Estimated Amount
ABC BIOMEDICAL	IV Pump rental	7,000.00
AMERISOURCE BERGEN	Pharmacy Supplies	50,000.00
ANESTHESIA SERVICE INC	Service	5,000.00
ARAMARK	Linens purch svs	16,200.00
AT&T	Fax Service	6,000.00
BAXTER HEALTHCARE	Pharmacy Supplies	10,000.00
BENISH AND ASSOCIATES	1099 Provider	32,000.00
BLUTH FAMILY MEDICINE	1099 Provider	5,000.00
CARDINAL 110 LLC	Pharmacy Supplies	100,000.00
CENTERPOINT ENERGY ARKLA	Utilities	3,000.00
CITY OF MANGUM	Utilities	10,000.00
COHESIVE HEALTHCARE MGMT	Mgmt and provider Fees	400,000.00
COHESIVE HEALTHCARE RESOURCES	Payroll	600,000.00
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	20,000.00
COHESIVE REVOPS	Billing purch svs	70,000.00
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	200,000.00
COMPLIANCE CONSULTANTS	Lab Consultant	1,000.00
CONEXUS SOLUTIONS LLC	Agency Staffing	150,000.00
CONTROL SOLUTIONS	Supplies	500.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	5,000.00
CPSI	EHR software	100,000.00
DOBSON TECHNOLOGIES TRANSPORT	Internet	3,700.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	25,000.00
DR RYAN MAJOR, MD	1099 Provider	20,000.00
DR. JOHN CHIAFFIETELLI	1099 Provider	28,848.00
DR. MORGAN	1099 Provider	4,766.00
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	7,500.00
FEDEX	Postage	300.00
FOX BUILDING SUPPLY	Plant Ops Supplies	2,000.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	750.00
GERAINT HARRIS	1099 Provider	30,000.00
GLOBAL EQUIPMENT COMPANY INC.	Supplies	3,500.00
GRAINGER	Maintenance Supplies	3,500.00
HAC INC	Dietary Supplies	500.00
HAMILTON MEDICAL INC.	Ventilator supplies	3,500.00
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,000.00
HENGST PRINTING	Pharmacy Supplies	500.00
HENRY SCHEIN	Lab Supplies	15,000.00
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	9,805.00
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	500.00
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	2,500.00
KCI USA	Supplies	4,000.00
LABCORP	Lab purch svs	25,000.00
LAMPTON WELDING SUPPLY	Patient Supplies	4,000.00
LOCKE SUPPLY	Plant Ops Supplies	2,500.00
MATT MONROE	Rent	850.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	45,000.00

Vendor	Description	Estimated Amount
MEDLINE INDUSTRIES	Patient Care Supplies	45,000.00
MEDTOX DIAGNOSTICS, INC	Lab supplies	3,000.00
MISC EMPLOYEE REIMBURSEMENTS	To reimburse employees for travel and suppl	5,000.00
NUANCE COMMUNICATIONS INC	Supplies	600.00
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	1,000.00
PATIENT REFUNDS	Credits due to payors	15,000.00
PHILIPS HEALTHCARE	Supplies	1,000.00
PIPETTE COM	Supplies	500.00
PRESS GANEY ASSOCIATES, INC	Purchased Service	2,048.00
RAMSEY AND GRAY, PC	Legal Fees	10,000.00
SMB MOBILE PRACTICE INC.	1099 Provider	40,000.00
SCHAPEN LLC	RHC rent	1,750.00
SHRED-IT	Secure doc disposal	2,500.00
SIZEWISE	equipment rental	7,500.00
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	1,750.00
SOUTHWEST HOT STEAM CLEANING	Dietary Puch svs	300.00
SPARKLIGHT BUSINESS	Cable service	1,000.00
STANDLEY	Printer Lease	500.00
STANDLEY SYSTEMS LLC	Printer Lease	5,000.00
STAPLES ADVANTAGE	Office Supplies	3,000.00
STERICYCLE INC	Waste Disposal svs	10,000.00
STRYKER INSTRUMENTS	Surgery Supplies	5,000.00
TECUMSEH OXYGEN & MEDICAL SUPP	Supplies	5,000.00
THE COMPLIANCE TEAM	RHC Consultant	2,190.00
TOTAL MEDICAL PERSONNEL STAFF.	agency staffing	15,000.00
TOUCHPOINT MEDICAL, INC	pharmacy purch svs	1,500.00
TSYS	CC processing service	3,000.00
UMPQUA	Lab Eq Note	5,000.00
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	12,000.00
US MED-EQUIP LLC	Swing bed eq rental	15,000.00
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	10,000.00
WETERN COMMERCE BANK	Insurance	7,100.00
CONTEMPORARY HEALTHCARE SVCS	1099 Provider	40,000.00
TELEFLEX	Supplies	2,500.00
OK STATE BOARD	Credentialing	500.00
CINTAS CORPORATION #628	Supplies	8,500.00
BIO-RAD LABORATORIES INC	Supplies	3,500.00
AMBS CALL CENTER	Hotline	200.00
APEX	COVID Capital	180,000.00
LINET	COVID Capital	15,500.00
GE HEALTHCARE	COVID Capital	1,170,000.00
Reyes Electric	COVID Capital	75,000.00
Avanan, INC	COVID Capital	16,800.00
Universal Medical	COVID Capital	2,500.00
Stryker	COVID Capital	16,000.00
Stryker	Old Surgery Supplies	6,000.00
	TOTAL Estimate	**3,810,457.00**

AGREEMENT BETWEEN
Mangum City Hospital Authority
DBA: Mangum Regional Medical Center
AND
THE OKLAHOMA BLOOD INSTITUTE

THIS AGREEMENT is entered into as of _____, by Mangum City Hospital Authority DBA: Mangum Regional Medical Center, 1 Wickersham Drive Mangum, OK 73554 ("Facility") and the Sylvan N. Goldman Center, Oklahoma Blood Institute, an Oklahoma not for profit corporation with its principal office located at 1001 North Lincoln Boulevard, Oklahoma City, OK, 73104 ("Blood Institute").

The Facility desires to utilize the services of the Blood Institute for the procurement of blood, blood components and related services. The charges and fees payable to the Blood Institute for blood and blood components are to compensate the Blood Institute for its direct and indirect costs incurred for the administrative, medical, and technical services provided in the drawing, processing, storage, and delivery of blood or blood components; for donor recruitment; and, for the maintenance of an inventory of blood and blood components (collectively, "blood services").

The Facility and the Blood Institute agree as follows:

1. Provision of Blood and Blood Components. During the term of this agreement the Facility will obtain from the Blood Institute all of the blood components required by the Facility in its daily operations and the Blood Institute will supply all such blood components and services, subject to Paragraph 5 herein. These products and services are for the sole use of the Facility and will be utilized only within the Facility's facility at the address above and the Facility's affiliated facilities.

2. Processing and Services Fees. The Facility shall pay to the Blood Institute the processing and services fees shown on the attached Schedule 2.0.

   2.1 Fee Increases. The Blood Institute, in its sole discretion, may increase the fees paid by the Facility during the term of this agreement if one or more of the following should occur:

      (a) The U.S. Food and Drug Administration ("FDA") mandates, endorses, or licenses the implementation of a new test; or

      (b) Significant change occurs in the cost of compliance with blood banking industry standards, in either the technology used in product manufacturing, or testing, or the offering of new products for patient use.

   2.2 Fees for Extended Term. The Blood Institute may increase the processing and services fees in each year by up to four percent, excluding the increased cost of any new test.

2.3 Notice of Changes. The Blood Institute will provide the Facility with at least 30 days written notice of any changes to the fees payable under this agreement.

3. Billing and Payment. The Blood Institute will provide an itemized monthly statement of charges to the Facility as of the last day of the month, unless the Facility has requested semi-monthly billing. Payment in full is expected no later than thirty (30) days from the date of the invoice. A prompt payment discount of 0.5% will be applied to all invoices paid within ten (10) days of the invoice date. A late penalty of 1.5% per month will be added to each invoice not paid within 30 days from the date of the invoice**.** At the Blood Institute's discretion, the late payment penalty may be suspended for a reasonable period of time in order to resolve any good faith disputes over payment.

4. Sample Labeling Requirements. The Facility shall provide properly identified blood samples in sufficient volume to the Blood Institute for laboratory testing in accordance with the Blood Institute's SOPs and AABB and FDA guidelines. The Blood Institute may refuse mislabeled samples and require the Facility to collect new, properly labeled samples. If multiple mislabeled samples are received from the Facility, then the Blood Institute may suspend cross-matching services until the Facility can provide reasonably satisfactory written assurance to the Blood Institute that corrective action has been implemented.

5. Transfusion Records. A copy of the blood administration record (Bag Tag) documenting the transfusion of the product must be maintained at the facility in accordance with AABB & regulatory guidelines.

6. Delivery and Storage. It shall be the responsibility of the Facility to make arrangements with the Blood Institute for the pickup and delivery of blood samples and components. Once the components have left the Blood Institute's premises, it shall be the responsibility of the Facility tomaintain the proper storage temperature of the components according to AABB and FDA guidelines.The Facility shall store blood components only in a refrigerator that is approved for blood product storage. The Facility will monitor the storage unit and immediately notify the Blood Institute if any blood component has not been maintained at the appropriate temperature. The Facility will returnsuch component in accordance with the Facility's SOPs.

7. Peer Review. The Facility is responsible for the peer review of its transfusion practices. Upon request, the Blood Institute can provide transfusion related statistical data compilations for the Facility's review. If Facility is not able to perform peer review of its transfusion practices, Blood Institute can provide this service.

8. Quality Standards and Regulatory Compliance. The Blood Institute shall maintain standards of performance consistent with its experience, research, and expertise in blood banking. Both parties shall maintain standards of performance in accordance with the applicable recommendations of the Center for Biologics Evaluation and Research (CBER) of the FDA, the applicable requirements of all applicable state regulatory agencies, and to comply with all other applicable laws, rules, and regulations. The Facility shall notify the Blood Institute as soon as practicable of any adverse reactions resulting from the transfusion of any blood product it receives from the Blood Institute. The Facility shall maintain a record of the adverse reaction, conduct an investigation and provide a completed Investigation of Suspected Transfusion Reaction Form (OBI-CL-FORM 255) to the Blood Institute, as required by 21 CFR §606.170(a). Both parties shall comply with

OSHA Bloodborne Pathogen Exposure Final Rule 29 C.F.R. Part 1910.1030, effective March 2, 1996, and any subsequent revisions thereof. Compliance Statements are included in Schedule 8.0. All of the foregoing requirements are collectively referred to as the "Regulations."

9. Records and Patient Information. The Facility will provide the Blood Institute with all transfusion records and patient information necessary for the provision of products and services under this agreement. The parties will use and disclose protected health information in accordance with and as required by the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic & Clinical Health Act and the implementing regulations thereunder, as they may be amended from time to time (collectively, "HIPAA"), and will execute the Business Associate Agreement set forth in the attached Exhibit A. The Blood Institute will provide the Facility such information as may be required by FDA recommended guidelines for look back and product recalls.

10. Indemnification.

10.1 The Blood Institute shall indemnify the Facility and its officers, directors, employees, and agents and hold each of them harmless from liability to and claims by third parties, including reasonable attorneys' fees, to the extent that they result from or arise in connection with the negligence or willful misconduct of the Blood Institute or its officers, directors, employees, or agents in the performance of this agreement.

10.2 The Facility shall indemnify the Blood Institute and its officers, directors, employees, and agents and hold each of them harmless from liability to and claims by third parties, including reasonable attorneys' fees, to the extent that they may result from or arise in connection with the negligence or willful misconduct of the Facility or its officers, directors, employees, or agents.

11. Insurance. Each of the parties shall, at its own expense, maintain in effect a policy of professional liability insurance with coverage in the amount of not less than $1,000,000 per claim and $3,000,000 per occurrence. This coverage shall insure a party and its employees against liability for damages directly or indirectly related to the performance of any services and other respective obligations under this agreement. Each party shall provide the other with a certificate from the insurance carrier evidencing the required coverage. With the Blood Institute's prior written consent, the Facility may opt to self-insure as to specifically identified risks. Each party shall notify the other of any adverse change in insurance coverage required by this agreement.

12. Force Majeure. Neither party will be liable for any failure to perform its obligations (except payment obligations) for any reason beyond the party's reasonable control, including acts of terrorism, strikes, fires, explosion, flood, riot, lock out, injunction, interruption of transportation, unavoidable accidents, or a significant change in any applicable law or regulation.

13. Affirmative Action. The Blood Institute wishes to comply with the provisions of Executive Order 11246 of September 24, 1965; Executive Order 11375 of October 13, 1967;

Executive Order 11758 of January 15, 1974; Section 503 of the Rehabilitation Act of 1973; the Vietnam Era Veterans Readjustment Act of 1974, as amended, 38 U.S.C. 4212 (formerly 2012); and the implementing regulations at 41 CFR Chapter 60. The Facility will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, handicap, or status as a disabled veteran or a veteran of the Vietnam Era. This policy not to discriminate in employment includes hiring, transfer, training during employment, and rates of pay.

14. Term. The term of this agreement will begin _____, and continue through July 31, 2026 (the "Initial Term"). After the Initial Term, the Agreement automatically renews from year to year (a "Successive Term") unless a Party provides written notice of termination at least thirty (30) days before the expiration of the Initial Term or any Successive Term. All terms and conditions of this Agreement shall remain in effect during any Successive Term. The Initial Term and any Successive Terms shall be referred to as the Term. Processing and services fees may be adjusted each year as provided in Section 2.

15. Confidentiality. Both parties acknowledge that the terms, conditions, and fee schedules of this agreement are confidential. This confidential information shall not be disclosed to any officer, director, employee, or agent of a party, except as necessary in carrying out the person's respective duties under this agreement. This confidential information shall not be used other than in connection with this agreement. Additionally, the parties shall keep confidential, and not divulge to anyone else any of the proprietary, confidential information of the other party, including information relating to such matters as finances, methods of operation and competition, pricing, marketing plans and strategies, operational requirements and information concerning personnel, referral sources, patients and suppliers.

16. Construction and Governing Law. The rule of construction that a document is to be construed most strictly against the party who drafted the document shall not be applicable because all parties participated in the preparation of this agreement. "Includes" and "including" are not limiting. The laws of the State of Oklahoma shall govern this agreement and the legal relations between the parties without giving effect to any conflict of law provision (whether of the State of Oklahoma or any other jurisdiction) that would cause the application of the law of any other jurisdiction.

17. No Assignment. Neither party may assign its rights or delegate its duties under this agreement without the prior written consent of the other party; such consent shall not be unreasonably withheld.

18. No Third Party Beneficiaries. Nothing in this agreement, express or implied, is intended to confer upon any person, firm, or corporation, other than the parties named herein, any right, remedy, or claim under or by reason of this agreement, as third party beneficiaries or otherwise.

19. Termination. A Party may unilaterally terminate this Agreement: (a) if the other Party fails to fulfill any one or more of its obligations under this Agreement ("Breach") and the Breach continues for a period of thirty (30) days after the non-breaching Party sends written notice of the Breach, (b) if any of the Regulations are amended in a way that precludes a Party from performing its obligations under this Agreement, effective upon the effective date of the amended Regulation; (c) if a Party ceases to operate or otherwise function as a business; or (d) if a Party fails to maintain professional liability insurance as required

herein. The Blood Institute may unilaterally terminate this Agreement upon notice to the Facility if (x) the Facility's state license to operate as a hospital in Oklahoma is suspended, terminated, or revoked by the State Department of Health, or (y) the Facility is excluded from participation in Medicare, Medicaid, or any other federal health care program. Termination of this agreement pursuant to this provision shall not constitute an election of remedies, and the terminating party shall retain all rights and remedies that may be available at law or in equity with respect to the default by the other party. Upon termination, the Facility shall, within 15 days of the termination date, pay the Blood Institute any and all amounts owing for blood products and related services provided through the date of termination.

20. Entire Agreement; Amendments; Waiver. This agreement is the final expression of the entire agreement of the parties. This agreement supersedes all prior agreements and understandings between the parties. This agreement may not be amended, modified, or waived except by a written agreement designated as such and signed by the party against whom it is to be enforced. The failure of a party to insist upon the strict observance or performance of any of the provisions of this agreement or to exercise any right or remedy shall not impair any such right or remedy or be construed as a waiver or relinquishment thereof with respect to subsequent defaults.

21. Counterparts. This agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this agreement and all of which, when taken together, will constitute one and the same agreement. The exchange of copies of this agreement and of signature pages by facsimile transmission shall constitute effective execution and delivery of this agreement and may be used in lieu of the original agreement for all purposes.

22. Inventory Control. If applicable, a minimum standing inventory of transfusable blood products will be agreed upon between the Blood Institute and the Facility. Such inventory shall be maintained at the Facility by the Blood Institute on a consistent basis, in the amount and varieties of types necessary to meet the routine needs of the Facility. The Facility will promptly notify the Blood Institute of any requests for specialized blood products, services, or variations to the Facility's standing inventory. Such requests may be subject to the Blood Institute's medical review and approval.

23. Credit/Return Policy (If applicable) Regular communication between the Facility and the Blood Institute must occur to prevent the expiration and destruction of blood or blood components. Credit will only be issued in accordance with the guidelines stated on the attached Credit/Return Policy, Schedule 23.0. The Blood Institute may modify the Credit/Return policy during the term of this agreement by giving 30-days written notice to the Facility.

24. Donor Source. Only blood donations from volunteer donors will be utilized in the preparation of blood products for transfusion.

25. Charges by Facility. The Facility fees provided in this agreement are intended to defer the Blood Institute's previously described operational costs. This agreement does not restrict the Facility's ability to add service charges as it deems reasonable and prudent to ensure proper patient service and as may be permitted by applicable law.

26. Notice. Any notice, consent or communication required or permitted to be given under this Agreement shall be deemed to have been duly given if in writing and either delivered personally, sent by electronic transmission, or sent by United States first class mail, postage prepaid to the addresses set forth in the introduction of this Agreement.

27. Binding Effect. This agreement shall be binding upon, and inure to the benefit of, the parties and their respective legal representatives, successors, and assigns.

28. Survivability of Terms. The terms and provisions and each party's obligations and/or agreements under Sections 9, 10 and 15 shall survive any termination or expiration of this Agreement and will be construed as agreements independent of any other provisions of this Agreement.

FOR: THE FACILITY

_____
Signature

_____
Date

_____
Print Name

_____
Print Title

FOR: THE BLOOD INSTITUTE

_____
John Armitage, M.D., President and CEO

_____
Date

Schedule 8.0
COMPLIANCE STATEMENTS

The Oklahoma Blood Institute (OBI) manufacturers Blood and Blood Products under Food and Drug Administration (FDA) license number 0766. Each OBI facility has an FDA assigned Establishment Identification Number (FEIN) and is inspected by the FDA to evaluate Current Good Manufacturing Practices (CGMP) and compliance with relevant sections of 21 CFR 200, 600, 800 and 1200.

AABB Blood Bank and Transfusion Services accreditation is maintained by OBI. In accordance with the Social Security Act and 42 CFR Parts 422.156, 422.157 and 422.158 the Health Care Financing Administration has granted AABB deemed status with the Centers for Medicare and Medicaid Services (CMS). Therefore, AABB standards have been found to meet or exceed all relevant CMS requirements for participation. AABB bi-annual assessments evaluate OBI against these standards.

Infectious Disease Testing is provided under CLIA number 37D0470358 and Immunohematology Testing is provided under CLIA number 37D2175055 in the headquarters location in Oklahoma City. Immunohematology Testing is also provided under CLIA number 37D0931105 in the Tulsa location, CLIA number 04D2096885 in the Little Rock location, and CLIA number 45D0507042 in the Coffee Memorial Blood Center location. CLIA compliance inspections and renewals are performed bi-annually by the AABB. OBI Laboratories participate in CMS approved proficiency testing programs. AABB Immunohematology Laboratory Accreditation is maintained by the Clinical Laboratories in Oklahoma City, Tulsa, Little Rock, and Coffee Memorial Blood Center.

OBI maintains a Quality Plan, Quality Manual, Emergency Preparedness and Disaster Plan, Transfusion Associated Disease Investigation Procedures, Look-Back Procedures (HCV and HIV), and Consignee Notification Procedures for Positive Test Results, Market Recalls and Market Withdrawals for non-conforming blood or blood components. Initial consignee notifications occur in accordance with federal and state statutes and regulations. Specifically within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection; within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available; and within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA. These documents can be made available for reference during relevant facility inspections.

OBI performs bacterial detection testing on all apheresis platelet components. This test is a culture that is incubated throughout the shelf life of the product.

OBI maintains a Privacy Policy, Notification of Privacy Practices and Business Associate Agreements that include relevant requirements identified in 45 CFR 164, Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

<u>For Regulatory or Compliance Issues, Call</u>
AVP, Quality Management (405) 297-5526
Compliance Officer (405) 297-5733

Schedule 23.0
BLOOD PRODUCTS CREDIT/RETURN POLICY
OKLAHOMA BLOOD INSTITUTE

The following blood products may be returned for credit or exchange to the Oklahoma Blood Institute in accordance with the following established guidelines:

Product	**Timeframe**
	Restrictions required to receive credit:
LEUKOREDUCED RED CELLS	a. Stored at 1 to 6 degrees Centigrade as documented by a continuous recording device;
	b. The blood container has not been entered;
	c. Product storage has met all other applicable CBER/FDA and AABB requirements;
	d. At least one crossmatch segment remains attached; and,
	e. Greater than 7 days of shelf life is remaining before the product outdates/expires.
LEUKOREDUCED PLATELETS (Single donor) (Aphereis-derived)	Greater than 24 hours of shelf life providing such products have been: a. Stored at 20 to 24 degrees Centigrade as documented by a continuous recording device; b. Stored with continuous agitation
	If less than 24 hours, OBI will assist Facility in offering the product to another facility [provided products have also been stored at 22 degrees Centigrade, plus or minus 2 degrees]. If successful, credit will be issued to Facility; if unsuccessful, credit will not be issued. *This policy provision will not apply where the product had 48 hours or less of remaining shelf life when supplied to Facility by OBI.* ***The Large Volume Delayed Sampling (LVDS) fee effective August 1, 2021 is non-refundable for returned platelets.***
PLASMA and PLASMA PRODUCTS	Plasma and Plasma Products will not be accepted for credit.
MODIFIED PRODUCTS	Products modified by Blood Institute or Facility will not be accepted for credit.
Autologous Units	No returns will be accepted/credited.

BLOOD PRODUCTS CREDIT/RETURN POLICY *
OKLAHOMA BLOOD INSTITUTE

The following blood products may be returned for credit or exchange to the Oklahoma Blood Institute in accordance with the following established guidelines:

Product	**Timeframe**
	Restrictions required to receive credit:
LEUKOREDUCED RED CELLS	a. Stored at 1 to 6 degrees Centigrade as documented by a continuous recording device;
	b. The blood container has not been entered;
	c. Product storage has met all other applicable CBER/FDA and AABB requirements;
	d. At least one crossmatch segment remains attached; and,
	e. Greater than 7 days of shelf life is remaining before the product outdates/expires.
LEUKOREDUCED PLATELETS (Single donor) (Apheresis-derived)	Greater than 24 hours of shelf life providing such products have been: a. Stored at 20 to 24 degrees Centigrade as documented by a continuous recording device; b. Stored with continuous agitation.
	If less than 24 hours, OBI will assist Facility in offering the product to another facility [provided products have also been stored at 22 degrees Centigrade, plus or minus 2 degrees]. If successful, credit will be issued to Facility; if unsuccessful, credit will not be issued. This policy provision will not apply where the product had 48 hours or less of remaining shelf life when supplied to Facility by OBI. ***The Large Volume Delayed Sampling (LVDS) fee effective August 1, 2021 is non-refundable for returned platelets.***
PLASMA AND PLASMA PRODUCTS	Plasma and Plasma Products will not be accepted for credit.
MODIFIED PRODUCTS	Products modified by Blood Institute or Facility will not be accepted for credit.
Autologous Units	No returns will be accepted/credited.

***Please post in the Blood Bank**

Exhibit A
BUSINESS ASSOCIATE AGREEMENT

THIS AGREEMENT is entered into as of _____, by Mangum City Hospital Authority DBA: Mangum Regional Medical Center, 1 Wickersham Drive Mangum, OK 73554 ("Facility") and the Sylvan N. Goldman Center, Oklahoma Blood Institute, an Oklahoma not for profit corporation with its principal office located at 1001 North Lincoln Boulevard, Oklahoma City, OK, 73104 ("Blood Institute").

A. The Blood Institute provides services for the procurement of blood and blood components and related services (the "Services") for the Facility pursuant to a written agreement between the parties (the "Services Agreement").

B. The Blood Institute and the Facility are subject to the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic & Clinical Health Act, and the implementing regulations promulgated thereunder, as amended from time to time (collectively, "HIPAA").

C. To facilitate the provision of Services by the Blood Institute, it may be necessary for the Facility to disclose protected health information concerning its patients to the Blood Institute. "Protected health information" is demographic information collected from a patient which (a) is created or received by the Facility, (b) relates to the past, present or future physical or mental health condition, the provision of health care or the past, present or future payment for the provision of health care of a patient, and (c) identifies the patient, or the information can be used to identify the patient. "Protected health information" includes information that is transmitted, maintained or received electronically. Demographic information that identifies the patient or that could be used to identify a patient includes: name, street address, city, county, precinct, zip code, birth date, admission date, discharge date, date of death, telephone number, fax number, email address, social security number, medical record number, health plan beneficiary number, account number, certificate/license numbers, vehicle identifier and serial number, and full face photographic images and any comparable images.

D. The Facility wishes to obtain satisfactory assurances from the Blood Institute that the Blood Institute will safeguard protected health information from misuse and unauthorized disclosure and that the Blood Institute will assist the Facility in complying with other requirements related to protected health information.

In consideration of the covenants, terms and conditions set forth in this Agreement, the Facility and the Blood Institute agree as follows:

1. Protected Health Information. The Blood Institute and the Facility shall appropriately safeguard from misuse and unauthorized disclosure all data that is protected health information.

2. Business Associate Standards. By virtue of this Agreement, the Blood Institute may receive protected health information on behalf of Facility, and is thereby subject to the "business associate" standards set forth herein. The Blood Institute may use and disclose protected health information it receives from the Facility, in accordance with HIPAA, strictly for the following purposes, and only to the extent necessary for the Blood Institute to perform its obligations under the Services Agreement:

a. The Blood Institute may use and disclose protected health information it receives from the Facility (i) in the proper management and administration of the Blood Institute; (ii) as required by law; (iii) to carry out its legal responsibilities; (iv) to perform blood banking and transfusion services in accordance with recognized standards of care; or, (iv) to other person(s) who provide reasonable written assurances that the information will be held confidentially, under the same conditions and restrictions that apply to the Blood Institute, and used or further disclosed only as required by law or for the purpose for which it was disclosed to such person, and that such person(s) will notify the Blood Institute of any instances which it is aware or becomes aware that the confidentiality of the information has been breached;

b. The Blood Institute may use and disclose protected health information it receives from Facility to provide data aggregation services relating to the health care operations of the Facility;

c. The Blood Institute may use and disclose protected health information it receives from the Facility for purposes related to the testing and analysis of specimens and for internal operational purposes, including: conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services or auditing functions; business planning, development and management; implementing and conducting compliance programs; performing aggregate data analysis; and conducting due diligence in connection with the sale of part or all of the business.

d. With respect to information that it has received from Facility, the Blood Institute shall:

(i) Not use or further disclose the information other than as permitted or required by this Agreement or as required by law, not copy, duplicate or otherwise reproduce any part of the information except as required to perform services under the Services Agreement, and comply with the HIPAA privacy regulations with respect to any obligations under HIPAA that the Blood Institute is performing on behalf of the Facility;

(ii) Promptly report to Facility if the Blood Institute becomes aware of any use or disclosure of protected health information not permitted by this Agreement or any other security incident related to the protected health information, and take all necessary actions to promptly remedy the situation and to minimize any adverse consequences of such use, disclosure or security incident;

(iii) Ensure that any agents, representatives, subcontractors or others to whom the Blood Institute provides protected health information received from, or created or received by the Blood Institute on behalf of the Facility (each, a “Subcontractor”) enters into a written agreement with Blood Institute that imposes the same obligations on Subcontractor that are imposed on Blood Institute under this Business Associate Agreement;

(iv) Make available protected health information in accordance with 45 CFR 164.524;

(v) Make available protected health information for amendment and incorporate any amendments to protected health information in accordance with 45 CFR 164.526;

(vi) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528;

(vii) Make its internal practices, books and records relating to the use and disclosure of protected health information received from, or created or received by the Blood Institute on behalf of the Facility, available to the Secretary of the Department of Health and Human Services for purposes of determining the Facility's compliance with 45 CFR 164.500 – 534; and,

(viii) At termination of this Agreement, if feasible, return, destroy or permanently delete all protected health information received from, or created or received by the Blood Institute on behalf of the Facility that the Blood Institute still maintains in any form and retain no copies of such information, except (A) the Blood Institute may retain, use and disclose such protected health information to meet quality standards and public health and regulatory requirements related to its blood banking and transfusion services, or (B) the Blood Institute may retain such protected health information if return or destruction is not feasible and the Blood Institute extends the protections of this Agreement to retained information and limits further uses and disclosures to the purposes that make return or destruction infeasible.

e. Facility shall be responsible for obtaining all consents and authorizations of patients, in accordance with HIPAA.

3. Use of Safeguards. The Blood Institute shall use appropriate safeguards to prevent the use or disclosure of the protected health information other than as provided for by this Agreement. If protected health information is transmitted, maintained or received electronically, the Blood Institute shall use administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of such information, including access controls, workstation security, integrity controls, data backup and storage and encryption.

4. Reporting. The Blood Institute shall promptly report to the Facility not later than 30 days after the Blood Institute becomes aware of (a) any acquisition, access, use or disclosure of protected health information not permitted by this Agreement or HIPAA, or (b) any other security incident related to protected health information of which the Blood Institute becomes aware (an "Incident") whether or not the Incident qualifies as a "reportable breach" under HIPAA. With respect to a reportable breach, the Blood Institute shall provide the following information to the Facility: (a) a brief description of the Incident; (b) a description of the nature and extent of protected health information involved in the Incident; (c) the individual who impermissibly used the protected health information; (d) a description of the Blood Institute's actions to mitigate the consequences of the Incident and to prevent further Incidents; and (e) if requested by the Facility, contact procedures for individuals to contact the Blood Institute for additional information. Except as directed by the Facility, the Blood Institute shall not directly report an Incident to the Secretary, the media, or any individual, and shall keep the matter strictly confidential. The parties shall take all necessary actions to promptly remedy the situation and to minimize any adverse consequences of such Incident.

5. Independent Contractor Status. The Blood Institute is performing services for the Facility as an independent contractor. Nothing in this Agreement shall be construed as creating an agency, partnership, employment or joint venture relationship between the Blood Institute and the Facility. Neither party may bind, or create any obligations on behalf of, the other party.

6. Obligation to Disclose Information. This Agreement does not impose any specific obligations on the Facility to disclose protected health information.

7. Binding Effect. This Agreement shall be binding upon the parties hereto and their respective legal representatives, successors and assigns.

8. Governing Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Oklahoma.

9. Assignment. This Agreement may not be assigned by the Blood Institute, nor may the Blood Institute delegate its duties hereunder, without the express prior written consent of the Facility.

10. Amendments. This Agreement may not be amended except by an instrument in writing signed by the Facility and the Blood Institute.

11. Notices. Any and all notices, consents or other communications by one party intended for the other shall be deemed to have been properly given if in writing and personally delivered, transmitted by electronic means, or deposited in the United States, postpaid, to the addresses or numbers set forth below the signatures of the parties.

12. No Waiver. No waiver of a breach of any provision of this Agreement shall be construed to be a waiver of any breach of any other provision. No delay in acting with regard to any breach of any provision of this Agreement shall be construed as a waiver of such breach.

13. Entire Agreement. This Agreement constitutes the entire understanding and agreement of the parties with respect to its subject matter and cannot be changed or modified except by another agreement in writing signed by the parties.

EXECUTED as of the date written above.

FOR: THE FACILITY

_____
Signature

_____
Date

_____
Print Name

_____
Print Title

FOR: THE BLOOD INSTITUTE

_____
John Armitage, M.D., President and CEO

_____
Date

Exhibit B
Quality Standards

1. The Facility agrees that it will use only trained individuals to perform sample collections, patient consents and blood transfusions. The Facility further agrees to annually assess and document the competency of these individuals as required by federal law in 42 CFR 493.1235 and 42 CFR 493.1451.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide OBI with documentation of compliance, when requested by the Blood Institute

2. The Facility agrees to maintain a list of the employees, agents or consultants, identifiers or initials used by the Facility to track those responsible for collecting samples, consenting patients or performing transfusions. This list will contain the inclusive dates of employment.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide OBI with documentation of compliance, when requested by the Blood Institute

3. The Facility agrees that blood or blood products will only be stored in a validated storage device or container and that the device will be continuously monitored and equipped with an alarm system and to notify OBI of temperature excursions.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide Blood Institute with these records, when requested, to ensure that temperature excursions do not occur.

4. The Facility agrees to develop and administer transfusion consent forms that adequately describe risks associated with transfusions and to utilize the transfusion service physician or designee as a resource in identifying and describing the associated risks.

   The Facility, through its employees, agents or consultants, agrees to be solely responsible for performing and documenting this quality requirement. Additionally, the Facility agrees to provide OBI with documentation of compliance, when requested by the Blood Institute

FOR: THE FACILITY

_____
Signature

_____
Date

_____
Print Name

_____
Print Title

FOR: THE BLOOD INSTITUTE

_____
John Armitage, M.D.
President and CEO

_____
Date

Clinic Operations Report

Mangum Medical Clinic

June 2021

Clinic Operations (encompassing Quality Improvement and Community Outreach)

Cohesive Clinic Manager Meeting at Cohesive Corporate Office/Shawnee:

- Cohesive Clinic Operations Presentations:
  - Managing PTO (Manager Tool)
    - Identifying gaps in Staff and Provider coverage and how to manage needs of community with resources.
  - Medical Necessity Education (Take-Back Exercise)
    - Tutorial PowerPoint presentation to share with Clinic Teams
    - Tip Sheet for Common Lab Testing along with covered diagnosis codes
  - RHC Rounding Tool (Manager Tool)
    - Checklist for regulatory items within the clinic to maintain ongoing compliance.
  - RHC Program Evaluation Workbook (Take-Back Exercise)
    - Annual Review of Clinic to assess if community needs are being met and to set focus for future goals.
      - Next Steps assigned:
        - Formation of Committee-Review of who should be included.
        - Kickoff Meeting-Review of purpose and structure.

- Clinic Manager Presentations:
  (Successful application of previously shared tools)
  - Process Improvement using daily graph and "why exercise"-No Show Appointment trends.
  - Patient Satisfaction Portal-How to increase surveys and how to act on results.
  - Waiting Room Binder-Required and helpful community resources.
  - Clinic and QAPI Meeting Organization for Teams Upload-Agenda/Sign in sheet and how to organize them.

- Brainstorming Session:
  - Community Vaccine Events (Flu or additional COVID vaccines needed): Idea-gathering to reach the community with vaccines and education quickly and efficiently.

Visits per Productive Hour=Goal 2.00 (Swingbed visits and time reflected beginning in March)

Mangum Clinic	21-Jan	21-Feb	21-Mar	21-Apr	21-May	21-Jun	20-Jul	20-Aug	20-Sep	20-Oct	20-Nov	20-Dec
Visits	235.00	185.00	213.00	218.00	202.00	286.00	254.00	212.00	261.00	242.00	192.00	202.00
Provider hours	154.2	156.5	168.0	144.0	136.6	175.0	167.5	119.5	157.0	168.9	127.0	131.0
Vists per Productive Hr	1.52	1.18	1.27	1.51	1.48	1.63	1.52	1.77	1.66	1.43	1.51	1.54
Increase/Decrease prior month			START	19%	-2%	10%						
Increase/Decrease overall				19%	17%	27%						

Mangum Regional Medical Center

Chief Clinical Officer Report
June 2021

Excellent Patient Care

- Monthly Education topics included: American Heart Association's Basic Life Support, Advanced Cardiopulmonary Life Support and Pediatric Advances Life Support.
- Non-Clinical staff participated in and received certification in American Heart Basic Life Support class.
- Emergency Department provided rapid diagnostics and appropriate transfer of an ischemic stroke patient.

Excellent Client Service

- Patients continue to rely on MRMC as their local hospital. Patient days decreased from 345 in May to 316 days in June. This represents an average daily census of 11. In addition, MRMC Emergency Department provided care to 167 patients in June.
- June COVID-19 Stats at MRMC: Swabs (33-PCR & 49-Antigen)3 Positives & 79 Negatives.
- Greer County June COVID-19 Statistics: 591 Positive Cases and 22 Deaths (3.72% death rate).

Preserve Rural Healthcare

Mangum Regional Medical Center												
2021 Monthly Census Comparison												
	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Inpatient	15	15	11	16	36	34						
Swing Bed	10	20	13	19	22	11						
Observation	0	2	1	2	1	0						
Emergency Room	104	133	127	143	149	167						
Lab Completed/ Rad completed	2140/ 180	2286/ 246	2387/ 223	1984/ 222	1964 /200	2134/ 213						

Preserve Rural Jobs

- Open Positions include Full Time RT, MLT, RN, LPN, and CNA.
- Open Director positions include Rehabilitation and Laboratory Manager.
- For the clinical team MRMC has hired a Core RN and LPN
- Recruiting efforts included positing of positions on mangumregional.net and Facebook.

Chief Executive Officer Report
July 2021

COVID - 19 Activity and Overview

- ✓ Patient care continues to be outstanding at Mangum Regional Medical Center.
- ✓ We continue to participate in daily Region 3 Merc email briefings.
- ✓ Cohesive and hospital leadership continue to ensure the staff and providers are kept up to date regarding any changes or new policies pertaining to COVID-19.

Hospital Staff and Operations Overview:

- ✓ Current open positions include RN, LPN, RT, MT, Part time Dietary Aide, Rehab Director and Lab Director.
- ✓ Newly filled positions include Finance Director; AP Clerk; RN, Case Manager; RN, Quality Manager; LPN; MLT, Lab and Dietary Aide.
- ✓ Covid Project/Cares Act equipment purchases are proceeding as planned.
- ✓ Our census has continued to be strong with an average daily census of 11.
- ✓ The 4H members along with their sponsors Glenadee Edwards, Carol Toole and Cheryl Lively planted flowers in the flower beds around the hospital.

Contracts, Agreements and Appointments to be presented to the board:

- ✓ BKD Agreement to prepare cost report due 7/31/21
- ✓ Respiratory Protection Program Evaluation Summary for 2021
- ✓ Respiratory Program Administrator Appointment, Karli Bowles, RN
- ✓ Hospital Debit Card needed for payment of specific board approved services
- ✓ Cody Griffin, DO, Contract Renewal
- ✓ Kenna Wenthold, APRN, Contract Renewal
- ✓ Jeff Phillips, PA, Contract Renewal
- ✓ Brian Bluth, MD, Supervisory Agreement

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Security Management Plan		**LS-400**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Life Safety (Environment of Care)	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

The Security Management Plan is Hospital-wide in scope.

PURPOSE

The Environment of Care (EOC) Security Management Plan is established to provide a safe environment and to protect all staff, patients, and visitors from harm and to ensure staff is knowledgeable of their roles and responsibilities during any security event.

POLICY

The Hospital's Security Management Plan contains processes to ensure standard work practices are followed and to mitigate any risks to patients, staff or building in the event of a security event.

PROCEDURE

A. Identification of hospital personnel: Personnel will be identified by badges and are to be worn completely visible at all times while on duty.

B. Identification of patients: Patients will be identified by an arm bracelet, issued upon admission, which contains their name; admit date, their physician's name, and other demographic information.

C. Identification of vendors: Vendors will be identified by badges and are to be worn and completely visible at all times while on the premises.

D. Security Issues: Any security issue concerning patients (including patient elopement, when applicable), visitors, personnel, and property will be appropriately investigated and reported as appropriate to law enforcement, Administration and Quality/Risk Manager.

E. Controlling access: Access to sensitive areas (e.g., pharmacy, medical records, lab, central supply, biohazard, storage, and plant operations) will be controlled and restricted to those persons authorized by the Hospital to access those areas.

F. Emergency Codes: The Hospital utilizes a set of emergency codes to alert staff in the event of an emergency/disaster/security event so the appropriate action and interventions can be enacted quickly and efficiently for the safety and protection of the patients, staff, visitors, environment, and /or building. See a detailed description of the codes in the Hospital Emergency Preparedness Plan, Appendix 9.

G. Security Incidents: Refer to Hospital Plan Gen-014 for information on process to document/report any security incident.

ORIENTATION/EDUCATION

A. Initial orientation regarding the plan will be given to new employees by the Plant Operations Manager. Annual education regarding the plan will be done annually for all Hospital employees. Orientation/Education will include:

1. Addressing security concerns
2. Reporting requirements/mechanism
3. Proper identification
4. Security procedures
5. Access control

MONITORING THE PLAN

A. Performance standards for the Security Management Plan are acknowledged through staff testing, monitoring and inspection activities, and review of security logs.

B. Security Management Plan data is collected concurrently by the Plant Operations Department (i.e. Maintenance, Environmental Services) and reviewed by the Quality Committee monthly.

C. Data is collected based on staff input and observation of the physical environment, internal and external monitoring, and testing and maintenance of the essential security systems. This review will ensure that certain performance standards are met and maintained.

D. Quality Improvement: At least one aspect of EOC will be monitored on a quarterly basis and a report of the results will be forwarded to the Quality Committee, Medical Staff Committee, and Governing Body.

EVALUATION

A. The objectives scope, performance, and effectiveness of the Hospital's Security Management Program are evaluated annually.

B. Any necessary changes are prepared and presented to the Hospital's Quality Committee and changes made to improve the plan are based on committee recommendations.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Fire Management Plan		**LS-500**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Life Safety (Environment of Care)	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

The Fire Management Plan is Hospital-wide in scope.

PURPOSE

The Environment of Care (EOC) Fire Management Plan is established to provide a safe environment for patients, visitors and staff while minimizing the risk of fire.

POLICY

The Hospital's Fire Management Plan contains policies and processes to ensure standard work practices are followed and to minimize the risk of fire and to quickly and appropriately act in the event of a fire to ensure safety for patients, visitors and staff.

PROCEDURE

A. The Plant Operations Department:

1. Ensures that all departments are compliant with all aspects of the Hospital's Fire Plan.
2. Establishes a Fire Plan that is compliant with all standards and regulatory requirements.
3. Responds to all activations of the Fire Plan.
4. Establishes and maintains telephone contact between the fire scene and the switchboard operator.
5. Summons additional staff from unaffected areas of the Hospital as needed.
6. Coordinates fire suppression activities until the Fire Department arrives.
7. Directs all activities in the absence of the Administrator.
8. Initiates and supervises any needed patient evacuation.

9. Assists with the evaluation and critique of all activities of the Fire Plan.
10. Maintains documentation of inspection and annual preventive maintenance of all fire alarm systems.
11. Ensures that there are current drawings or documents that address the location of all features of the fire protection.
12. Ensures that there are inspection procedures, test criteria, and performance of an annual inspection and testing for all automatic fire extinguishing systems.
13. Coordinates the inspection and maintenance of all portable fire extinguishers.
14. Ensures that a process is in place that addresses all areas of the building, activation of dampers, smoke management systems, activation/deactivation of fan units to minimize smoke transmission.
15. Assures flame resistant capabilities which shall be required of bedding, window treatments, furnishings, decorations, and trash containers.

B. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.
   1. Staff will be familiar with procedures and will be aware of their role during a fire.
   2. When drills are conducted between the hours of 9:00 pm and 6:00 am, a coded announcement may be used instead of an audible alarm.
   3. The Plant Operations department will be responsible for planning and conducting fire drill and maintain records of each drill in the Plant Operations department.

C. Smoke detectors and sprinkler systems are properly maintained/cleaned, inspected and tested annually. Annual inspection of the entire system is conducted by a qualified contracted vendor. There will be adequate water supply equipped with water flow, valves and tamper switches which are connected to the fire alarm system. Records of each inspection is maintained in the Plant Operations department.

D. Fire extinguishers are located in the hospital in conspicuous areas. Class A, B or C are throughout the hospital. Class K (specifically for fires involving grease and oils) are located in the kitchen. Extinguishers are fully charged and operational at all times and have visible operating instructions. A monthly inspection is conducted for each extinguisher with date and initials of person conducting the inspection. Annual maintenance of all extinguishers is conducted by qualified contracted vendors and records will be maintained in the Plant Operations department.

E. Range Hood: Cooking facilities will be protected from fire hazards in part with properly maintained range hoods. Range hoods will be constructed of heavy weight corrosive resistant materials. Grease removal equipment, filters, drip trays will be cleaned semi-annually. Pull stations and fire extinguisher is not blocked or obstructed. Range hood is inspected/cleaned every six (6) months by a qualified contracted vendor. Records will be maintained for range hood maintenance in the Plant Operation department.

F. Alcohol based hand rub dispensers will meet certain parameters to ensure safety:
1. Not installed directly above an electrical outlet or light switch.
2. Does not leak onto the floor.
3. Capacity of each dispenser is less than 1.2 liters.
4. Spacing at least four (4) feet between dispensers.
5. Not more than 10 gallons are used in a single smoke compartment.

G. A fire alarm system will provide effective warning of fire in any part of the building.
1. Activation of the fire alarm system shall be made by manual fire alarm initiation, automatic detection or extinguishing system operation (including smoke detectors or sprinkler system).
2. Fire alarm system will automatically transmit the signal to the fire department or monitoring agency.
3. The fire alarm system will be connected to a back-up power supply.
4. Pull stations are within 200 feet of nurses' stations and in path of egress.
5. Fire alarm system is tested and maintained at regular intervals.
6. Records of fire alarm tests and records of maintenance are kept readily available.
7. There will be annunciation of the fire alarm system to a central station.
8. In the event the fire alarm system is out of service for more than four (4) hours in a 24 hour period (smoke detectors, sprinkler systems or any other component of the fire alarm system) a fire watch procedure will be implemented.
9. Assigned personnel will walk the hospital once every hour to observe and document any sign of smoke or fire for purposes of notifying the fire department and building occupants.
10. The hospital will notify the local fire department that a fire watch has been initiated.
11. Fire watch personnel will be trained to extinguish small fires and to appropriately activate the fire alarm system, notify the fire department and begin evacuation procedures as necessary.

ORIENTATION/EDUCATION

A. Initial orientation regarding the plan will be given to new employees by the Plant Operations Manager. Annual education regarding the plan will be done annually for all hospital employees. Orientation/Education will include:
1. Location of fire pulls and fire extinguishers.
2. Emergency shut off controls for oxygen.
3. Emergency procedures for patient care areas.
4. How to use a fire extinguisher.
5. How to announce a fire.

MONITORING THE PLAN

A. Performance standards for Fire Management is acknowledged through staff testing, monitoring and inspection activities, and the review of hospital incident reports.

B. Fire Management Plan data is collected concurrently by the Plant Operations Department (i.e.; Maintenance, Environmental Services) and reviewed by the Quality Committee monthly.

C. Data is collected based on staff input and observation of the physical environment and maintenance records. This review ensures that certain performance standards are met and maintained.

D. Quality Improvement: At least one aspect of the EOC is monitored on a quarterly basis and a report of the results forwarded to the Quality Committee, Medical Staff Committee, and Governing Body.

EVALUATION

A. The objectives, scope, performance, and effectiveness of the Hospital's Fire Management Program are evaluated annually.

B. Any necessary changes are prepared and presented to the Hospital's Quality Committee and changes made to improve the plan are based on committee recommendations.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Hazardous Materials Management Plan		**LS-700**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Life Safety (Environment of Care)	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

The Hazardous Materials Management Plan is Hospital-wide in scope.

PURPOSE

The Environment of Care (EOC) Hazardous Materials Management Plan is established to provide a safe environment for patients, visitors and staff while handling and disposing of hazardous materials.

POLICY

The Hospital's Hazardous Materials Management Plan contains policies and processes to ensure standard work practices are followed and to mitigate any risks to patients, staff or visitors while handling and disposing of hazardous materials.

PROCEDURE

A. MSDS (Material Safety Data Sheets) are maintained for each hazardous material and chemical used in the Hospital.
   1. The Hospital may utilize an MSDS online program or paper binder.
   2. The MSDS online program will be available in each department containing all hazardous materials in use in the department and Hospital.
   3. Paper binders will be centrally located and the location known to each employee.
   4. The MSDS information is to be available to employees at all times.
   5. Each Department Manager will be responsible for adding or deleting of MSDS.

B. Identification: Departments will define hazardous materials:

1. Hazardous Chemical Material: Any material which may be explosive, flammable, poisonous, corrosive, oxidizing, irritating, or otherwise harmful and is likely to cause internal or external injury to humans or the environment.

2. Hazardous Gaseous and Vaporous Material**:** Any substance which may be dispersed through the air and act as a poison, irritant, or asphyxiate.
3. Infectious Waste Material: Any material possessing a significant potential for cross-infection or to be contagious, including sharps.
4. Radioactive Hazardous Material**:** Any material which is capable of giving off radiant energy in the form of particles or rays, such as alpha, beta, or gamma rays.

C. Labeling: The Materials Management Department will be responsible for receiving, identifying, and delivering all hazardous materials used in the hospital.

1. The labels must contain the identity of the hazardous chemical or material and an appropriate hazard warning, which contains the nature of the hazard (i.e., poison, corrosive, inflammable, etc.).

D. Handling: The specific precautions, procedures, and protective equipment used during hazardous material and waste spills or exposures.

1. Spill procedures: In the event a spill or leak of a hazardous material occurs, the following emergency response procedure is to be used, remembering the CLEAN acronym:

C-contain the spill with towels or absorb pillows.
L-leave area, get staff and others out of danger.
E-emergency care to those exposed (as needed).
A-access the MSDS sheet (departmental).
N-notify your supervisor or House Supervisor.

E. Storage: flammable materials should be stored in a cool, dry, well-ventilated storage area away from combustible materials, a fire-proof cabinet or in the Hazardous Materials Waste Storage Area and be supplied with fire extinguishers.

1. Acids, alkaline, and corrosive materials will be stored separately in well-ventilated areas.
2. Bio-hazardous containers will be lined with red bags and stored with proper signage.

F. Disposal: Staff will wear appropriate PPE and dispose of waste in appropriate containers.

1. Hospitals may use hazardous waste transport companies to remove waste from the hospital and provide manifest documentation.
2. All hazardous material are handled and disposed of in accordance with the Environmental Protection Agency (EPA), Oklahoma Department of

Environmental Quality, Oklahoma Corporation Commission, Department of Transportation (DOT) and state/local/federal regulations.

G. Eye wash stations are available to provide immediate first aid and safety for staff. Eye wash stations are available, accessible and functioning in the Hospital.

1. These stations will provide for quick drenching or flushing of the eyes for immediate emergency use when eyes are exposed to corrosive or caustic hazardous materials or as indicated on MSDS.
2. Eye wash stations are included in monthly EOC/safety round checklists to ensure availability, accessibility and function.
3. The area around the eye wash station must be well-lit and include a highly visible signage and are inspected weekly by Plant Operations staff.

ORIENTATION/EDUCATION

A. Initial orientation regarding the plan will be given to new employees by the Plant Operations Manager. Annual education regarding the plan will be done annually for all hospital employees. Orientation/Education will include:

1. Location of and how to interpret MSDS sheets
2. Appropriate spill procedures, location of eye wash stations.
3. Proper handling and disposing of hazardous materials.
4. Reporting requirements/mechanism of spills or accidents
5. Personal protective equipment
6. How to interpret warning labels

MONITORING THE PLAN

A. Performance standards for Hazardous Materials Management is acknowledged through staff testing, monitoring and inspection activities, and the review of hospital incident reports.

B. Hazardous Materials Management Plan data is collected concurrently by the Plant Operations Department (i.e.; Maintenance, Environmental Services) and reviewed by the Quality Committee monthly.

C. Data is collected based on staff input and observation of the physical environment and maintenance records. This review ensures that certain performance standards are met and maintained.

D. Quality Improvement: At least one aspect of the EOC is monitored on a quarterly basis and a report of the results forwarded to the Quality Committee, Medical Staff Committee, and Governing Body.

EVALUATION

A. The objectives, scope, performance, and effectiveness of the Hospital's Hazardous Materials Management Program are evaluated annually.

B. Any necessary changes are prepared and presented to the Hospital's Quality Committee and changes made to improve the plan are based on committee recommendations.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Utility Management Plan		**LS-300**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Life Safety (Environment of Care)	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

The Utility System Management Plan is Hospital-wide in scope.

PURPOSE

The Environment of Care (EOC) Utility System Management Plan is established to minimize the risks of utility systems failure and to ensure that staff is knowledgeable of their roles and responsibilities during disruptions of critical utility systems that are vital to patient care.

POLICY

The Hospital's Utility System Management Plan contains policies and procedures to ensure standard work practices are followed and to mitigate any risks to patients, staff or building in the event of a utility system(s) failure.

The Utilities Systems Management Plan includes equipment that meets the following criteria:

- Equipment maintains the climatic environment in patient care areas.
- Equipment that constitutes a risk to patient life support upon failure.
- Equipment is a part of a building system, which is used for infection control.
- Equipment that is a part of the communication system, which may affect the patient or the patient care environment.
- Equipment is an auxiliary or ancillary part of a system control or interface to patient care environment, life support or infection control.

PROCEDURE

A. Develop special guidelines and procedures to be followed in the event of failure in any one of the following utility systems: electrical, natural gas, HVAC (heating, ventilation, and air conditioning), medical gases, sewage, and water.

B. Newly acquired equipment is evaluated for the above listed criteria.

C. Inspecting, testing, and maintaining critical operating components:
   1. Critical operating components are maintained on the safety and preventive maintenance program by the Plant Operations Department.

D. Developing and maintaining current utility system operational plans:
   1. These plans are developed and maintained by the Plant Operations Department. Floor plans and policies and procedures, and regulatory standards are filed in the department.

E. Mapping the layout of utility systems and labeling controls for emergency shutdown:
   1. Plans, policies, and procedures are maintained by the Plant Operations Department.

F. Investigating utility system problems, failures, or user errors:
   1. Failures, problems, and user errors are reported to Plant Operations for correction. Non-routine failures are reported to the Safety Officer via the event reporting system. These issues are also routinely presented to the Quality Committee for evaluation and recommendations to prevent recurrences.

ORIENTATION/EDUCATION

A. Initial orientation regarding the plan will be given to new employees by the Plant Operations Manager. Annual education regarding the plan will be done annually for all hospital employees. Orientation/Education will include:
   1. Utility system capabilities
   2. Emergency shutoff controls
   3. Emergency procedures for patient care

MONITORING THE PLAN

A. Performance standards for Utility System Management is acknowledged through staff testing, monitoring and inspection activities, and the review of hospital incident reports.

B. Utility System Management Plan data is collected concurrently by the Plant Operations Department (i.e.; Maintenance, Environmental Services) and reviewed by the Quality Committee monthly.

C. Data is collected based on staff input and observation of the physical environment and maintenance records. This review ensures that certain performance standards are met and maintained.

D. Quality Improvement: At least one aspect of the EOC is monitored on a quarterly basis and a report of the results forwarded to the Quality Committee, Medical Executive Committee, and Governing Body.

EVALUATION

A. The objectives, scope, performance, and effectiveness of the hospital's Utility Systems Management Program are evaluated annually.

B. Any necessary changes are prepared and presented to the hospital's Quality Committee and changes made to improve the plan are based on committee recommendations.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Equipment Management Plan		**LS-600**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Life Safety (Environment of Care)	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

The Equipment Management Plan is Hospital-wide in scope.

PURPOSE

The Environment of Care (EOC) Equipment Management Plan is established to minimize the risks of equipment failure and to ensure a safe environment to protect staff, patients, and visitors.

POLICY

The Hospital's Equipment Management Plan contains policies and processes to ensure standard work practices are followed and to mitigate any risks to patients or staff in the event of an equipment failure.

PROCEDURE

A. The Equipment Management Plan applies to all hospital departments where fixed or portable patient care or other electrical equipment is used at any time. All such fixed or portable equipment used for the diagnosis, treatment, monitoring, and care of patients shall be included in the Equipment Management Program, including contract and leased medical equipment.

B. The Plant Operations Manager ensures all elements of the Equipment Management Plan are implemented, maintained, and properly documented.

C. The Materials Management department notifies the Plant Operations Manager of the arrival of new equipment for safety inspection prior to release for use.

D. Each Department Manager or employee notifies the Plant Operations Manager whenever there is an equipment problem or failure and removes the equipment from use to a designated area and applies a lock-out tag to the equipment to prevent use until repair is made.

E. The Plant Operations department maintains a current, accurate, inventory of equipment.

F. The Bio-medical qualified contracted vendor will be responsible for inspecting and tagging all equipment every 6 months and maintaining/repairing as needed with proper and complete documentation kept on file in the Plant Operations department.

G. Notification for equipment recalls is made through notification from the manufacturer and through the National Recall Alert Center. As soon as a notification is received, the equipment is removed from use and turned over to the Plant Operations Manager. All equipment recalls will be reported to the Quality Committee.

H. **Monitoring and reporting incidents in which a medical device is connected to the death, serious injury, or serious illness of any individual, is required by the Safe Medical Devices Act of 1990.**
If a medical device is involved in the death, serious injury, or serious illness of any individual, a record will be filed with the Safe Medical Devises Act. This is accomplished by immediately notifying the Plant Operations Manager. The affected medical device will be immediately removed from use if such an incident occurred. Any such incidents will be thoroughly documented. Documentation of all equipment problems and failures, including user errors, that have or may have an adverse effect on patient safety by means of the Occurrence Reporting System and referring all such relevant information to the Plant Operations Manager for reporting to the Quality Committee and follow-up.

ORIENTATION/EDUCATION

A. Initial orientation regarding the plan will be given to new employees by the Plant Operations Manager. Annual education regarding the plan will be done annually for all hospital employees. Orientation/Education will include:

1. How to identify and report unsafe equipment.
2. How to safety operate equipment (department specific orientation).
3. Process for Bio-Med stickers on equipment.
4. Process for identifying and storing unsafe equipment in need of repair.

MONITORING THE PLAN

A. Performance standards for Equipment Management is acknowledged through staff testing, monitoring and inspection activities, and the review of hospital incident reports.

B. Equipment Management Plan data is collected concurrently by the Plant Operations Department (i.e.; Maintenance, Environmental Services) and reviewed by the Quality Committee monthly.

C. Data is collected based on staff input and observation of the physical environment and maintenance records. This review ensures that certain performance standards are met and maintained.

D. Quality Improvement: At least one aspect of the EOC is monitored on a quarterly basis and a report of the results forwarded to the Quality Committee, Medical Staff Committee, and Governing Body.

EVALUATION

A. The objectives, scope, performance, and effectiveness of the Hospital's Equipment Management Program are evaluated annually.

B. Any necessary changes are prepared and presented to the Hospital's Quality Committee and changes made to improve the plan are based on committee recommendations.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Consent for Photography/Multimedia and Authorization for Use or Disclosure

Patient or Employee Name: _____

Consent for Photograph or Multimedia

□ **Patient or Patient Representative:**

I hereby consent to be photographed while at name of hospital by its employees to record or document my care or treatment, or other images of me. The term "photograph" includes video, or still photography, in digital or any other format, and any other means of recording or reproducing images, testimonials, and any other later developed mediums and for the purpose of:

_____

*Patient/Patient Representative Signature*_____

□ **Employee:**

I hereby consent to be photographed at name of hospital by its employees, on hospital property, or other areas that the hospital may deem appropriate. The term "photograph" includes video, or still photography, in digital or any other format, and any other means of recording or reproducing images, testimonials, and any other later developed mediums and for the purpose of:

_____

*Employee Signature*_____

Authorization for Use and Disclosure

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to:

_____
(Person(s)/Organization(s) authorized to receive the information)

_____
(Address: Number, Street, City, State, Zip Code)

This Authorization expires (*insert date):*_____
Upon expiration of this Authorization, the hospital will not permit further release of any photograph(s), but will not be able to call back any photographs or information already released.

Purpose

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (check all that apply):
□ Dissemination to Hospital staff (medical providers, health professionals) □ Emergency/Disaster Notification
□ Educational □ Treatment □ Research □ Scientific □ Public Relations □ Marketing □ News Media
□ Charitable Purposes □ Law Enforcement □ Legal □ Other: _____

Date: _____/_____/_____ Time: _____ AM/PM

I and any persons as my successors agree to release name of hospital and its employees from any claim or cause of action, now or in the future from any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient/Patient Representative or Employee Signature:_____

If signed by someone other than patient, indicate relationship: _____

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

TITLE		POLICY
Photography and Multimedia Imaging		**GEN-026**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Hospital Plans		
DEPARTMENT	REFERENCE	
	See below	

SCOPE

This policy applies to all patients, visitors, workforce members, and medical staff members of Insert name of hospital (Hospital) that may be the subject of photography and/or multimedia activities performed by the Hospital and its employees.

PURPOSE

The Hospital is committed to ensuring compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Rule), 45 CFR Parts 160 and 164 and any other Federal or State regulations and guidelines. To establish guidelines for the photography and multimedia imaging of patients, visitors, workforce and medical staff members to ensure their privacy and protected health information as applicable is protected whenever photography and/or multimedia activities are performed by the Hospital and its employees. For the purposes of this policy, photography is referred to in a broad sense including, but not limited to: photographs, videotaping, recording, audio/visual, or other imaging mediums, and including other such mediums that may be developed in the future.

DEFINITIONS

Audio Monitoring- For the purposes of this policy, "audio monitoring" refers to monitoring an individual's voice using video cameras, cellular phones, tape recorders, wearable technology, or other technologies capable of capturing audio or transmitting sound for monitoring purposes.

Audio Recording- For the purposes of this policy, "audio recording" refers to the capture and storage of the individual's voice or sounds using capable technology (e.g., video camera, cellular telephones, tape recorders, wearable technology).

Multimedia- Is the integration of multiple forms of media. This includes text, graphics, audio, video, etc.

Photography- For the purposes of this policy, "photography" refers to recording an individual's likeness (e.g., image, picture) using photography (e.g., cameras, cellular phones), video recordings (e.g., video cameras, cellular phones), digital imaging (e.g., digital cameras, web cameras), wearable technology, or other technologies capable of capturing an image (e.g., Skype). This does not include medical imaging i.e., MRIs, CTs, images of specimens, etc. Not all patient photos contain protected health information (PHI) but are identified as health information. A patient photo is considered to contain PHI if it has any of the following patient identifiers:

- Any portion of the face;
- Unique identifying marks (e.g., tattoos, birthmarks);
- Name or Initials;
- Birth Date;
- Social Security Number;
- Address;
- Date of Service;
- Medical Record Number

Video Monitoring- For the purposes of this policy, "video monitoring" refers to monitoring an individual or transmitting PHI or the patient's likeness using technologies capable of transmitting a video (e.g., video cameras, cellular phones, web cameras, wearable technology) regardless of whether the transmission is recorded.

Video Recording-For the purposes of this policy, "video recording" refers to the capture and storage of the individual's likeness using video technologies (e.g., video cameras, cellular phones, web cameras, wearable technology).

POLICY

The Hospital shall take reasonable steps to protect patients, visitors, workforce members, and medical staff members from unauthorized photography as defined in the broadest sense of this policy (photographs, videotaping, recording, audio/visual, or other imaging mediums, and including other such mediums that may be developed in the future). The Hospital shall follow the guidelines and procedures outlined in this policy before allowing, or prior to photographing or other such related activities of patients, visitors, workforce and medical staff members to protect patient and workforce member information and privacy. The Hospital shall follow device standards and guidance before using devices, applications, and/or software for photographs and multimedia in order to adhere to the Hospital's security and privacy requirements.

PROCEDURE

1. Devices used for the purpose of obtaining images of patients, visitors, workforce and medical staff members must be company-owned and company-approved for use by the

Hospital. In the event a device does not meet this criteria, approval by the Hospital Administrator to use the device must be obtained prior to use.

2. All devices will be securely stored and accessed only by designated personnel with authority or the responsibility for using the devices.
3. Consent shall be obtained from the patient or workforce and medical staff member prior to obtaining the image or recording. Patient consents will be maintained in the patient's medical record. Employee consents will be maintained in the workforce member's personnel file (See GEN-026A Consent for Photographs/Multimedia and Authorization for Use and Disclosure).
4. Photographs and recordings will not be permanently stored on the device (e.g., camera, wearable technology), or on unencrypted memory cards and must be transferred or stored to a permanent location (e.g., patient's medical record) in a timely manner and deleted from the device.
5. The Hospital is not required to obtain consent from the patient under the following situations:
    - When the patient is the subject of the photography and is performed by the patient or patient's visitors;
    - When a workforce member is asked by the patient to photograph the patient using the patient's or patient's visitor device;
6. Patient's and/or the patient's visitors are not permitted to take photographs of other patients, workforce and medical staff members without consent.
7. The Hospital may permit law enforcement agencies and applicable public health agencies (e.g., child protective services) to photograph or record a patient if the patient consents and the patient's medical provider agrees the patient is medically stable.
8. The Hospital may disclose photographs and/or audio recordings to law enforcement agencies or applicable public health agencies (e.g., child protective services) when required by state law, such as for child abuse and neglect, domestic abuse, elder abuse, and similar disclosures required by law.
9. If it is necessary to discontinue taping during a procedure or there is unintentional alteration or erasure of a tape, the reason for and a description of the discontinuance, alteration or erasure is documented in the medical record in a timely manner.
10. Clinical photography does not include:
    a) Reproductions in illustrations or medical publications and requires patient consent.
    b) Patients for the purposes of promotion, artwork or advertising. The use of such photographs for these purposes may only be used after consultation and approval with Hospital Administration and according to HIPAA standards.
11. The patient or patient representative has the right to refuse photography/audio recordings.
12. The patient or patient representative has the right to withdraw consent at any time by contacting any one of the following: Hospital Administrator, Quality Manager, Charge Nurse, or Compliance Officer.
13. The Hospital must obtain written consent and authorization from the patient or workforce member prior to photographing/audio recording the patient or workforce member for publicity purposes, receipt of gifts, or commemorative purposes. The authorization is only good for the type of photographs/recordings indicated and the timeframe listed in the authorization. Otherwise, a new authorization form must be obtained.

14. Patients should be provided with the knowledge of what is being shared and with whom it is being shared.
15. The Hospital is not required, but may permit, news media to photograph or record a patient if the patient consents and the patient's medical provider agrees the patient is medically stable.
16. In the event of an emergency or disaster the hospital must ensure the patient agrees to the photograph/recording and was provided with the opportunity to object and did not, or it was inferred from the circumstances, based on the exercise of professional judgment that the patient did not object.
17. In the event of an emergency or disaster, if the patient is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the patient's incapacity or an emergency circumstance, the workforce member or medical staff member with access to PHI may, in the exercise of professional judgment, determine whether the disclosure of the photograph is in the best interest of the patient.
18. Workforce and medical staff members are strictly prohibited from photographing/audio recording patients or patient's visitors within the Hospital for their personal use. This includes, but is not limited to, taking pictures to share with friends and/or co-workers, to post on the internet using social media (e.g., Facebook, Twitter, etc.).
19. Signage should be posted in conspicuous patient areas to support this policy and should read: "Patient and staff permission required before photos are taken or recordings are made."

STORAGE

1. Photographs/audio recordings related to the care and treatment of the patient will be stored in the patient's medical record.
2. Photographs and recordings that contain protected health information (PHI) and determined not to be included in the patient's medical record will be stored in the Medical Records Department.
3. All photographs and recordings must be clearly identified (patient name, medical record number, account number, date of admission), securely stored, and readily accessible for retrieval.

DISCLOSURES

1. Photographs/audio recordings will not be released without specific written authorization from the patient or workforce and medical staff member, unless the disclosure is for treatment, payment, or health care operations.
2. Unless prohibited by law, photographs/audio recordings may be released to the patient in accordance with the patient's right of access to their medical record. The Hospital will retain the originals.

WORKFORCE AND MEDICAL STAFF MEMBERS

1. Written consent and/or authorization for photographs/audio recordings must be obtained prior to the performance of the following activities, but not limited to:
    - Dissemination to Hospital staff (medical providers, health professionals);
    - Emergency/Disaster Notification;
    - Educational;
    - Research;
    - Scientific;
    - Public Relations;
    - Marketing;
    - News Media;
    - Charitable Purposes;
    - Law Enforcement;
    - Legal

2. It is the policy of this Hospital that any photographs/audio recordings of workforce members that occur in conjunction with an organized meeting (e.g., Zoom, Teams, tape recorders) are to be used strictly for work and historical purposes and are not to be shared with others not privileged to such information and deleted once the information is transcribed into a permanent format. Workforce member consent is not required for these purposes.
3. In the event any workforce members use personal devices that have a camera and/or audio/video recording any interaction with any workforce members on Hospital property, such photographs or video recordings shall not be publicly shared, such as on the internet, social media, or in public viewings. Workforce members shall immediately notify the Hospital Administrator of such photographs or audio/video recordings.
4. The Hospital shall obtain written consent from workforce members prior to using photographs or audio/video recordings related to Hospital event functions on publicly shared media such as on the internet, social media, or public viewings.
5. Consent is not required from workforce members for Hospital use of photographs or audio/video recordings related to Hospital event functions on privately shared media, such as the Hospital intranet or newsletter.

ACCOUNTABILITY

1. Failure to follow this policy may result in corrective action up to and including termination.
2. Staff are encouraged to report any HIPAA violations to the Hospital Compliance Officer without fear of retaliation.
3. The Hospital will provide education and training to the workforce members on hire, annually, and as needed.

REFERENCES

HIPAA Journal. (2018). *HIPAA Social Media Rules.* Retrieved from Journal https://www.hipaajournal.com/hipaa-social-

media/#:~:text=HIPAA%20and%20Social%20Media&text=The%20HIPAA%20Privacy%20Rule%20prohibits,in%20a%20patient%20being%20identified.

ATTACHMENTS

GEN-026A Consent for Photographs/Multimedia and Authorization for Use and Disclosure

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Electrical Wiring		**LS-305**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Utility Management Life Safety Plan	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

This policy applies to all personnel working within the Plant Operations department of Mangum Regional Medical Center and are responsible for the maintenance of the electrical wiring within the Hospital.

PURPOSE

To provide guidelines for Electrical Wiring.

POLICY

The Hospital has developed and maintained a safe and effective electrical wiring program in accordance with National Fire Protection Association (NFPA) chapter 70 regulations to maintain continued reliability/safety.

PROCEDURE

A. Elements of appropriate inspection and maintenance by Plant Operations staff include:
   1. Wiring and appliances in good repair.
   2. No extension cords used as permanent wiring.
   3. All extension cords have current/ground fault protection and cannot be daisy-chained together. Surge protectors in place.
   4. Flexible electrical cords are free of splices, fraying.
   5. Motor driven appliances such as refrigerators, and air conditioners are attached by a single plug to a receptable.
   6. Electrical outlet, receptacle and junction boxes covered.

B. Inspection of all electrical outlets and ground impedance testing are conducted every 2-3 years with hospital grade receptacles or annually if non-hospital grade outlets, or after

initial installation, replacement or service.

C. Routine maintenance is performed either in house or through a qualified contracted vendor.

D. Documentation of all inspections and testing is maintained by Plant Operations staff in maintenance binders for a period of five (5) years.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Mangum Regional Medical Center

TITLE		POLICY
Elevator		**LS-306**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Utility Management Life Safety Plan	**TBD**	**TBD**
DEPARTMENT	REFERENCE	
Plant Operations	See references below	

SCOPE

This policy applies to all personnel working within the Plant Operations department of Mangum Regional Medical Center and are responsible for the maintenance of a safe and effective elevator.

PURPOSE

To provide guidelines for Elevator.

POLICY

The Hospital has developed and maintained a safe and effective elevator in accordance with National Fire Protection Association (NFPA) chapter101 regulations to maintain continued reliability/safety.

PROCEDURES

A. Elements of appropriate inspection and maintenance by Plant Operations staff semi-annually include:
   1. Doors close properly.
   2. Floor of elevator is level with building floor when door is open.
   3. Elevator car has functioning emergency lighting.
   4. Capacity plate is in place.
   5. Equipped with alarm bell or 2- way communication device.

B. Annual inspection of elevator is performed by qualified professionals through a contracted vendor then certificate issued by Department of Labor and posted inside the elevator.

C. Routine maintenance is performed by Plant Operations staff.

E. Documentation of all inspections and testing is maintained by Plant Operations staff in maintenance binders for a period of five (5) years.

REFERENCES

Centers for Medicare & Medicaid Services (2020) State Operations Manual Appendix W – Survey Protocol, Regulations, and Interpretative Guidelines for Critical Access Hospitals. §485.623 Physical Plant and Environment. [Electronic Version]. Retrieved on 06/01/21 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

National Fire Protection Association (2012). Life Safety Code Handbook.

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Name of Hospital

Emergency Department

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COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

Name of Hospital

Nursing Services Policies

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COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
HOSPITAL NAME

Pediatric Sepsis Guidelines

Purpose: The purpose of this guide is to assist the Provider in the care and treatment of the pediatric patient with sepsis/and or septic shock.

Contents:

1. **World Health Organization (WHO) Fluid Management Guidelines.**
2. **WHO Gender Weight-For-Age Growth Standards.**

World Health Organization 2016 guidelines: Fluid management in children with signs of impaired circulation in resource-limited settings.

Children Who Are Not in Shock but Have Signs of Circulatory Impairment
1. Children with only 1 or 2 signs of impaired circulation (e.g., cold extremities, capillary refill >3 seconds, or a weak and fast pulse) but who do not have the full clinical features of shock (i.e., all 3 signs present together) should not receive any rapid infusion of fluids but should still receive maintenance fluids appropriate for their age and weight.
2. In the absence of shock, rapid IV infusion of fluids may be particularly harmful to children who have severe febrile illness, severe pneumonia, severe malaria, meningitis, severe acute malnutrition, severe anemia, congestive heart failure with pulmonary edema, congenital heart disease, renal failure, or diabetic ketoacidosis.
3. Children with any sign of impaired circulation (i.e., cold extremities; prolonged capillary refill; or weak, fast pulse) should be prioritized for full assessment and treatment and reassessed within 1 hour.
Children who are in shock

1. Children who are in shock (i.e., who have all the following signs: cold extremities with capillary refill >3 seconds and a weak and fast pulse) should receive IV fluids.
• They should be given 10 to 20 mL/kg body weight of isotonic crystalloid fluids over 30 to 60 minutes.
• They should be fully assessed, an underlying diagnosis made, receive other relevant treatment, and their condition monitored.
• The child should be reassessed at the completion of infusion and during subsequent hours to check for any deterioration:
  ○ If the child is still in shock, consider giving a further infusion of 10 mL/kg body weight over 30 minutes
  ○ If shock has resolved, provide fluids to maintain normal hydration status only (maintenance fluids)
• If, at any time, there are signs of fluid overload, cardiac failure, or neurologic deterioration, the infusion of fluids should be stopped and no further IV infusion of fluids should be given until the signs resolve.

2. Children in shock and with severe anemia (erythrocyte volume fraction [hematocrit] <15 or hemoglobin <5 g/dL as defined by WHO) should receive a blood transfusion as early as possible and receive other IV fluids only to maintain normal hydration.
3. Children with severe acute malnutrition* who are in shock should receive 10 to 15 mL/kg body weight of IV fluids over the first hour. Children who improve after the initial infusion should receive only oral or nasogastric maintenance fluids. Any child who does not improve after 1 hour should be given a blood transfusion (10 mL/kg body weight slowly over at least 3 hours).
IV: intravenous; WHO: World Health Organization; MUAC: mid-upper arm circumference. * In infants and children aged 6 to 59 months, severe acute malnutrition is defined as weight-for-height Z-score <–3 using WHO growth standards, MUAC <11.5 cm, or clinical signs of bilateral edema of nutritional origin.

WHO Gender Weight-For-Age Growth Standards.

Figure 1A Weight-for-age percentiles, girls 0 to 24 months, WHO growth standards

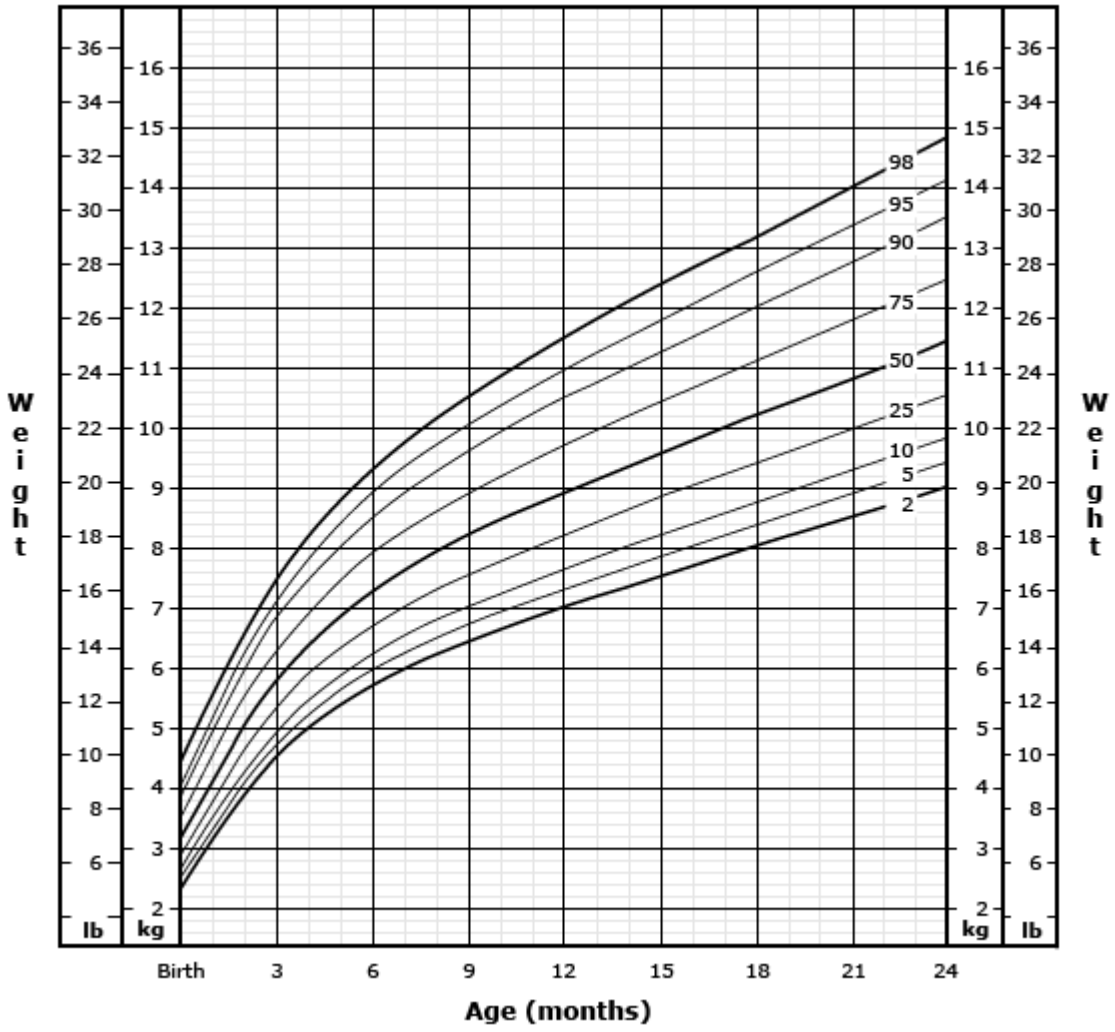


Figure 1B Weight-for-age percentiles, boys 0 to 24 months, WHO growth standards

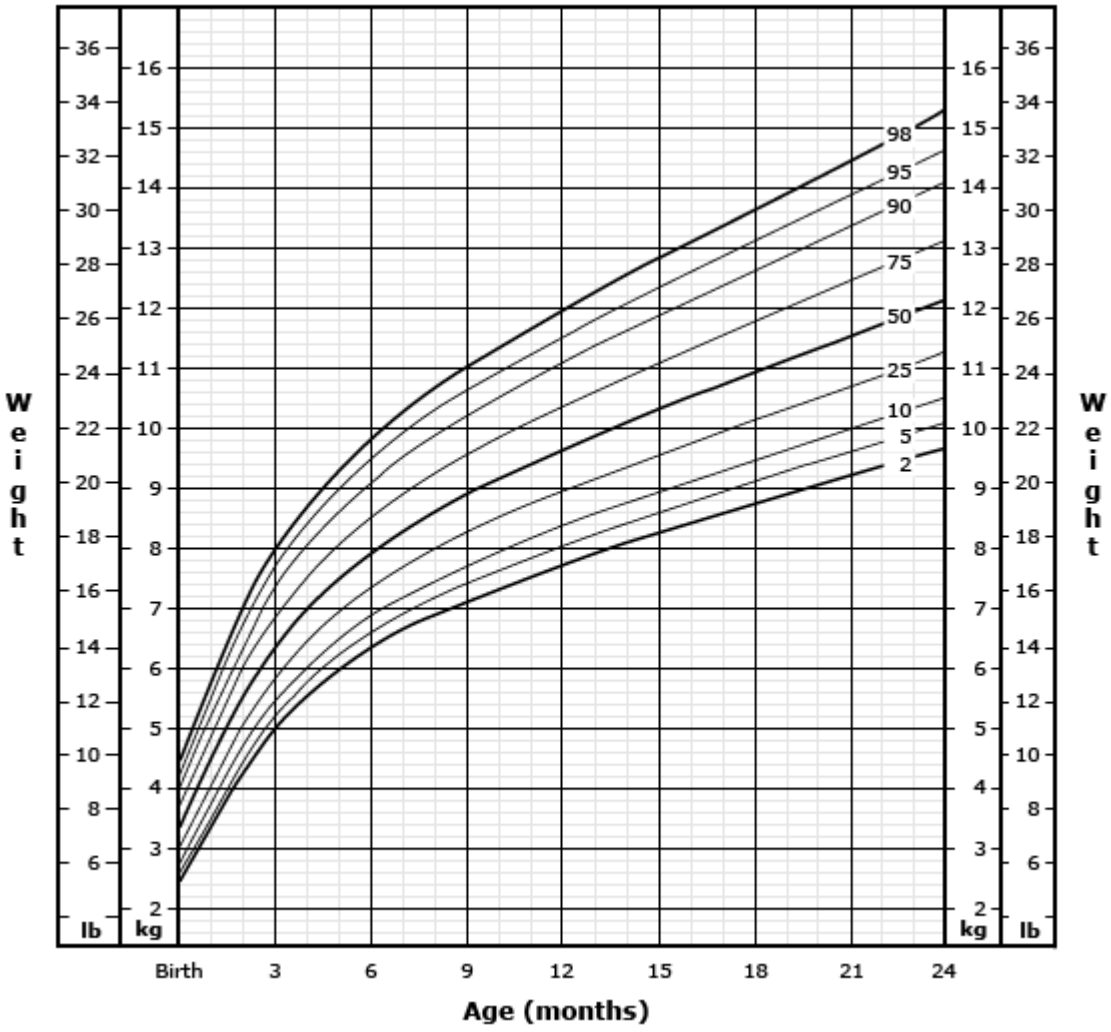


Figure 2A Weight-for-age percentiles, boys, 2 to 20 years, CDC growth charts: United States

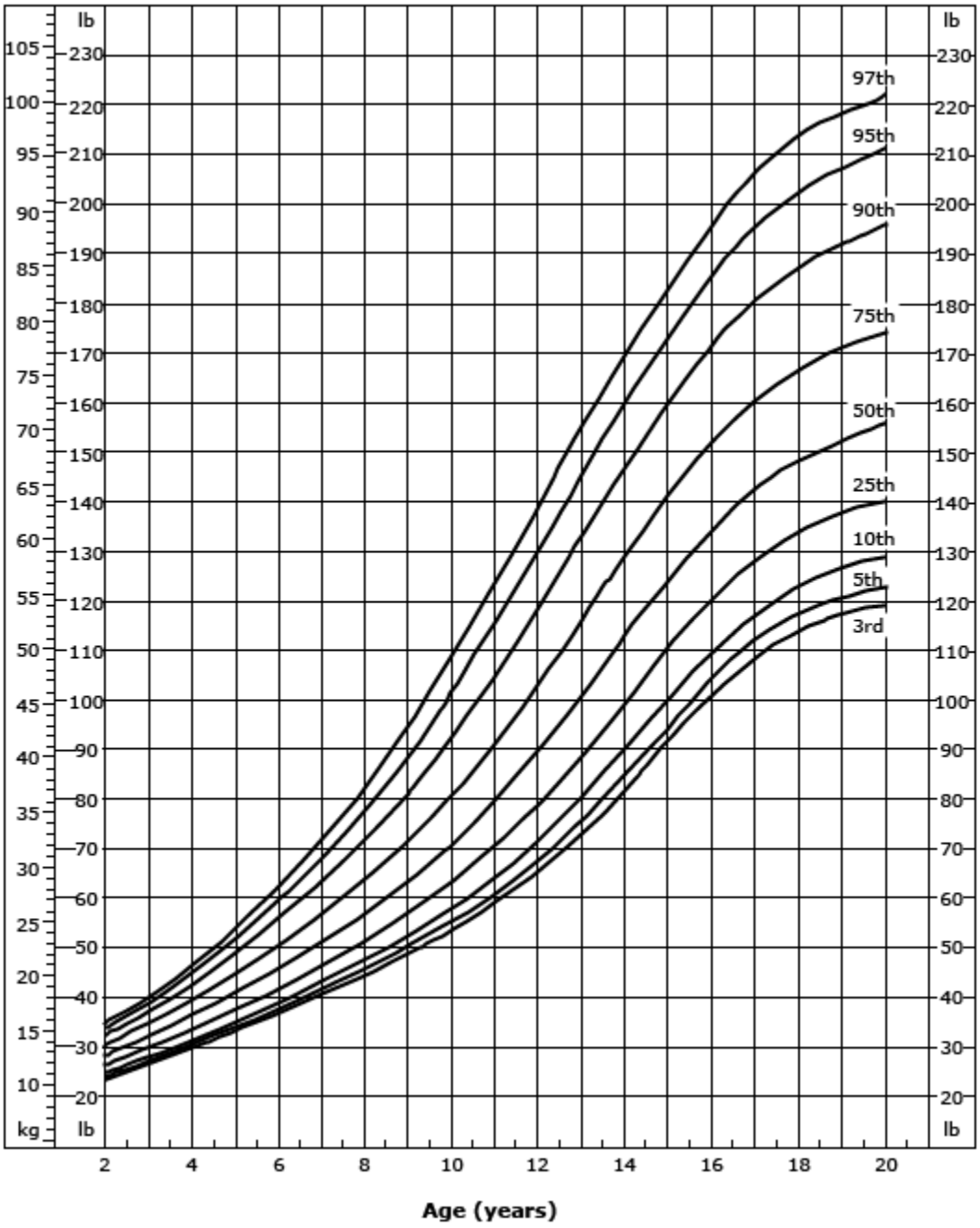
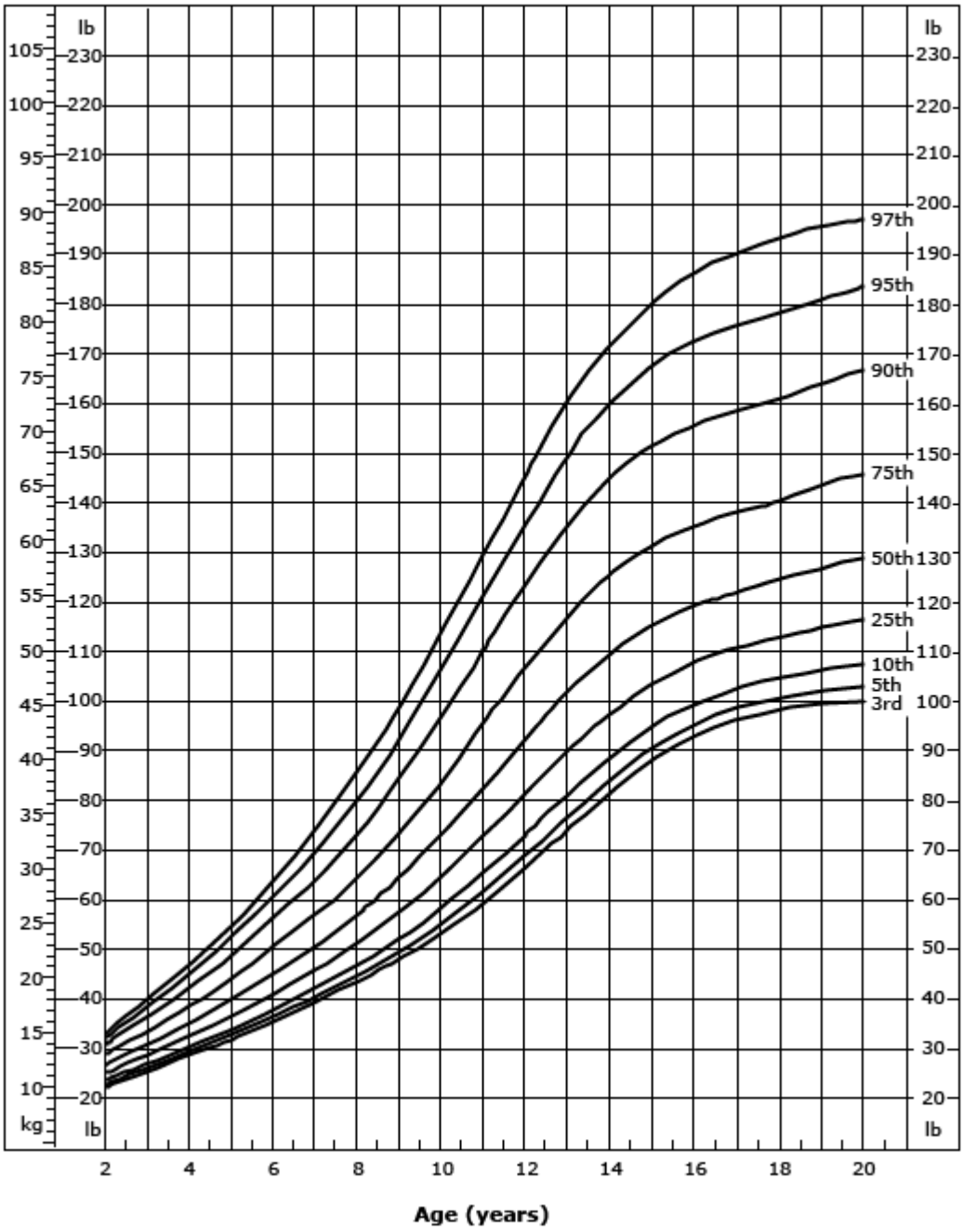


Figure 2B Weight-for-age percentiles, girls, 2 to 20 years, CDC growth charts: United States



FACT SHEET FOR PATIENTS, PARENTS AND CAREGIVERS
EMERGENCY USE AUTHORIZATION (EUA) OF REGEN-COV™
(casirivimab and imdevimab) FOR CORONAVIRUS DISEASE 2019 (COVID-19)

You are being given a medicine called **REGEN-COV (casirivimab and imdevimab)** for the treatment of coronavirus disease 2019 (COVID-19). This Fact Sheet contains information to help you understand the potential risks and potential benefits of taking REGEN-COV, which you may receive.

Receiving REGEN-COV may benefit certain people with COVID-19.

Read this Fact Sheet for information about REGEN-COV. Talk to your healthcare provider if you have questions. It is your choice to receive REGEN-COV or stop at any time.

WHAT IS COVID-19?
COVID-19 is caused by a virus called a coronavirus. People can get COVID-19 through contact with another person who has the virus.

COVID-19 illnesses have ranged from very mild (including some with no reported symptoms) to severe, including illness resulting in death. While information so far suggests that most COVID-19 illness is mild, serious illness can occur and may cause some of your other medical conditions to become worse. People of all ages with severe, long-lasting (chronic) medical conditions like heart disease, lung disease, and diabetes, for example, and other conditions including obesity, seem to be at higher risk of being hospitalized for COVID-19. Older age, with or without other conditions, also places people at higher risk of being hospitalized for COVID-19.

WHAT ARE THE SYMPTOMS OF COVID-19?
The symptoms of COVID-19 include fever, cough, and shortness of breath, which may appear 2 to 14 days after exposure. Serious illness including breathing problems can occur and may cause your other medical conditions to become worse.

WHAT IS REGEN-COV (casirivimab and imdevimab)?
REGEN-COV is an investigational medicine used to treat mild to moderate symptoms of COVID-19 in non-hospitalized adults and adolescents (12 years of age and older who weigh at least 88 pounds (40 kg)), and who are at high risk for developing severe COVID-19 symptoms or the need for hospitalization. REGEN-COV is investigational because it is still being studied. There is limited information known about the safety and effectiveness of using REGEN-COV to treat people with COVID-19.

The FDA has authorized the emergency use of REGEN-COV for the treatment of COVID-19 under an Emergency Use Authorization (EUA). For more information on EUA, see the **"What is an Emergency Use Authorization (EUA)?"** section at the end of this Fact Sheet.

WHAT SHOULD I TELL MY HEALTH CARE PROVIDER BEFORE I RECEIVE REGEN-COV?
Tell your healthcare provider about all of your medical conditions, including if you:

- Have any allergies

- Are pregnant or plan to become pregnant
- Are breastfeeding or plan to breastfeed
- Have any serious illnesses
- Are taking any medications (prescription, over-the-counter, vitamins, and herbal products)

HOW WILL I RECEIVE REGEN-COV (casirivimab and imdevimab)?

- REGEN-COV consists of two investigational medicines, casirivimab and imdevimab, given together as a single intravenous infusion (through a vein).
- You will receive one dose of REGEN-COV by intravenous infusion. The infusion will take 20 to 50 minutes or longer. Your healthcare provider will determine the duration of your infusion.
- If your healthcare provider determines that you are unable to receive REGEN-COV as an intravenous infusion which would lead to a delay in treatment, then as an alternative, REGEN-COV can be given together in the form of subcutaneous injection (medicine is injected in the tissue just under the skin). One dose will consist of 4 subcutaneous injections given in separate locations around the same time.

WHAT ARE THE IMPORTANT POSSIBLE SIDE EFFECTS OF REGEN-COV (casirivimab and imdevimab)?

Possible side effects of REGEN-COV are:

- Allergic reactions. Allergic reactions can happen during and after infusion with REGEN-COV. Tell your healthcare provider right away if you get any of the following signs and symptoms of allergic reactions: fever, chills, nausea, headache, shortness of breath, low or high blood pressure, rapid or slow heart rate, chest discomfort or pain, weakness, confusion, feeling tired, wheezing, swelling of your lips, face, or throat, rash including hives, itching, muscle aches, feeling faint, dizziness and sweating. These reactions may be severe or life threatening.
- Worsening symptoms after treatment: You may experience new or worsening symptoms after infusion, including fever, difficulty breathing, rapid or slow heart rate, tiredness, weakness or confusion. If these occur, contact your healthcare provider or seek immediate medical attention as some of these events have required hospitalization. It is unknown if these events are related to treatment or are due to the progression of COVID-19.

The side effects of getting any medicine by vein may include brief pain, bleeding, bruising of the skin, soreness, swelling, and possible infection at the infusion site. The side effects of getting any medicine by subcutaneous injection may include pain, bruising of the skin, soreness, swelling, and possible infection at the injection site.

These are not all the possible side effects of REGEN-COV. Not a lot of people have been given REGEN-COV. Serious and unexpected side effects may happen. REGEN-COV is still being studied so it is possible that all of the risks are not known at this time.

It is possible that REGEN-COV could interfere with your body's own ability to fight off a future infection of SARS-CoV-2. Similarly, REGEN-COV may reduce your body’s immune response to a vaccine for SARS-CoV-2. Specific studies have not been conducted to address these possible risks. Talk to your healthcare provider if you have any questions.

WHAT OTHER TREATMENT CHOICES ARE THERE?
Like REGEN-COV (casirivimab and imdevimab), FDA may allow for the emergency use of other medicines to treat people with COVID-19. Go to https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization for information on other medicines used to treat people with COVID-19. Your healthcare provider may talk with you about clinical trials you may be eligible for.

It is your choice to be treated or not to be treated with REGEN-COV. Should you decide not to receive REGEN-COV or stop it at any time, it will not change your standard medical care.

WHAT IF I AM PREGNANT OR BREASTFEEDING?
There is limited experience treating pregnant women or breastfeeding mothers with REGEN-COV (casirivimab and imdevimab). For a mother and unborn baby, the benefit of receiving REGEN-COV may be greater than the risk from the treatment. If you are pregnant or breastfeeding, discuss your options and specific situation with your healthcare provider.

HOW DO I REPORT SIDE EFFECTS WITH REGEN-COV (casirivimab and imdevimab)?
Tell your healthcare provider right away if you have any side effect that bothers you or does not go away.

Report side effects to **FDA MedWatch** at www.fda.gov/medwatch or call 1-800-FDA-1088 or call 1-844-734-6643.

HOW CAN I LEARN MORE?
- Ask your health care provider.
- Visit www.REGENCOV.com
- Visit https://www.covid19treatmentguidelines.nih.gov/
- Contact your local or state public health department.

WHAT IS AN EMERGENCY USE AUTHORIZATION (EUA)?
The United States FDA has made REGEN-COV (casirivimab and imdevimab) available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Service (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

REGEN-COV has not undergone the same type of review as an FDA-approved product. In issuing an EUA under the COVID-19 public health emergency, the FDA must determine, among other things, that based on the totality of scientific evidence available, it is reasonable to believe that the product may be effective for diagnosing, treating, or preventing COVID-19, or a serious or life-threatening disease or condition caused by COVID-19; that the known and potential benefits of the product, when used to diagnose, treat, or prevent such disease or condition, outweigh the known and potential risks of such product; and that there are no adequate, approved and available alternatives. All of these criteria must be met to allow for the medicine to be used in the treatment of patients during the COVID-19 pandemic.

The EUA for REGEN-COV is in effect for the duration of the COVID-19 declaration justifying emergency use of these products, unless terminated or revoked (after which the products may no longer be used).

REGENERON

Manufactured by:
Regeneron Pharmaceuticals, Inc.
777 Old Saw Mill River Road
Tarrytown, NY 10591-6707

Revised: 06/2021

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

TITLE		POLICY
Sepsis-Care and Management Guidelines for the Adult Patient		**NUR-026**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing		
DEPARTMENT	REFERENCE	
Nursing	See below	

SCOPE

This policy applies to all adult patients of insert name of hospital (Hospital) and nursing staff (RNs, LPNs, CNAs), respiratory therapists, and medical providers (MDs/DOs, NPs, PAs) who are responsible for the care and management of patients who present or develop sepsis and/or septic shock.

PURPOSE

The purpose of this policy is to:

- Provide early identification and recognition of sepsis;
- Provide prompt care and treatment of patients with sepsis; and
- Improve patient outcomes, decrease length of hospital stays, decrease debility and mortality associated with sepsis, and decrease costs associated with sepsis and septic shock.

According to the Sepsis Alliance Organization sepsis is the number one cost of hospitalization in the U.S. Costs for acute sepsis hospitalization and skilled nursing are estimated to be $62 billion annually. This is only a portion of all sepsis-related costs since there are substantial additional costs after discharge for many. The average cost per hospital admission for sepsis is double the average cost per admission across all other conditions. And, sepsis is the primary cause of readmission to the hospital, costing more than $3.5 billion each year. The Center for Disease Control (CDC) reports each year, at least 1.7 million adults in America develop sepsis, and nearly 270,000 Americans die as a result of sepsis, and one in three patients who dies in a hospital has sepsis. In addition, up to 50% of patients who survive sepsis may suffer from Post-Sepsis Syndrome (PSS). With this condition, physical or psychological symptoms may persist after the patient has been discharged from the hospital after being treated for sepsis.

Studies investigating survival have reported slightly different numbers, but it appears that on average, approximately 30% of patients diagnosed with severe sepsis do not survive. Up to 50%

of survivors suffer from post-sepsis syndrome. Until a cure for sepsis is found, early detection and treatment is essential for survival and limiting disability for survivors.

Sepsis is more likely to affect very young children, older adults, people with chronic illnesses, and those with weakened immune systems. Sepsis is an equal-opportunity killer, affecting people of all ages and levels of health. Sepsis occurs most often in people 65 years or older or younger than one (1) year, persons with weakened immune systems, or with chronic medical conditions (e.g., diabetes). While less common even healthy infants, children, and adults can develop sepsis from an infection, especially when not treated properly. The CDC reports sepsis begins outside of the hospital for nearly 80% of patients.

Certain infections and germs lead to sepsis most often. Common germs that can cause sepsis are Staphylococcus Aureus (S. aureus), Escherichia Coli (E. coli), and some types of Streptococcus. Four types of infections are often associated with sepsis:

- Lung infection (e.g., pneumonia); the respiratory tract is the most common site of infection that leads to sepsis.
- Urinary Tract Infection (e.g., kidney infection).
- Gut Infection.
- Skin Infection.

DEFINITIONS

Mean Arterial Pressure (MAP): Defined as the average pressure in a patient's arteries during one cardiac cycle. It is considered a better indicator of perfusion to vital organs than systolic blood pressure (SBP). True MAP can only be determined by invasive monitoring and complex calculations; however, it can also be calculated using a formula of the SBP and the diastolic blood pressure (DBP). Formula for MAP: double the diastolic blood pressure and add the sum to the systolic blood pressure, then divide by 3 (e.g., SBP + 2(DBP)/3=MAP).

Multiple Organ Dysfunction Syndrome (MODS): Present when there is more than one failing organ in the body. MODS is progressive organ dysfunction in which the patient cannot maintain homeostasis without medical intervention. It may be caused by an infectious etiology as sepsis or septic shock, or it may be of noninfectious etiology as in the case of SIRS from pancreatitis. Primary MODS is organ dysfunction related to the injury directly. Secondary MODS results from the host's response to an injury elsewhere.

Quick Sepsis Related Organ Failure Assessment (qSOFA): Quick Sepsis Related Organ Failure Assessment is a risk stratification tool and is incorporated into the Sepsis Screen to:

- Identify patients with suspected infection that are at a high risk for in-hospital mortality; and
- Can help increase suspicion or awareness of a severe infectious process and prompt further testing and/or closer monitoring.

Sepsis: Sepsis is a life-threatening, time sensitive condition and medical emergency that occurs when the body's systemic inflammatory response to a source of infection causes injury to tissues and organs. It is a dysregulated immune response to infection that results in organ dysfunction and is the leading cause of death from infection if not recognized early and treated quickly.

Septic Shock: Sepsis with the presence of circulatory, cellular, metabolic dysfunction, and tissue hypoxia caused by reduced oxygen delivery or increased oxygen consumption or inadequate oxygen utilization that can be attributed to various causes and is associated with a higher risk of mortality than sepsis alone. In addition, patients with septic shock can be identified with a clinical construct of sepsis with persisting hypotension requiring vasopressors to maintain MAP ≥ 65 mm/Hg and having a serum lactate level > 2 mmol/L despite adequate volume resuscitation.

Systemic Inflammatory Response Syndrome (SIRS): Systemic inflammatory response, which is an appropriate response by the body to an infection or any other stimulus that activates inflammation (SIRS is not exclusively the result of infection; there are many noninfectious causes of SIRS, e.g., MI, cirrhosis, adrenal insufficiency, and autoimmune disorders).

POLICY

The hospital will use an interdisciplinary approach in identifying patients who have a suspected or confirmed infection and/or condition and may develop or progress to sepsis. In addition, the hospital will utilize evidence-based practices and tools in the identification, care, and treatment of patients with signs or symptoms of sepsis. Hospital leadership including but not limited to, the Infection Preventionist (IP) and Chief Clinical Officer (CCO) are responsible for ensuring that all clinical staff adhere to the requirements of this policy.

Early recognition of sepsis is critical. Early identification of sepsis is paramount at first contact and later in the continuum of care as sepsis can develop at any time during care. Older adults often present atypically with infection and sepsis requiring astute evaluation of the patient.

Effective sepsis management is about time. It is important to look for a combination of the warning signs of sepsis. Identifying these symptoms early could prevent the patient from progressing to septic shock and could save a life. Watch for TIME:

- **T-Temperature:** higher or lower than normal;
- **I-Infection:** May have signs and symptoms of infection;
- **M-Mental decline:** Confused, sleepy, difficult to rouse; and
- **E-Extremely ill:** Severe pain, discomfort, shortness of breath.

PROCEDURE

A. **Initial Assessment-** All patients with signs and symptoms suggestive of sepsis whether an inpatient or who present to the Emergency Department (ED) should be treated as a potential life-threatening situation. The primary care nurse should immediately assess the patient for sepsis using the Adult Sepsis Screen (NUR-026A Adult Sepsis Screen). Signs and symptoms that may indicate sepsis:
    1. Shivering, fever, or very cold;

2. Extreme pain or discomfort;
3. Clammy or sweaty skin;
4. Confusion or disorientation;
5. Short of breath;
6. High heart rate.

B. If the patient presents or exhibits any of the above symptoms and is suspect for or has a known infection, the patient should be assessed using the qSOFA criteria on the Adult Sepsis Screen by the primary care nurse.

C. If the patient qSOFA score is 2 or more with suspect or confirmed infection OR less than 2 and infection still suspected the primary care nurse will notify the Provider immediately. A positive qSOFA in a patient who otherwise was not believed to have infection should be a prompt to suspect infection. A score of two (2) or more with suspected or confirmed infection may indicate the need for prompt and aggressive treatment. A score of two (2) or more may pose a greater risk for a poor outcome; if the score is two (2) or less and infection is still suspected proceed to the SIRS screening assessment. Criteria for qSOFA includes:
    1. Respiratory rate 22 or greater;
    2. Systolic blood pressure 100mm/Hg or lower; and
    3. Altered mental status (confusion, disorientation, changes in the Glasgow Coma Scale {GCS} of less than 15).

D. The qSOFA tool should be utilized at regular intervals to evaluate inpatients for sepsis to assist in the rapid and prompt identification of patients with suspected or confirmed infection.

E. If the patient qSOFA scores are 2 or more or less than 2 and infection is still suspected assess the patient using the SIRS assessment. Clinically, the Systemic Inflammatory Response Syndrome (SIRS) is the occurrence of at least two of the following criteria and includes:
    1. Temperature greater than 100.4° or less than 96.8° (Hyperthermia at time of presentation with sepsis has been found to strongly indicate progression of sepsis to shock within 72 hours of presentation);
    2. Heart rate greater than 90 bpm;
    3. Respiratory rate greater than 20;
    4. PaCO2 less than 32 mm/Hg;
    5. Leukocyte (WBC) count greater than 12,000 mm^3 or less than 4,000 mm^3 or over 10% immature forms or bands.

F. **Important note:** When a patient presents with two or more SIRS criteria but with hemodynamic stability (i.e. blood pressure at baseline), a clinical assessment must be made to determine the possibility of an infectious etiology versus a non-infectious etiology (e.g., viral illness).

G. The primary care nurse will initiate the Sepsis Bundle for a patient with a SIRS score of 2 or more and/or symptoms indicative of sepsis or patient presents with known or suspected infection (NUR-026B Adult Sepsis Standing Orders).

H. The Provider will conduct an initial investigation to determine the suspected source of sepsis to help guide empiric therapy and additional testing. Components of the initial investigation include:
    1. Brief history and head-to-toe physical examination;

2. Laboratory and microbiology (including cultures) studies; and
3. Imaging studies (e.g., x-ray).

I. Consider organ dysfunction if the following are present:
   1. Significantly decreased urine output.
   2. Abrupt change in mental status.
   3. Decrease in platelet count.
   4. Difficulty breathing.
   5. Abnormal heart function.
   6. Abdominal pain.

J. The primary care nurse will be responsible for performing a rapid and focused head to toe assessment of the patient.

K. **Initial Care and Management-** For adults with sepsis/septic shock, the following management steps should be initiated within **one hour** of recognition:
   1. Secure the airway and stabilize respiration. Supplemental oxygen should be supplied to all patients with sepsis. Apply O2 per nasal cannula 2-6 LPM to maintain oxygen saturation greater than 90%.
   2. Obtain baseline vital signs: Temperature, Pulse, Respiration, Blood Pressure, and SpO2.
   3. Obtain Mean Arterial Pressure (MAP). True MAP can only be determined by invasive monitoring and complex calculations; however, it can also be calculated using a formula of the systolic blood pressure (SBP) and the diastolic blood pressure (DBP). Formula for MAP: double the diastolic blood pressure and add the sum to the systolic blood pressure, then divide by 3:
      - SBP + 2(DBP)/3=MAP.
   4. Obtain IV access times two.
   5. Obtain stat labs and diagnostics:
      - Lactate level; remeasure lactate if initial lactate elevated (>2 mmol/L).
      - CBC with differential.
      - CMP.
      - D-dimer.
      - Blood Cultures. Obtain blood cultures times two before antibiotics are administered whenever possible. Do not delay antibiotic administration solely to complete this task. Once a patient is identified as having septic shock, an antibiotic should be administered as soon as possible within one hour. Once the decision is made for antibiotics, the antibiotic(s) should be ordered on a STAT basis with accelerated delivery and initiation of the antibiotic(s) to the patient.
      - Urine Culture & Sensitivity (C&S).
      - Sputum Culture & Sensitivity (C&S).
      - Wound Culture & Sensitivity (C&S) (if applicable).
      - Fingerstick Blood Sugar (FSBS).
      - ABGs.
      - EKG.
      - Chest X-ray.
   6. Obtain weight in kilograms.
   7. Place urinary catheter.

8. Administer broad-spectrum antibiotics as ordered by the Provider.
9. Begin rapid administration of fluid bolus of 30 mL/kg crystalloid for hypotension or lactate ≥ 4 mmol/L. A history of heart failure, liver failure, or renal failure is **not** a contraindication to fluid resuscitation. These patients might need less total fluid or smaller boluses with more frequent reassessment of intravascular volume status. Do not delay fluid and vasopressor therapy if indicated.
10. Apply vasopressors if hypotensive during or after fluid resuscitation to maintain a mean arterial pressure (MAP) ≥ 65 mm/Hg.

L. **Patient Monitoring**

1. Monitor vital signs and oxygen saturation every 15 minutes until stable, then every hour. Oxygenation should be monitored continuously with pulse oximetry. Notify Provider if:
    - Temperature > 100.4°F or < 96.8°F.
    - Pulse > 90 BPM.
    - Respiratory Rate > 20.
    - SpO2 < 90%.
    - Blood pressure.
2. Monitor MAP every 30 minutes until stable, then every hour; if MAP < 60 mm/Hg notify Provider.
3. Monitor FSBS values every hour; if FSBS value is >180 mg/dL or < 60mg/dL notify Provider.
4. Monitor urinary output every hour; if output < 0.5 mL/kg hour notify Provider.
5. After fluids and empiric antibiotics have been administered, the therapeutic response should be assessed frequently at a minimum of every hour or more if indicated.
6. Monitor skin color every hour.
7. Monitor mental status every hour.
8. Monitor ABGs. Worsening gas exchange may be a clue to the presence of pulmonary edema from excessive fluid resuscitation and also help detect other complications including pneumothorax from central catheter placement, acute respiratory distress syndrome, or venous thromboembolism. ABGs may be obtained based on assessment of the patient:
    - Failure to maintain SpO2 > 90%.
    - Respiratory distress.
9. The following lab studies may be performed every 6 hours or more as indicated until values have reached normal or baseline or as otherwise ordered by the Provider:
    - Lactate level.
    - Platelet count.
    - Serum chemistries.
    - Liver function tests.
    - CBC.
    - Additional cultures as ordered by the Provider. The results should prompt alteration of antibiotic choice if a better and safer regimen can be substituted and/or directed toward source control.

- Additional imaging studies (e.g., MRI, CT) may be required to determine a source cause.

M. The primary care nurse will be responsible for documenting the care and treatment of the patient.

N. **Post-Acute Sepsis Care:**

1. Additional investigations may be required by the Provider to determine the suspected source(s) if unknown and should be considered in patients with sepsis as promptly as feasible (e.g., within the first 12 hours) using imaging, lab, and microbiologic diagnostic samples.
2. Source Control: Source control (i.e., physical measures to eradicate a focus of infection and eliminate or treat microbial proliferation and infection) should be undertaken in a timely manner (6-12 hours) after diagnosis by the Provider. The assessment and evaluation of invasive devices or procedures (e.g., implants/hardware, lines, drains, surgical procedures, etc.), and wounds to determine if this may be a source of infection. Source control should consider the risk of a specific intervention and its potential risk of complications.
3. Once the patient has demonstrated a response to therapy, the Provider should direct attention to:
    a. De-escalation of fluids:
        - Patients who respond to initial fluid therapy should have the rate of fluid administration reduced or stopped, vasopressor support weaned, and, if necessary, diuretics administered.
    b. Careful and frequent monitoring of the patient is essential because:
        - Patients with sepsis may develop cardiogenic and noncardiogenic pulmonary edema (i.e., acute respiratory distress syndrome {ARDS}).
    c. De-escalation and duration of antibiotics:
        - It is appropriate that de-escalation and duration of antimicrobial agents be assessed daily.
        - After culture and susceptibility results return and/or after patients clinically improve, consider narrowing antimicrobial therapy to a few days.
        - Antimicrobial therapy should also be pathogen and susceptibility directed if known.
        - If a broad-spectrum antimicrobial therapy is used and the patient demonstrates improvement (vital signs, lab, and imaging data) then a fixed course of therapy of 3 to 5 days may be appropriate.
    d. Duration of antibiotics:
        - The duration of antibiotics should be individualized for each patient.
        - Antibiotics should be discontinued as early as is feasible to minimize colonization for infection with drug-resistant microorganisms and superinfection with other pathogens.
        - For most patients, the duration of therapy is typically 7 to 10 days.

- Longer courses may be appropriate in patients who have a slow clinical response or other causation (e.g., undrainable focus of infection, bacteremia, viral infection, endocarditis, osteomyelitis, large abscesses, highly resistant gram-negative pathogens with limited sensitivities, neutropenia, or immunological deficiencies).

POST-SEPSIS SYNDROME (PSS)

A. Symptoms of PSS can be physical or psychological and vary in severity:
    1. Insomnia, difficulty getting to sleep or staying asleep.
    2. Nightmares, vivid hallucinations, and panic attacks.
    3. Disabling muscle and joint pains.
    4. Extreme fatigue.
    5. Poor concentration.
    6. Decreased mental (cognitive) functioning.
    7. Loss of self-esteem and self-belief.

B. There is no specific treatment for PSS. Interventions include emotional and psychological support, and physical therapy. Health professionals, particularly nurses, need to ensure that sepsis survivors are given appropriate information and that appropriate referrals are made upon discharge by the Case Manager, so they can access help should they develop post-sepsis syndrome.

CLINICAL ROLES AND RESPONSIBILITIES IN SEPSIS CARE

A. Providers:

- Perform an appropriate assessment if an inpatient or Medical Screening Exam if an Emergency Department patient upon notification by the nurse of the patient's qSOFA score.
- Assist in stabilizing the patient and placing orders for care and treatment of the patient based on patient assessment, lab and diagnostic findings.
- Discuss need for admission to the Hospital or transfer to a higher level of care provider with the patient/family.
- Establish contact with a higher level of care provider if indicated to request emergent transfer and acceptance of patient with sepsis. Complete transfer orders and transfer protocol.
- For ED patients, ensure all appropriate EMTALA forms are completed prior to patient transfer.
- Complete all documentation related to the care and treatment of the patient with sepsis.

B. Inpatient and Emergency Department Nurses:

- Rapid and prompt identification of the patient's level of urgency and recognizing signs and symptoms of infection.
- Assess for signs and symptoms of sepsis/septic shock: shivering, fever, or very cold, extreme pain, discomfort, clammy or sweaty skin, confusion, or disorientation, short of breath, high heart rate.
- Screen patient for sepsis/septic shock using the Adult Sepsis Screen.

- Conduct qSOFA assessment: Respiratory rate 22 or greater, systolic blood pressure 100mm/Hg or lower, altered mental status (confusion, disorientation, changes in the Glasgow Coma Scale less than 15) and notify Provider immediately if score is 2 or more with suspect or confirmed infection OR less than 2 and infection still suspected.
- Initiate the Sepsis Bundle for patient with a SIRS score of 2 or more and/or symptoms indicative of sepsis or patient presents with known or suspected infection.
- Complete a full nursing assessment of the patient.
- Obtain vital signs.
- Ensure standing orders are implemented.
- Monitor the patient's status, response to treatment, or change in status. Notify Provider as directed per standing orders or as indicated by the patient's condition.
- Communicate effectively and thoroughly with fellow staff members to coordinate care of the patient with sepsis. If there is a concern about a patient, express that concern with the Provider, House Supervisor/Charge Nurse, or other Nurses during a shift change. Be the patient's advocate, communicate to the team you are concerned about sepsis in the patient.
- Ensure proper precautions are followed to help prevent the spread of Healthcare Associated Infections (HAIs).
- Educate and inform patients and families about sepsis; to prevent, recognize, and report symptoms of infection promptly.
- Ensure that aides who collect vital signs report abnormalities directly to the nurse.
- Be vigilant about sepsis and signs and symptoms that may indicate sepsis for inpatients.
- Complete all documentation related to the care and treatment of the patient with sepsis.

C. Nurse Aides/Techs:

- Promptly report vital signs or changes in the patient's mental status or condition to the primary care nurse that may indicate impending sepsis to the patient.
- Ensure proper precautions are followed to help prevent the spread of Healthcare Associated Infections (HAIs).

D. Respiratory Therapists:

- Be vigilant about sepsis and signs and symptoms that may indicate sepsis for patients (e.g., RR > 20, PaCO2 less than 32 mm/Hg), or altered mental status (e.g., confusion, disorientation).
- Assist with monitoring the patient's respiratory status.
- Promptly report findings to the primary care nurse that may indicate impending sepsis to the patient.
- Ensure proper precautions are followed to help prevent the spread of Healthcare Associated Infections (HAIs).

ADDITIONAL INFORMATION

A. **Sepsis Criteria**:

1. Diagnostic criteria for sepsis:
    a. Generalized Variables:
        - Temperature changes (temperature range less than 96.8°F or greater than 100°F).
        - Extreme pain or discomfort.
        - Clammy or sweaty skin.
        - Altered Mental Status: confusion or disorientation.
        - Short of breath.
        - Tachypnea (RR greater than 20).
        - High Heart Rate (greater than 90 bpm).
    b. Inflammatory Variables:
        - Leukocytosis (white blood cell count greater than 12,000 mm^3).
        - Leukopenia (white blood cell count less than 4,000 mm^3).
        - Normal white blood cell count with greater than 10% immature forms.
        - Plasma c-reactive protein greater than 3.0 mg/L.
    c. Hemodynamic Variables:
        - Hypotension < 90 mm/Hg, or a systolic blood pressure drop greater than 40 mm/Hg in adults.
    d. Organ Dysfunction Variables:
        - Arterial hypoxemia (PAO2/FiO2 less than 300).
        - Acute oliguria (< 0.5 mL/kg/hr for at least 2 hours despite fluid resuscitation).
        - Creatinine increase (> 0.5 mg/dL or 44.2 mmol/L).
        - Coagulation abnormalities (PTT > 60 seconds, INR > 5).
        - Ileus (absent bowel sounds).
        - Thrombocytopenia (platelet count < 100,000).
        - Hyperbilirubinemia (plasma bilirubin > 4 mg/dL or 70 mmol/L).
        - Hyperlactatemia (> 1 mmol/L).
        - Decreased capillary refill or mottling.

B. **Pharmacological/Antibiotic Considerations:**
1. **Antibiotics:** Obtain appropriate cultures before antibiotics are initiated, but do not delay antibiotic administration solely to complete this task. Once a patient is identified as having septic shock, an antibiotic should be administered as soon as possible within one hour.
2. Selection of antibiotic(s) should take into consideration the history and physical examination of the patient, and culture results if known. The Infectious Disease Society of America (IDSA) recommends that, if the Provider decides that infection is plausible, antibiotics can and should be administered promptly with due consideration being given to noninfectious conditions, or infections that do not benefit from antibacterial agents, for example, viral infections and the severity of illness of the patient.
3. For patients with presumed sepsis or septic shock, the administration of antibiotic(s) should be initiated promptly; within one hour.

4. Once the decision is made for antibiotics, the antibiotic(s) should be ordered on a STAT basis with accelerated delivery and initiation of the antibiotic(s) to the patient.
5. While most patients with septic shock should receive broad spectrum Gram-positive and Gram-negative coverage that includes *Pseudomonas* coverage, it is important to consider when such coverage may not be needed, on the basis of the suspected source of infection, the previous health status of the patient, and the patient's severity of illness.
6. Narrower regimens should be considered when there is a concern about infection, but the patient is not demonstrating severe illness (i.e., patient who has a rapid response to fluids or does not require fluids at all), has no vasopressor requirement, and/or barely meets the sepsis definition).
7. Broad-spectrum therapy may be considered when a patient is critically ill.
8. Treatment duration considerations and recommendations should be determined per specific condition and discontinued as soon as feasible based on the patient's response to therapy.
9. **Vasopressors:** Intravenous vasopressors are useful in patients who remain hypotensive despite adequate fluid resuscitation or who develop cardiogenic pulmonary edema. The following vasopressors are recommended:
    a. Norepinephrine: first choice in vasoactive medication.
    b. Vasopressin or epinephrine: can be added to norepinephrine to raise MAP to target goal or adding to vasopressin to decrease epinephrine dosage.
    c. Dopamine: recommended as an alternative to norepinephrine only in patients with low risk for tachyarrhythmias or absolute or relative bradycardia.
    d. Dobutamine: recommended for patients with persistent hypoperfusion despite fluids and vasopressors. Dobutamine is an inotropic agent that may cause a blood pressure drop initially in low doses as a result of systemic artery dilation caused by peripheral vascular resistance. But as the dose increases, cardiac output increases enough to overcome the peripheral vascular resistance, and blood pressure is increased.
10. **Glucocorticoid Therapy:** Glucocorticoids are recommended only if the patient's blood pressure does not respond to adequate fluid resuscitation and vasopressor medications.
11. **Blood Transfusion if Indicated:** Blood transfusions are reserved for those patients who have a hemoglobin level of less than 7 unless it is suspected that the patient has myocardial ischemia, severe hypoxemia, or acute hemorrhagic shock.
12. **Insulin Therapy if Indicated**: Blood glucose levels should be kept under 180 mg/dL. Insulin therapy should not be started unless there are two consecutive blood glucose levels greater than 180 mg/dL. Levels should be monitored every one-to-two hours until stabilized.
13. **Venous Thromboembolism Prophylaxis:** Patients who have sepsis or septic shock are at risk for developing blood clots, measures should be taken to prevent the formation of clots. Pharmacologic and mechanical agents may be useful and include:
    a. Low molecular weight heparin.

b. Lovenox may be used to prevent or treat deep vein thrombosis (DVT).
c. Pneumatic compression or compression stockings.

14. **Stress Ulcer Prophylaxis:** Stress ulcer prevention may include proton pump inhibitors (PPIs), or histamine receptor antagonists in the patient who has factors for gastrointestinal bleeding. The use of stress ulcer prophylaxis should be used with caution to avoid an adverse reaction (e.g., C. diff, spontaneous bacterial peritonitis in patients with cirrhosis).

PREVENTION OF SEPSIS

A. The prevention of a Healthcare Acquired Infection (HAI) and sepsis is a high priority, and all Healthcare Workers (HCWs) are responsible for ensuring infection control and prevention measures are practiced and adhered to as designed to provide optimal outcomes for all patients. Following are general recommendations for the prevention of infection and sepsis.
    1. Assess patients for the need for isolation precautions:
        - Neutropenic, immunological disorder.
        - Diarrhea.
        - Skin rashes.
        - Known communicable diseases.
        - Known carriers of an epidemic bacteria (e.g., MRSA, VRE, ESBL, MDRO).
    2. Identify patients who are at risk for developing an HAI:
        - Age greater than 70 years.
        - Shock.
        - Major trauma.
        - Coma.
        - Prior antibiotics.
        - Mechanical ventilation.
        - Drugs affecting immune system (steroids, chemotherapy).
        - Indwelling catheters.
    3. Standard Precautions should be followed with every patient:
        a. **Gloves**
            - Sterile gloves should be worn after hand hygiene while touching mucous membranes, nonintact skin, performing sterile procedures (e.g., insertion of central line or foley catheter).
            - Clean nonsterile gloves are safe for touching blood, other body fluids, contaminated items, any other potentially infectious materials.
            - Change gloves between tasks and procedures in the same patient, especially when moving from a contaminated body area to a clean body area.
            - Never wear the same pair of gloves for the care of more than one patient.
            - Remove gloves after caring for patient.

- Practice hand hygiene whenever gloves are removed.

b. **Gown**
   - Wear gown to prevent soiling of clothing and skin during procedures likely to generate splashes of blood, body fluids, secretions, or excretions.
   - Sterile gown is required only for aseptic procedures (e.g., insertion of central line), for the rest a clean nonsterile gown is sufficient.
   - Remove soiled gown as soon as possible, with care to avoid contamination.

c. **Mask**
   - Wear a mask with adequate eye protections or a face shield to protect mucous membranes of the eyes nose, and mouth during procedures and patient care activities likely to generate splashes/sprays of blood and body fluids.
   - Patients, relatives, and health care workers presenting with respiratory symptoms (e.g., cough) should also use mask.

d. **Device Related Measures**
   - Remove devices if no longer necessary.
   - Do not insert devices if they are not indicated.
   - Consider alternative non-invasive devices if feasible (e.g., external male and female catheters).
   - Pay close attention to infection control prevention measures for patient care devices at these key points: insertion, maintenance, and removal.
   - Ventilator Associated Pneumonia (VAP) Prevention Bundle.
   - Catheter Associated Urinary Tract Infection (CAUTI) Prevention Bundle.
   - Catheter Associated Bloodstream Infection (CAUTI) Prevention Bundle.

e. **Hand Hygiene**
   - Adherence to CDC Hygiene Guidelines.
   - When using soap and water hand hygiene: wash hands thoroughly for a minimum of 20 seconds.
   - When using an alcohol-based hand rub (ABHR) thoroughly rub product into hands, and rub until product is dry.
   - If hands are visibly dirty, wash with soap and water.
   - If hands are not visibly dirty, use an alcohol-based hand rub (ABHR).
   - Before direct contact with patient and after patient contact.
   - Before donning sterile gloves for an invasive procedure (e.g., central line, foley insertion).

- Before donning gloves for peripheral catheter placement, urinary catheter placement, or placing other invasive devices that do not require surgery.
- After contact with a patient's skin (e.g., taking VS, positioning/moving patient).
- After contact with body fluids or excretions, nonintact skin, wound dressings, mucous membranes.
- Before moving to clean body site after touching a contaminated body site during care of the patient.
- After contact with inanimate objects in the same general area as the patient (tables, chairs, IV poles, computer keyboards).
- After removing gloves.
- Note: Use soap and water hand hygiene after contact with a patient with infectious diarrhea, C. diff, Bacillus anthracis, before eating, and after using the restroom.

DOCUMENTATION

A. Nursing will document sepsis care and treatment for the adult patient.
B. Providers shall document sepsis care and treatment for the adult patient.

STAFF EDUCATION

A. Medical, nursing, and clinical staff (RNs, LPNs, CNAs, RTs) will receive education and training on sepsis upon initial orientation, annually, and as needed (e.g., such as when guidelines and recommendations change, performance improvement initiatives). At a minimum education will include:
    1. Hospital policy;
    2. What is sepsis, septic shock;
    3. Early recognition and identification of sepsis;
    4. Signs and symptoms of septic shock;
    5. Risk groups and risk factors;
    6. Care and management of the patient with sepsis; and
    7. Prevention of infection and sepsis.
B. Documentation of training will be retained in the employee's personnel file.

QUALITY ASSURANCE

A. The Infection Control and Prevention Department will track and monitor compliance to the sepsis guidelines as outlined by this policy. For any identified areas of concern or non-compliance a corrective action plan will be developed, implemented, and monitored to ensure the actions demonstrate improvement.
B. All findings will be reported to following committees: Infection Prevention, Quality, Medical Staff and Governing Board.

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ATTACHMENTS

NUR-026A Adult Sepsis Screen
NUR-026B Adult Sepsis Standing Orders

REVISIONS/UPDATES

Date	Brief Description of Revision/Change

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

ADULT SEPSIS STANDING ORDERS

Date:	**Time:**
Patient Name:	**Age:**
Allergies:	
Weight (Kg):	
CODE STATUS: □ FULL CODE □ DNR □ DNI	
ORDERS	
ALL ITEMS WITH AN AUTOCHECK "√" ARE AUTOMATICALLY INITIATED	
√ Obtain baseline vital signs: Temperature, Pulse, Respiration, Blood Pressure, SpO2, and Mean Arterial Pressure (MAP)	
√ O2 per NC @ 2-6 LPM to maintain SpO2 > 90%. Monitor SpO2 continuously via pulse oximeter. Notify Provider if unable to maintain SpO2 > 90%	
√ Obtain IV access x2	
√ Sodium Chloride 0.9% 10 mL, Flush PRN for line patency	
√ Blood Cultures x2 from 2 peripheral sites (Obtain prior to administration of antibiotics, ***BUT DO NOT DELAY ANTIBIOTICS IF RESULTS ARE NOT RETURNED IN ONE (1) HOUR OR LESS***	
LABS & DIAGNOSTICS	
√ Obtain Stat Labs: *Lactic Acid, CBC with diff, CMP, D-dimer (*if initial Lactate level >2 mmoL/L; remeasure)	
√ Urine C&S, Sputum C&S, Wound C&S (if indicated)	
√ Obtain FSBS; if value is > 180 mg/dL or < 60 mg/dL notify Provider	
√ Obtain ABGs	
√ Obtain EKG	
√ Obtain Single View Chest X-ray	
√ Obtain weight in kg	
MONITORING & OTHER ORDERS	
√ Monitor vital signs and SpO2 every 15 minutes, and MAP every 30 minutes (**See footnote below to calculate MAP) until VS and MAP stable then monitor every hour.	
√ Notify Provider if Temperature > 100.4°F or < 96.8°F, or Pulse > 90 BPM or Resp Rate > 20, SpO2 < 90%, or if MAP < 60 mm/Hg	
√ Place Urinary Catheter and monitor output every hour. Notify Provider if output < 0.5 mL/kg/hour	
√ Monitor FSBS values every hour; if FSBS value is > 180 mg/dL or < 60 mg/dL notify Provider	
√ Monitor Lactate level every 6 hours until level < 2	
FEVER MANAGEMENT	
√ Tylenol 1000mg IV over 15 minutes every 6 hours PRN Temp > 100.4°F if unable to tolerate PO	
√ Tylenol 500mg PO every 6 hours PRN Temp > 100.4°F	
CONCOMITANT MEDICATIONS	
√ Zofran 4mg IVP every 6 hours PRN for nausea or vomiting if unable to tolerate PO	
√ Zofran 4mg PO every 6 hours PRN for nausea or vomiting	

Nurse Signature:	**Time:**	**Date:**	**□ TORB □ VORB □ N/A**
Provider Signature:	**Time:**	**Date:**	

Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead
U	Unit	X.0 mg	X.0 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

□ Protonix 40 mg IV push daily	□ Protonix 40 mg IV push BID
□ Protonix 40 mg PO daily	□ Other:
□ Other:	□ Other:
□ Other:	□ Other:
FLUID RESUSCITATION	
□ Normal Saline 0.9% 1000 mL 30mL/kg rapid administration for hypotension or lactate ≥ 4 mmoL/L _____mL x1	
□ Normal Saline 0.9% 1000 mL _____mL x1 over _____ minutes	
□ Normal Saline 0.9% 500 mL x1 over _____ minutes	
□ Normal Saline 0.9% 250 mL x1 over _____ minutes	
□ Lactated Ringers 1000 mL 30mL/kg rapid administration for hypotension or lactate ≥ 4 mmoL/L _____mL x1	
□ Lactated Ringers 1000 mL _____mL x1 over _____ minutes	
□ Lactated Ringers 500 mL x1 over _____ minutes	
Other:	
ANTIBIOTICS	
□ Azithromycin 500 mg IV x1	□ Ciprofloxacin 400 mg IV x1
□ Ceftriaxone 1 gram IV x1	□ Vancomycin 1 gram IV x1
□ Meropenem 500 mg IV x1	□ Vancomycin _____ (15mg/kg IV) x1
□ Zosyn 4.5 grams IV x1	□ Other:
VASOPRESSORS	
□ Norepinephrine 4mg/D5W 250 mL IV: Start 0.5 mcg/min Titrate by 1 mcg/min PRN every 15 minutes up to 12mcg/min to keep MAP > 65 mm Hg or SBP > 90	
□ Epinephrine 4mg/NS 250 mL IV: Start at 0.05 mcg/kg/min Titrate by 0.05 mcg/kg/min PRN every 15 minutes up to 2 mcg/kg/min to keep MAP > 65mm Hg or SBP > 90	
□ Vasopressin: Start at 0.01units/min Titrate by 0.01units/min PRN every 15 minutes up to 0.04units/kg to keep MAP > 65 mm Hg or SBP > 90	
□ Dopamine: Start at 5 mcg/kg/min Titrate by 5mcg/kg/min PRN every 15 minutes up to 20mcg/kg/min to keep MAP > 65 mm Hg or SBP > 90	
□ Dobutamine: Start at 2mcg/kg/min Titrate by 2.5mcg/kg/min PRN every 15 minutes up to 15mcg/kg/min to keep MAP > 65 mm Hg or SBP > 90	
□ Other:	
VENOUS THROMBUS EMBOLUS (VTE) PROPHYLAXIS	
□ Lovenox 40 mg Subcutaneous daily	□ Lovenox 30 mg Subcutaneous daily (if CrCl < 30 mL/min)
□ Heparin 5000 Units Subcutaneous every 8 hours	□ Heparin 5000 Units Subcutaneous every 12 hours
□ Sequential Compression Device (SCD)	□ Compression Stockings

Nurse Signature:					**Time:**		**Date:**			□ **TORB** □ **VORB** □ **N/A**	
Provider Signature:					**Time:**		**Date:**				
Do Not Use	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**
U	Unit	X.0 mg	X.0 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

Date	Time	ADDITIONAL ORDERS

*Reference: Adapted from: Hour-1 Bundle Initial Resuscitation for Sepsis and Septic Shock. 2019 the Society of Critical Care Medicine and the European Society of Intensive Care Medicine. All Rights Reserved. Retrieved from https://www.sccm.org/getattachment/SurvivingSepsisCampaign/Guidelines/Adult-Patients/Surviving-Sepsis-Campaign-Hour-1-Bundle.pdf?lang=en-US

**Formula for figuring MAP: To calculate a mean arterial pressure, double the diastolic blood pressure and add the sum to the systolic blood pressure, then divide by 3 (e.g., SBP + 2(DBP)/3=MAP).

Nurse Signature:	**Time:**	**Date:**	□ **TORB** □ **VORB** □ **N/A**
Provider Signature:	**Time:**	**Date:**	

Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead	Do Not Use	Use Instead
U	Unit	X.0 mg	X.0 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Casirivimab/Imdevimab (Combination Therapy)
Emergency Use Authorization (EUA) Standing Orders

All items with an autocheck "√" are automatically initiated

Name:	**Date:**	**Time:**
Date of Birth:		
Allergies:	**Code Status:** □ **Full** □ **DNR** □ **DNI**	**Wt:**

Initial below in the box by each item:	**I certify the patient/legal representative was (initial each item below):**		
	Instructed on risks, benefits, & alternatives to Casirivimab/Imdevimab.		
	Given the "Fact Sheet for Patients, Parents, and Caregivers" prior to administration.		
	The patient meets the appropriate criteria for administration (check each item as applicable):		
	□ ≥ 12 years of age	□ ≥ 40 kg (weight)	□ Mild to moderate COVID-19 disease
	□ At high risk for progressing to severe COVID-19 and/or hospitalization.		
	□ ***NOT*** hospitalized due to COVID-19, or □ ***DO NOT*** require oxygen therapy due to COVID-19, or □ ***DO NOT*** require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related co-morbidity.		

Date of symptom onset:	**Date of positive test:**

Qualifying Reasons for Administration (Must choose at least one of the following):

□ BMI ≥ 35	□ Have chronic kidney disease	□ Diabetes
□ Immunosuppressive Disease	□ Currently receiving immunosuppressive treatment	□ Age ≥ 65 years

Are ≥ 55 years of age **AND** have □ Cardiovascular disease, **or** □ Hypertension, **or** □ COPD/other chronic respiratory disease

Are 12-17 years of age **AND** have **(Check all that apply):** □ BMI ≥ 85th percentile for their age and gender based on CDC growth charts, **or** □ Sickle Cell Disease, **or** □ Congenital or acquired heart disease, **or** □ Neurodevelopmental disorders, i.e., Cerebral Palsy, **or** □ Medical-related technological dependence, i.e., tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19), **or** □ Asthma, reactive airway disease or other chronic respiratory disease that requires daily medication for control.

ORDERS

√ **Casirivimab 600mg/Imdevimab 600mg IV infusion over 60 minutes** as soon as possible after positive viral test for SARS-CoV-2 and within 10 days of symptom onset. Once the infusion is complete, flush the tubing with 0.9% Sodium Chloride to ensure delivery of the dose.

√ Administer infusion using 0.2 micron filter tubing.

√ Obtain baseline VS (Temp, Pulse, Respiration, BP, O2 Sat) prior to infusion.

Nurse Signature:	**Time:**	**Date:**	□ **TORB** □ **VORB**
Provider Signature:	**Time:**	**Date:**	

Do Not Use	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**
U	Unit	1.0 mg	1 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

√ **Monitor VS (Temp, Pulse, Respiration, BP, O2 Sat) every 30 minutes until one hour after infusion is complete. Notify Provider if patient exhibits any of the following signs or symptoms:**					
Temp > 100.4°F	Chills	Nausea	Headache	Bronchospasm	Hypotension
Angioedema	Throat Irritation	Rash/Urticaria	Pruritis	Myalgia	Dizziness

□ **Outpatient:** Instruct patient to continue to self-isolate and use infection control measures according to CDC guidelines (i.e. wear a mask, social distance, avoid sharing personal items, clean & disinfect "high touch surfaces," frequent hand hygiene).

Allergic/Anaphylaxis Reactions

□ If allergic reaction related to the infusion occurs, STOP the infusion. Initiate a Rapid Response or Code Blue as appropriate and notify the Provider immediately.

□ Initial management of anaphylaxis: establish and/or maintain airway, place patient in supine or Trendelenburg position, administer supplemental oxygen 2-6 LPM per NC to maintain SpO2 > 92%.

Cardiovascular-Hypoperfusion (decreased circulation)

□ Infuse 0.9% Normal Saline at _____ mL/hour to maintain systolic BP > 90mm/Hg

Respiratory-Acute Respiratory Distress (stridor, wheezing)

□ Epinephrine 1:1000 0.3mg IM or Subcutaneous if patient has respiratory distress (inspiratory & expiratory wheezing, stridor, and/or laryngeal edema), hypotension, and/or acute loss of consciousness. May repeat x1 in 10 minutes if necessary.

□ Albuterol 2.5mg via nebulizer over 10 minutes. May repeat as needed every 2 hours.

□ If wheezing persists and BP is > 90mm/Hg, may give Atrovent 0.5mg via nebulizer x1.

Central Nervous System-(headache, dizziness, seizure)

□ Acetaminophen 1000mg PO for headache x1

□ Seizures: Contact physician immediately

GI-(abdominal pain, nausea, emesis, diarrhea)

□ Diphenhydramine 50mg IV or IM x1

Skin-(rash, itching, welts, hives)

□ Diphenhydramine 50mg IV or IM for severe itching and/or hives x1

□ Methylprednisolone 125mg IV x1

ADDITIONAL ORDERS

Nurse Signature:	**Time:**	**Date:**	□ **TORB** □ **VORB**
Provider Signature:	**Time:**	**Date:**	

Do Not Use	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**
U	Unit	1.0 mg	1 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

ADULT SEPSIS SCREEN

Date:			**Time:**		
Patient Name:			**Age:**		
Allergies:					
Weight (Kg):					
CODE STATUS: □ FULL CODE □ DNR □ DNI					
Sepsis Screen (To be performed by Nursing Staff)					
Initial Assessment: Did patient present with or exhibit one or more of the signs or symptoms listed below. If CHECKED think SEPSIS/WATCH FOR TIME: T=TEMP I=INFECTION M=MENTAL DECLINE E=EXTREMELY ILL					
□ Shivering, Fever, Very Cold		□ Extreme Pain or Discomfort		□ Clammy or Sweaty Skin	
□ Confusion or Disorientation		□ Short of Breath		□ High Heart Rate	
Does the patient present with known or suspected infection? □ YES □ NO **If Yes: Check below all that apply:**					
□ Pneumonia	□ Wound Infection	□ UTI	□ Abdominal Pain/Distention/ Firmness	□ Cough	□ Recent Surgery
□ Immunocompromised	□ Indwelling Device	□ Current Antibiotic Use	□ Nursing Home	□ LTAC	□ Other
ACTION ALERT! If any of the above are checked, perform qSOFA Screen listed below. Score of 2 or more with suspect or confirmed infection OR less than 2 and infection still suspected PROCEED TO SIRS ASSESSMENT and notify Provider.					
□ Respiratory Rate ≥ 22		□ Systolic BP 100mm/Hg or lower		□ Altered Mental Status or GCS < 15	
SIRS ASSESSMENT: Systemic Inflammatory Response Syndrome is the occurrence of at least 2 of the following (Check below all that apply):					
□ Temp > 100.4°F or < 96.8°F	□ Heart rate > 90 BPM	□ Respiratory Rate > 20	□ PACO2 < 32 mm/Hg	□ WBC count >12,000 mm³ or < 4,000 mm³ or over 10% immature forms or bands	
ACTION ALERT! Initiate Sepsis Bundle for patient with a SIRS score of 2 or more and/or symptoms indicative of sepsis or patient presents with known or suspected infection.					

*****Reference: Adapted from: Hour-1 Bundle Initial Resuscitation for Sepsis and Septic Shock. 2019 the Society of Critical Care Medicine and the European Society of Intensive Care Medicine. All Rights Reserved. Retrieved from https://www.sccm.org/getattachment/SurvivingSepsisCampaign/Guidelines/Adult-Patients/Surviving-Sepsis-Campaign-Hour-1-Bundle.pdf?lang=en-US

Signature of Nurse: _____ Date: _____/_____/_____

Signature of Nurse: _____ Date: _____/_____/_____

Fact Sheet for Patients, Parents and Caregivers
Emergency Use Authorization (EUA) of Bamlanivimab and Etesevimab for Coronavirus Disease 2019 (COVID-19)

You are being given two medicines together called **bamlanivimab and etesevimab** for the treatment of coronavirus disease 2019 (COVID-19). This Fact Sheet contains information to help you understand the potential risks and potential benefits of taking bamlanivimab and etesevimab, which you may receive.

Receiving bamlanivimab and etesevimab together may benefit certain people with COVID-19.

Read this Fact Sheet for information about bamlanivimab and etesevimab. Talk to your healthcare provider if you have questions. It is your choice to receive bamlanivimab and etesevimab or stop them at any time.

What is COVID-19?
COVID-19 is caused by a virus called a coronavirus. People can get COVID-19 through contact with another person who has the virus.

COVID-19 illnesses have ranged from very mild (including some with no reported symptoms) to severe, including illness resulting in death. While information so far suggests that most COVID-19 illness is mild, serious illness can happen and may cause some of your other medical conditions to become worse. People of all ages with severe, long-lasting (chronic) medical conditions like heart disease, lung disease, and diabetes, for example, and other conditions including obesity, seem to be at higher risk of being hospitalized for COVID-19. Older age, with or without other conditions, also places people at higher risk of being hospitalized for COVID-19.

What are the symptoms of COVID-19?
The symptoms of COVID-19 include fever, cough, and shortness of breath, which may appear 2 to 14 days after exposure. Serious illness including breathing problems can occur and may cause your other medical conditions to become worse.

What are bamlanivimab and etesevimab?
Bamlanivimab and etesevimab are investigational medicines used to treat mild to moderate symptoms of COVID-19 in adults and adolescents (12 years of age and older who weigh at least 88 pounds (40 kg)), and who are at high risk for developing severe COVID-19 symptoms or the need for hospitalization. Bamlanivimab and etesevimab are investigational because they are still being studied. There is limited information known about the safety or effectiveness of using bamlanivimab and etesevimab to treat people with COVID-19.

The FDA has authorized the emergency use of bamlanivimab and etesevimab together for the treatment of COVID-19 under an Emergency Use Authorization (EUA). For more information on EUA, see the section "**What is an Emergency Use Authorization (EUA)?**" at the end of this Fact Sheet.

What should I tell my healthcare provider before I receive bamlanivimab and etesevimab?
Tell your healthcare provider about all of your medical conditions, including if you:
- Have any allergies
- Are pregnant or plan to become pregnant
- Are breastfeeding or plan to breastfeed
- Have any serious illnesses
- Are taking any medications (prescription, over-the-counter, vitamins, and herbal products)

How will I receive bamlanivimab and etesevimab?
- Bamlanivimab and etesevimab are given to you at the same time through a vein (intravenous or IV).
- You will receive one dose of bamlanivimab and etesevimab by IV infusion. The infusion will take 21 – 60 minutes or longer. Your healthcare provider will determine the duration of your infusion.

What are the important possible side effects of bamlanivimab and etesevimab?

Possible side effects of bamlanivimab and etesevimab are:

- Allergic reactions. Allergic reactions can happen during and after infusion with bamlanivimab and etesevimab. Tell your healthcare provider right away if you get any of the following signs and symptoms of allergic reactions: fever, chills, nausea, headache, shortness of breath, low or high blood pressure, rapid or slow heart rate, chest discomfort or pain, weakness, confusion, feeling tired, wheezing, swelling of your lips, face, or throat, rash including hives, itching, muscle aches, dizziness, and sweating. These reactions may be severe or life threatening.
- Worsening symptoms after treatment: You may experience new or worsening symptoms after infusion, including fever, difficulty breathing, rapid or slow heart rate, tiredness, weakness or confusion. If these occur, contact your healthcare provider or seek immediate medical attention as some of these events have required hospitalization. It is unknown if these events are related to treatment or are due to the progression of COVID-19.

The side effects of getting any medicine by vein may include brief pain, bleeding, bruising of the skin, soreness, swelling, and possible infection at the infusion site.

These are not all the possible side effects of bamlanivimab and etesevimab. Not a lot of people have been given bamlanivimab and etesevimab. Serious and unexpected side effects may happen. Bamlanivimab and etesevimab are still being studied so it is possible that all of the risks are not known at this time.

It is possible that bamlanivimab and etesevimab could interfere with your body's own ability to fight off a future infection of SARS-CoV-2. Similarly, bamlanivimab and etesevimab may reduce your body’s immune response to a vaccine for SARS-CoV-2. Specific studies have not been conducted to address these possible risks. Talk to your healthcare provider if you have any questions.

What other treatment choices are there?

Like bamlanivimab and etesevimab, FDA may allow for the emergency use of other medicines to treat people with COVID-19. Go to https://www.covid19treatmentguidelines.nih.gov/ for information on the emergency use of other medicines that are not approved by FDA to treat people with COVID-19. Your healthcare provider may talk with you about clinical trials you may be eligible for.

It is your choice to be treated or not to be treated with bamlanivimab and etesevimab. Should you decide not to receive bamlanivimab and etesevimab or stop it at any time, it will not change your standard medical care.

What if I am pregnant or breastfeeding?

There is limited experience treating pregnant women or breastfeeding mothers with bamlanivimab and etesevimab. For a mother and unborn baby, the benefit of receiving bamlanivimab and etesevimab may be greater than the risk from the treatment. If you are pregnant or breastfeeding, discuss your options and specific situation with your healthcare provider.

How do I report side effects with bamlanivimab and etesevimab?

Tell your healthcare provider right away if you have any side effect that bothers you or does not go away.

Report side effects to **FDA MedWatch** at www.fda.gov/medwatch, call 1-800-FDA-1088, or contact Eli Lilly and Company at 1-855-LillyC19 (1-855-545-5921).

How can I learn more?

- Ask your healthcare provider
- Visit www.BAMandETE.com
- Visit https://www.covid19treatmentguidelines.nih.gov/
- Contact your local or state public health department

What is an Emergency Use Authorization (EUA)?
The United States FDA has made bamlanivimab and etesevimab available under an emergency access mechanism called an EUA. The EUA is supported by a Secretary of Health and Human Service (HHS) declaration that circumstances exist to justify the emergency use of drugs and biological products during the COVID-19 pandemic.

Bamlanivimab and etesevimab have not undergone the same type of review as an FDA-approved or cleared product. The FDA may issue an EUA when certain criteria are met, which includes that there are no adequate, approved, and available alternatives. In addition, the FDA decision is based on the totality of scientific evidence available showing that it is reasonable to believe that the product meets certain criteria for safety, performance, and labeling and may be effective in treatment of patients during the COVID-19 pandemic. All of these criteria must be met to allow for the product to be used in the treatment of patients during the COVID-19 pandemic.

The EUA for bamlanivimab and etesevimab together is in effect for the duration of the COVID-19 declaration justifying emergency use of these products, unless terminated or revoked (after which the product may no longer be used).

Literature revised May 14, 2021

Eli Lilly and Company, Indianapolis, IN 46285, USA

C2.0-ETE-0001-EUA PAT-20210514

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Bamlanivimab/Etesevimab (Combination Therapy) Emergency Use Authorization (EUA) Standing Orders

All items with an autocheck "√" are automatically initiated

Name:	**Date:**	**Time:**
Date of Birth:		
Allergies:	**Code Status:** □ **Full** □ **DNR** □ **DNI**	**Wt:**

Initial below in the box by each item:	**I certify the patient/legal representative was (initial each item below):**		
	Instructed on risks, benefits, & alternatives to Bamlanivimab/Etesevimab.		
	Given the "Fact Sheet for Patients, Parents, and Caregivers" prior to administration.		
	The patient meets the appropriate criteria for administration (check each item as applicable):		
	□ ≥ 12 years of age	□ ≥ 40 kg (weight)	□ Mild to moderate COVID-19 disease
	□ At high risk for progressing to severe COVID-19 and/or hospitalization.		
	□ ***NOT*** hospitalized due to COVID-19, or □ ***DO NOT*** require oxygen therapy due to COVID-19, or □ ***DO NOT*** require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related co-morbidity.		

Date of symptom onset:	**Date of positive test:**

Qualifying Reasons for Administration (Must choose at least one of the following):

□ BMI ≥ 35	□ Have chronic kidney disease	□ Diabetes
□ Immunosuppressive Disease	□ Currently receiving immunosuppressive treatment	□ Age ≥ 65 years

Are ≥ 55 years of age **AND** have □ Cardiovascular disease, **or** □ Hypertension, **or** □ COPD/other chronic respiratory disease

Are 12-17 years of age **AND** have **(Check all that apply):** □ BMI ≥ 85th percentile for their age and gender based on CDC growth charts, **or** □ Sickle Cell Disease, **or** □ Congenital or acquired heart disease, **or** □ Neurodevelopmental disorders, i.e., Cerebral Palsy, **or** □ Medical-related technological dependence, i.e., tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19), **or** □ Asthma, reactive airway disease or other chronic respiratory disease that requires daily medication for control.

ORDERS

√ **Bamlanivimab 700mg/Etesevimab 1400mg IV infusion over 70 minutes** as soon as possible after positive viral test for SARS-CoV-2 and within 10 days of symptom onset. Once the infusion is complete, flush the tubing with 0.9% Sodium Chloride to ensure delivery of the dose.

√ Administer infusion using 0.2 micron filter tubing.

√ Obtain baseline VS (Temp, Pulse, Respiration, BP, O2 Sat) prior to infusion.

Nurse Signature:	**Time:**	**Date:**	□ **TORB** □ **VORB**
Provider Signature:	**Time:**	**Date:**	

Do Not Use	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**
U	Unit	1.0 mg	1 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

√ **Monitor VS (Temp, Pulse, Respiration, BP, O2 Sat) every 30 minutes until one hour after infusion is complete. Notify Provider if patient exhibits any of the following signs or symptoms:**				
Temp > 100.4°F	Hypoxia (O2 Sat < 90%)	Tachypnea	Arrhythmia (e.g., atrial fibrillation, sinus tachycardia, bradycardia)	
Chest pain/discomfort	Weakness/Fatigue	Hypertension/Hypotension	Diaphoresis	Altered Mental Status

□ **Outpatient:** Instruct patient to continue to self-isolate and use infection control measures according to CDC guidelines (i.e. wear a mask, social distance, avoid sharing personal items, clean & disinfect "high touch surfaces," frequent hand hygiene).

Allergic/Anaphylaxis Reactions

□ If allergic reaction related to the infusion occurs, STOP the infusion. Initiate a Rapid Response or Code Blue as appropriate and notify the Provider immediately.

□ Initial management of anaphylaxis: establish and/or maintain airway, place patient in supine or Trendelenburg position, administer supplemental oxygen 2-6 LPM per NC to maintain SpO2 > 92%.

Cardiovascular-Hypoperfusion (decreased circulation)

□ Infuse 0.9% Normal Saline at _____ mL/hour to maintain systolic BP > 90mm/Hg

Respiratory-Acute Respiratory Distress (stridor, wheezing)

□ Epinephrine 1:1000 0.3mg IM or Subcutaneous if patient has respiratory distress (inspiratory & expiratory wheezing, stridor, and/or laryngeal edema), hypotension, and/or acute loss of consciousness. May repeat x1 in 10 minutes if necessary.

□ Albuterol 2.5mg via nebulizer over 10 minutes. May repeat as needed every 2 hours.

□ If wheezing persists and BP is > 90mm/Hg, may give Atrovent 0.5mg via nebulizer x1.

Central Nervous System-(headache, dizziness, seizure)

□ Acetaminophen 1000mg PO for headache x1

□ Seizures: Contact physician immediately

GI-(abdominal pain, nausea, emesis, diarrhea)

□ Diphenhydramine 50mg IV or IM x1

Skin-(rash, itching, welts, hives)

□ Diphenhydramine 50mg IV or IM for severe itching and/or hives x1

□ Methylprednisolone 125mg IV x1

ADDITIONAL ORDERS

Nurse Signature:	**Time:**	**Date:**	□ **TORB** □ **VORB**
Provider Signature:	**Time:**	**Date:**	

Do Not Use	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**	**Do Not Use**	**Use Instead**
U	Unit	1.0 mg	1 mg	QD	Daily	MS or MSO4	Morphine	cc	mL	SC, SQ, Sub q	Subcutaneous
IU	International Unit	.X mg	0.X mg	QOD	Every Other Day	MgSO4	Magnesium Sulfate	qhs	nightly	D/C	Discharge or Discontinue

Mangum Board Meeting Financial Reports

	REPORT TITLE
1	Cash Receipts - Cash Disbursements - NET
2	Financial Update (page 1)
3	Financial Update (page 2)
4	Stats
5	Balance Sheet Trend
6	Cash Collections
7	Medicare Payables (Receivables)
8	Income Statement
9	Income Statement Trend
10	Financial Summary
11	AP Aging Summary
12	Claims List

COHESIVE HEALTHCARE MANAGEMENT + CONSULTING

July 27, 2021

Board of Directors
Mangum Regional Medical Center

June 2021 Financial Statement Overview

- Statistics
  - The average daily census (ADC) for June 2021 was 10.53. This was slightly below our target of 11.0 but continues our annual upward trend of YTD ADC at 9.34.
  - FY21 YTD Medicare swing bed patient days through June were 1,287 as compared to the PY total of 1,749 (approximately -26%). Accordingly, this continues to be an area of focus.
  - We experienced an increase in collections in June ($939K) over May ($817K) due to the ADC increase in May over April (reminder, there is approximately a one-month lag between the net revenue generated each month & the majority of the cash collected).

- Balance Sheet Highlights
  - The operating cash balance as of June 30th was $110K. This decrease of $75K from the May 2021 balance was primarily due to material payments made towards vendors.
  - AR increased $164K from May. This was primarily volume-driven as the facility continued its rebounding trend to an ADC of 10.53.
  - AP increased drastically by over $2M due to the COVID capital invoices approved and recorded in June. Accordingly, ALL remaining COVID funds have been fully recognized in June, reducing the COVID grant liability to zero.

COHESIVE HEALTHCARE MANAGEMENT • CONSULTING

- Income Statement Highlights
    - Current month gross patient revenue is higher compared to PY primary due to OP volumes (COVID had a much higher impact on OP CAH & clinic volumes in FY20).
    - Current month total operating revenue of $4M, which is an increase of $3.2M compared to prior year is driven primarily by the recognition of the remaining COVID grant funds.
    - Operating expenses were $116K higher in June due to a catch up of prepaid amortizations, and prior period expenses captured in the current month from a delay in AP invoice coding.

- Other
    - Other attached reports include an income statement trend, CY financial statement comparisons to FY17-FY20, Accounts Payable Aging and estimated claims lists – updated estimated June claims list showing payments made MTD and the July 2021 estimated claims list.

Mangum Regional Medical Center
Admissions, Discharges & Days of Care
Fiscal Year 2021

	January	February	March	April	May	June	12/31/2021 YTD	12/31/2020 PY Comparison
Admissions								
Inpatient	15	15	11	16	14	23	94	89
Swingbed	10	20	13	19	22	11	95	123
Observation	0	0	0	0	0	0	0	2
	25	35	24	35	36	34	189	214
Discharges								
Inpatient	14	15	11	14	16	19	89	81
Swingbed	5	10	8	8	14	8	53	66
Observation	0	0	0	0	0	0	0	2
	19	25	19	22	30	27	142	149
Days of Care								
Inpatient-Medicare	23	31	10	30	24	51	169	157
Inpatient-Other	27	15	14	13	21	11	101	89
Swingbed-Medicare	133	243	171	217	269	254	1,287	1,749
Swingbed-Other	0	35	48	20	31	0	134	119
Observation	0	0	0	0	0	0	0	2
	183	324	243	280	345	316	1,691	2,116
Calendar days	31	28	31	30	31	30	181	182
ADC - (incl OBS)	5.90	11.57	7.84	9.33	11.13	10.53	9.34	11.63
ADC	5.90	11.57	7.84	9.33	11.13	10.53	9.34	11.62

Ratio Analysis	1/31/21	2/28/21	3/31/21	4/30/21	5/31/21	6/30/21		12/31/20
Days cash on hand	32.21	13.81	18.12	6.71	4.32	2.53		27.75

Mangum Regional Medical Center
Comparative Balance Sheet - Unaudited
Fiscal Year 2021

	January	February	March	April	May	June	Prior Month Variance
Cash And Cash Equivalents	1,384,085	578,873	498,072	285,068	184,660	109,864	**(74,796)**
Reserved Funds	3,542,241	3,484,190	3,533,651	3,489,308	2,878,664	2,483,182	**(395,482)**
Patient Accounts Receivable, Net	1,636,678	1,816,370	2,014,423	2,292,323	2,477,836	2,641,397	**163,561**
Inventory	73,030	73,065	83,960	80,891	74,566	65,951	**(8,615)**
Prepaids And Other Assets	1,015,985	993,575	1,008,028	1,054,977	934,267	1,000,084	**65,817**
Capital Assets, Net	1,204,113	1,179,030	1,153,947	1,128,864	1,118,781	3,377,016	**2,258,235**
Total Assets	8,856,131	8,125,103	8,292,081	8,331,430	7,668,773	9,677,494	2,008,721
Accounts Payable	13,246,847	12,882,642	13,332,697	13,701,892	13,429,015	15,737,863	**2,308,848**
Due To Medicare	6,011,350	5,906,148	5,799,345	5,677,196	5,691,820	5,615,347	**(76,473)**
Covid Grant Funds	3,542,241	3,484,190	3,484,190	3,489,308	2,878,664	-	**(2,878,664)**
Due To Cohesive - PPP Loans	-	-	-	-	-	-	-
Notes Payable - Cohesive	242,500	242,500	242,500	242,500	242,500	242,500	-
Notes Payable - Other	435,254	412,382	389,510	389,510	343,766	320,894	**(22,872)**
Alliantz Line Of Credit	-	-	-	-	-	-	-
Leases Payable	362,765	359,258	359,258	355,732	348,013	345,038	**(2,975)**
Total Liabilities	23,840,957	23,287,120	23,607,500	23,856,138	22,933,778	22,261,642	(672,135)
Net Assets	(14,984,826)	(15,162,017)	(15,315,418)	(15,524,708)	(15,265,005)	(12,584,149)	**2,680,856**
Total Liablities and Net Assets	8,856,131	8,125,103	8,292,081	8,331,430	7,668,773	9,677,494	2,008,721

Mangum Regional Medical Center
June 2021

	Current Month	Year-To-Date
Cash Receipts	$ 939,092	$ 4,897,976
Cash Disbursements	$ (1,455,892)	$ (7,017,724)
NET	$ (516,800)	$ (2,119,748)

* Cash receipts exclude stimulus $
* Cash disbursements include stimulus $ so this will need to be segregated.

Mangum Regional Medical Center
Cash Receipts & Disbursements by Month
July 27, 2021 Board Meeting

2018		2019		2020			2021			
Month	Amount	Month	Amount	Month	Amount	Stimulus Funds	Month	Amount	Stimulus Funds	Disbursements
January-18	165,685	January-19	417,231	January-20	1,183,307		January-21	830,598		695,473
February-18	752,169	February-19	242,680	February-20	750,899		February-21	609,151		1,472,312
March-18	1,098,956	March-19	1,357,203	March-20	843,213		March-21	960,085	49,461	866,387
April-18	1,449,073	April-19	1,299,323	April-20	617,307	778,925	April-21	742,500		999,127
May-18	1,429,917	May-19	1,289,344	May-20	605,061	3,405,872	May-21	816,551		1,528,534
June-18	999,979	June-19	559,288	June-20	562,725		June-21	939,092		1,455,892
July-18	4,525,796	July-19	1,576,072	July-20	521,080	78,499	July-21			
August-18	924,838	August-19	346,302	August-20	611,529		August-21			
September-18	1,228,910	September-19	876,966	September-20	785,446		September-21			
October-18	1,101,494	October-19	1,148,666	October-20	1,168,624	11,577	October-21			
November-18	1,140,874	November-19	957,993	November-20	836,014		November-21			
December-18	458,871	December-19	1,500,316	December-20	1,940,134		December-21			
					10,425,338	4,274,873		4,897,976	49,461	7,017,724
Subtotal FY 2018	15,276,562	Subtotal FY 2019	11,571,384	Subtotal FY 2020	14,700,211		Subtotal FY 2021	4,947,438		

Mangum Regional Medical Center
Medicare Payables by Year
July 27, 2021 Board Meeting

Year	Original Loan Balance	Balance as of 06/30/21	Total Interest Paid as of 06/30/2021
2016 C/R Settlement	1,397,906.00	-	205,415.96
2017 Interim Rate Review - 1st	723,483.00	-	149,425.59
2017 Interim Rate Review - 2nd	122,295.00	-	20,332.88
2017 6/30/17-C/R Settlement *Estimate*	1,614,760.00	1,614,760.00	-
2017 12/31/17-C/R Settlement *Estimate*	(535,974.00)	(535,974.00)	-
2017 C/R Settlement Overpayment *Estimate*	3,539,982.21	3,539,982.21	-
2018 C/R Settlement	1,870,870.00	302,816.67	225,233.12
2019 Interim Rate Review - 1st	323,765.00	-	5,637.03
2019 Interim Rate Review - 2nd	1,802,867.00	861,127.78	214,432.87
2019 C/R Settlement	(967,967.00)	-	-
2020 C/R Settlement *8/31 Est. Receivable per C/R tool*	(1,815,759.00)	-	-
FY21 MCR pay (rec) estimate		**(167,365.63)**	
Total	**8,076,228.21**	**5,615,347.03**	**820,477.45**

Mangum Regional Medical Center
Statement of Revenue and Expense
For The Month and Year To Date Ended Jun 30, 2021
Unaudited

MTD				YTD		
Actual	Prior Year	Prior Yr Variance		Actual	Prior Year	Prior Yr Variance
264,350	154,409	109,941	Inpatient revenue	1,346,737	958,676	388,062
779,732	1,012,643	(232,910)	Swing Bed revenue	5,267,647	6,496,484	(1,228,837)
903,041	472,711	430,330	Outpatient revenue	4,274,632	3,126,918	1,147,715
14,614	128,778	(114,163)	Professional revenue	177,313	867,397	(690,084)
1,961,737	1,768,541	193,197	Total patient revenue	11,066,330	11,449,474	(383,144)
756,661	913,633	(156,972)	Contractual adjustments	3,874,179	5,395,374	(1,521,195)
(17,366)	-	(17,366)	Contractual adjustments: MCR Settlement	(167,366)	(791,984)	624,618
69,820	2,681	67,139	Bad debts	1,008,765	1,334,125	(325,361)
809,116	916,315	(107,199)	Total deductions from revenue	4,715,578	5,937,516	(1,221,937)
1,152,621	852,226	300,395	Net patient revenue	6,350,752	5,511,958	838,793
2,933,760	1,005	2,932,755	Other operating revenue	3,656,974	20,568	3,636,406
4,086,381	853,231	3,233,150	Total operating revenue	10,007,726	5,532,527	4,475,199
			Expenses			
380,185	358,110	22,075	Salaries and benefits	2,477,369	2,286,651	190,718
151,768	157,070	(5,303)	Professional Fees	750,304	936,594	(186,291)
300,005	270,408	29,597	Contract labor	1,442,338	1,217,532	224,806
110,787	84,769	26,018	Purchased/Contract services	424,786	461,943	(37,157)
225,000	225,000	-	Management expense	1,350,000	1,482,132	(132,132)
103,373	100,530	2,843	Supplies expense	631,236	507,401	123,835
17,004	21,195	(4,191)	Rental expense	111,347	136,570	(25,224)
21,026	13,826	7,199	Utilities	80,322	83,587	(3,265)
(300)	419	(719)	Travel & Meals	1,330	2,528	(1,198)
5,587	5,554	33	Repairs and Maintnenance	26,776	22,987	3,790
10,798	11,039	(241)	Insurance expense	68,730	64,860	3,870
43,092	38,727	4,364	Other Expense	262,341	292,948	(30,607)
1,368,324	1,286,649	81,675	Total expense	7,626,880	7,495,735	131,146
2,718,057	(433,418)	3,151,475	EBIDA	2,380,846	(1,963,208)	4,344,054
66.5%	-50.8%	117.3%	EBIDA as percent of net revenue	23.8%	-35.5%	59.3%
12,118	35,020	(22,902)	Interest	78,003	227,897	(149,894)
25,083	24,748	335	Depreciation	150,497	148,487	2,010
2,680,856	(493,185)	3,174,042	Operating margin	2,152,346	(2,339,592)	4,491,938
-	-	-	Other	-	-	-
-	-	-	Total other nonoperating income	-	-	-
2,680,856	(493,185)	3,174,042	Excess (Deficiency) of Revenue Over Expenses	2,152,346	(2,339,592)	4,491,938
65.60%	-57.80%	123.41%	Operating Margin %	21.51%	-42.29%	63.79%

Mangum Regional Medical Center
Statement of Revenue and Expense Trend - Unaudited
Fiscal Year 2021

	January	February	March	April	May	June	YTD
Inpatient revenue	257,967	260,085	107,948	212,813	243,574	264,350	1,346,737
Swing Bed revenue	448,245	990,856	910,210	1,051,745	1,086,859	779,732	5,267,647
Outpatient revenue	478,855	662,455	779,486	785,365	665,431	903,041	4,274,632
Professional revenue	110,525	20,140	2,828	14,261	14,946	14,614	177,313
Total patient revenue	1,295,592	1,933,535	1,800,472	2,064,184	2,010,810	1,961,737	11,066,330
Contractual adjustments	204,983	908,030	589,844	905,284	509,376	756,661	3,874,179
Contractual adjustments: MCR Settlement	(150,000)	-	-	-	-	(17,366)	(167,366)
Bad debts	211,971	121,036	100,979	2,665	502,293	69,820	1,008,765
Total deductions from revenue	266,954	1,029,066	690,823	907,950	1,011,669	809,116	4,715,578
Net patient revenue	1,028,638	904,469	1,109,649	1,156,234	999,141	1,152,621	6,350,752
Other operating revenue	55,095	59,867	342	(4,132)	612,043	2,933,760	3,656,974
Total operating revenue	1,083,732	964,336	1,109,991	1,152,102	1,611,183	4,086,381	10,007,726
	77.2%	79.2%	87.8%	84.9%	73.9%	82.0%	80.8%
Expenses							
Salaries and benefits	368,755	344,011	414,777	476,597	493,043	380,185	2,477,369
Professional Fees	112,344	140,725	100,926	127,933	116,608	151,768	750,304
Contract labor	274,135	192,165	197,257	246,672	232,105	300,005	1,442,338
Purchased/Contract services	102,240	62,920	41,721	52,265	54,853	110,787	424,786
Management expense	225,000	225,000	225,000	225,000	225,000	225,000	1,350,000
Supplies expense	137,287	62,321	122,172	103,022	103,061	103,373	631,236
Rental expense	16,781	19,756	21,845	19,441	16,519	17,004	111,347
Utilities	12,796	9,506	16,688	13,033	7,273	21,026	80,322
Travel & Meals	335	353	325	318	300	(300)	1,330
Repairs and Maintnenance	4,529	2,278	2,965	1,034	10,383	5,587	26,776
Insurance expense	11,660	11,660	11,660	11,660	11,290	10,798	68,730
Other	22,501	32,969	70,971	47,424	45,385	43,092	262,341
Total expense	1,288,365	1,103,665	1,226,308	1,324,400	1,315,819	1,368,324	7,626,880
EBIDA	$ (204,632)	$ (139,329)	$ (116,316)	$ (172,298)	$ 295,364	$ 2,718,057	$ 2,380,846
EBIDA as percent of net revenue	-18.9%	-14.4%	-10.5%	-15.0%	18.3%	66.5%	23.8%
Interest	18,617	12,779	12,002	11,909	10,578	12,118	78,003
Depreciation	25,083	25,083	25,083	25,083	25,083	25,083	150,497
Operating margin	$ (248,332)	$ (177,191)	$ (153,401)	$ (209,290)	$ 259,703	$ 2,680,856	$ 2,152,346
Other	-	-	-	-	-	-	-
Total other nonoperating income	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Excess (Deficiency) of Revenue Over Expenses	(248,332)	(177,191)	(153,401)	(209,290)	259,703	2,680,856	2,152,346
Operating Margin % (excluding other misc. revenue)	-22.91%	-18.37%	-13.82%	-18.17%	16.12%	65.60%	21.51%

MANGUM REGIONAL MEDICAL CENTER
BALANCE SHEET

	6/30/21	5/31/21	4/30/21	3/31/21	2/28/21	1/31/21	12/31/20
	Unaudited	Unaudited	Unaudited	Unaudited	Unaudited	Unaudited	Unaudited
CASH AND CASH EQUIVALENTS	109,864.25	184,659.89	285,067.57	498,072.47	578,873.27	1,384,085.42	1,193,977.29
RESERVED FUNDS	2,483,182.16	2,878,663.72	3,489,308.23	3,533,651.15	3,484,189.73	3,542,240.97	3,597,082.63
PATIENT ACCOUNTS RECEIVABLE, NE	2,641,396.70	2,477,835.66	2,292,322.54	2,014,423.05	1,816,369.66	1,636,677.73	1,704,448.97
INVENTORY	65,950.94	74,565.82	80,891.02	83,959.77	73,065.29	73,029.52	69,909.34
PREPAIDS AND OTHER ASSETS	1,000,083.50	934,266.55	1,054,976.63	1,008,028.04	993,574.83	1,015,984.57	1,034,287.86
CAPITAL ASSETS, NET	3,377,016.14	1,118,781.23	1,128,864.08	1,153,946.93	1,179,029.78	1,204,112.63	1,229,195.48
Total Assets	9,677,493.69	7,668,772.87	8,331,430.07	8,292,081.41	8,125,102.56	8,856,130.84	8,828,901.57
ACCOUNTS PAYABLE	15,737,863.31	13,429,014.92	13,701,892.06	13,332,696.81	12,882,642.44	13,246,846.97	12,627,653.51
DUE TO MEDICARE	5,615,347.03	5,691,819.93	5,677,195.90	5,799,345.33	5,906,147.58	6,011,350.38	6,260,875.37
COVID GRANT FUNDS	-	2,878,663.72	3,489,308.23	3,484,189.73	3,484,189.73	3,542,240.97	3,597,082.63
DUE TO COHESIVE - PPP LOANS	-	-	-	-	-	-	-
NOTES PAYABLE - COHESIVE	242,500.00	242,500.00	242,500.00	242,500.00	242,500.00	242,500.00	242,500.00
NOTES PAYABLE - OTHER	320,893.77	343,765.77	389,509.77	389,509.77	412,381.77	435,253.77	471,032.37
ALLIANTZ LINE OF CREDIT	-	-	-	-	-	-	-
LEASES PAYABLE	345,038.22	348,013.32	355,732.26	359,258.09	359,258.09	362,764.67	366,252.10
Total Liabilities	22,261,642.33	22,933,777.66	23,856,138.22	23,607,499.73	23,287,119.61	23,840,956.76	23,565,395.98
NET ASSETS	(12,584,148.64)	(15,265,004.79)	(15,524,708.15)	(15,315,418.32)	(15,162,017.05)	(14,984,825.92)	(14,736,494.41)
Total Liablities and Net Asset	9,677,493.69	7,668,772.87	8,331,430.07	8,292,081.41	8,125,102.56	8,856,130.84	8,828,901.57
	-	-	0.00	-	-	-	-

MANGUM REGIONAL MEDICAL CENTER
OPERATING STATEMENT

	6/30/21	5/31/21	4/30/21	3/31/21	2/28/21	1/31/21	12/31/20
	Unaudited	Unaudited	Unaudited	Unaudited	Unaudited	Unaudited	Unaudited
Inpatient revenue	1,346,737.49	1,082,387.62	838,813.41	626,000.22	518,051.97	257,967.41	2,230,761.99
Swing Bed revenue	5,267,647.12	4,487,914.74	3,401,056.19	2,349,311.15	1,439,100.88	448,244.89	11,519,484.90
Outpatient revenue	4,274,632.44	3,371,591.87	2,706,160.67	1,920,795.96	1,141,309.97	478,855.29	6,754,385.45
Professional revenue	177,313.07	162,698.60	147,753.00	133,492.37	130,664.42	110,524.58	1,708,155.05
Contractual adjustments	(3,874,179.37)	(3,117,517.89)	(2,608,141.89)	(1,702,857.47)	(1,113,013.70)	(204,983.25)	(9,181,056.04)
Contractual adjustments: MCR Settler	167,365.63	150,000.00	150,000.00	150,000.00	150,000.00	150,000.00	1,811,951.00
Bad debts	(1,008,764.69)	(938,944.37)	(436,651.42)	(433,986.34)	(333,007.11)	(211,971.13)	(2,714,251.14)
Net patient revenue	6,350,751.68	5,198,130.57	4,198,989.96	3,042,755.89	1,933,106.43	1,028,637.79	12,129,431.21
	80.85%	80.59%	82.36%	81.42%	78.15%	77.22%	77.24%
Other operating revenue	3,656,974.30	723,214.50	111,171.99	115,303.69	114,961.72	55,094.66	718,289.40
Salaries and benefits	2,477,369.03	2,097,184.13	1,604,141.46	1,127,544.00	712,766.60	368,755.41	4,530,484.70
Professional Fees	750,303.62	598,536.10	481,927.86	353,995.13	253,069.49	112,344.12	1,794,618.71
Contract labor	1,442,338.34	1,142,333.82	910,228.91	663,557.02	466,299.67	274,134.56	2,517,076.33
Purchased/Contract services	424,786.41	313,999.80	259,146.66	206,881.52	165,160.62	102,240.34	1,035,762.12
Management expense	1,350,000.00	1,125,000.00	900,000.00	675,000.00	450,000.00	225,000.00	2,832,132.00
Supplies expense	631,236.17	527,863.04	424,802.38	321,780.12	199,608.24	137,287.44	1,154,108.08
Rental expense	111,346.55	94,342.37	77,823.50	58,382.11	36,537.14	16,781.32	294,967.40
Utilities	80,321.98	59,296.44	52,023.04	38,989.82	22,302.09	12,796.14	170,793.30
Travel & Meals	1,330.25	1,630.25	1,330.25	1,012.68	687.28	334.71	3,976.25
Repairs and Maintnenance	26,776.41	21,189.27	10,806.51	9,772.51	6,807.31	4,528.92	38,981.08
Insurance expense	68,730.09	57,931.64	46,641.84	34,981.38	23,320.92	11,660.46	131,981.68
Other Expense	262,341.38	219,249.56	173,864.95	126,440.71	55,469.99	22,501.08	492,975.99
Interest	78,002.88	65,884.78	55,306.93	43,397.94	31,395.74	18,616.61	408,329.87
Depreciation	150,497.10	125,414.25	100,331.40	75,248.55	50,165.70	25,082.85	298,043.62
TOTAL EXPENSES	7,855,380.21	6,449,855.45	5,098,375.69	3,736,983.49	2,473,590.79	1,332,063.96	15,704,231.13
Change in Net Assets	2,152,345.77	(528,510.38)	(788,213.74)	(578,923.91)	(425,522.64)	(248,331.51)	(2,856,510.52)
Net Assets, Beginning of Yea	(14,736,494.41)	(14,736,494.41)	(14,736,494.41)	(14,736,494.41)	(14,736,494.41)	(14,736,494.41)	(11,879,983.89)
Net Assets, End of Period	(12,584,148.64)	(15,265,004.79)	(15,524,708.15)	(15,315,418.32)	(15,162,017.05)	(14,984,825.92)	(14,736,494.41)
	0.00	0.00	0.00	0.00	0.00	0.00	0.00

MRMC AP AGING SUMMARY
For Month Ending
6/30/2021

VENDOR - Under Litagation	Description	0-30	31-60	61-90	Over 90	6/30/2021	5/31/2021	4/30/2021
ADP INC	QMI Payroll Service Provider				4,276.42	4,276.42	4,276.42	4,276.42
ADP SCREENING AND SELECTION	QMI Payroll Service Provider				1,120.00	1,120.00	1,120.00	1,120.00
ALLIANCE HEALTH SOUTHWEST OKLA	Old Mgmt Fees				698,000.00	698,000.00	698,000.00	698,000.00
ELISE ALDUINO	1099 consultant				12,000.00	12,000.00	12,000.00	12,000.00
HEADRICK OUTDOOR MEDIA INC	Advertising				25,650.00	25,650.00	25,650.00	25,650.00
MEDSURG CONSULTING LLC	Equipment Rental Agreement				98,670.36	98,670.36	98,670.36	98,670.36
QUARTZ MOUNTAIN RESORT	Alliance Travel				9,514.95	9,514.95	9,514.95	9,514.95
SUBTOTAL-Vendor Under Litagation		-	-	-	**849,231.73**	**849,231.73**	**849,231.73**	**849,231.73**
VENDOR	**Description**	**0-30**	**31-60**	**61-90**	**Over 90**	**6/30/2021**	**5/31/2021**	**4/30/2021**
AAA PORTABLE TOILETS	Emergency purch svs			-		-	-	-
ABC BIOMEDICAL	IV Pump rental		-			-	2,025.00	2,025.00
ADCRAFT SIGNS OF MANGUM	Supplies	108.90				108.90	-	-
ADVANCE ALARMS INC	Monitor system	-				-	3,089.00	-
ALCO SALES & SERVICE CO	Supplies	181.07				181.07	-	-
ALPHA TECHNICS	Lab eq repair		-			-	-	-
AMBS CALL CENTER	Hotline		-			-	-	-
AMERICAN HEALTH TECH	Rental Equipment-Old				22,025.36	22,025.36	22,025.36	22,025.36
ANESTHESIA SERVICE INC	Service	3,081.44				3,081.44	776.19	4,566.82
APEX MEDICAL GAS SYSTEMS, INC	COVID Capital	176,716.80	900.00			177,616.80	-	-
ARAMARK	Linen Services	7,036.17				7,036.17	5,361.34	14,331.09
AT&T	Fax Service	-				-	-	2,793.54
AVANAN, INC.	COVID Capital	16,800.00				16,800.00	-	-
BAXTER HEALTHCARE	Pharmacy Supplies	-				-	-	3,090.72
BEC INTEGRATED	Nurse Call	-				-	-	-
BENISH AND ASSOCIATES	1099 Provider	-				-	-	-
BILLY WALKER CARPETS	Repairs/maintenance	-				-	-	-
BIO-RAD LABORATORIES INC	Lab Supplies	-				-	1,102.35	4,973.12
BLUESTREAM HEALTH, INC.	COVID Capital	12,000.00				12,000.00	-	-
C & C	Plant Ops supplies	-				-	-	-
C.R. BARD INC.	Surgery Supplies-Old				3,338.95	3,338.95	3,338.95	3,338.95
CANON FINANCIAL SERVICES INC	Ultrasound Lease	-				-	-	4,455.48
CARDINAL HEALTH 110, LLC	Pharmacy Supplies	-				-	(72,749.41)	29,654.55
CARRIER CORP	Repairs/maintenance	-				-	-	1,517.00
CENTERPOINT ENERGY ARKLA	Utilities	94.36				94.36	-	839.94
CINTAS CORPORATION #628	Linen Services	3,456.00	2,715.75	872.00		7,043.75	3,481.15	7,789.55
CITY OF MANGUM	Utilities	7,158.56				7,158.56	-	4,756.54
COHESIVE HEALTHCARE MGMT	Mgmt Fees	242,475.53	235,549.49	250,885.62	3,211,191.37	3,940,102.01	3,767,425.10	3,812,425.10
COHESIVE HEALTHCARE RESOURCES	Payroll	328,631.02	359,630.75	318,705.62	4,719,365.73	5,726,333.12	5,796,091.00	5,644,232.98
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service				-	-	-	2,323.50
COHESIVE REVOPS INTEGRATION	Billing Purch svs				-	-	-	40,461.29

VENDOR	Description	0-30	31-60	61-90	Over 90	6/30/2021	5/31/2021	4/30
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	51,233.54	6,927.32	25,829.62	1,376,220.13	1,460,210.61	1,496,549.91	1,634,679.45
COMMERCIAL MEDICAL ELECTRONICS	Quarterly Maintenance				-	-	-	-
COMPLIANCE CONSULTANTS	Lab Consultant				1,000.00	1,000.00	1,000.00	1,000.00
CONEXUS SOLUTIONS LLC	Agency Staffing	157,011.39	37,558.95			194,570.34	49,361.58	637,655.95
CONTEMPORARY HEALTHCARE SVCS	1099 Provider				-	-	-	-
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees				-	-	-	3,780.00
CPSI	EHR Software			31,900.40		31,900.40	-	276.00
CRITICAL ALERT	COVID Capital	160,132.00				160,132.00	-	-
CULLIGAN WATER CONDITIONING	Clinic Purchased Service	12.00				12.00	-	43.00
DAN'S HEATING & AIR CONDITIONI	COVID Capital	13,325.53				13,325.53	-	-
DELL INC	COVID Capital	18,155.86				18,155.86	-	-
DOBSON TECHNOLOGIES TRANSPORT	Internet				-	-	-	1,809.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	17,348.17		3,497.16	295,780.10	316,625.43	279,837.74	279,837.74
DONNA MCKELVEY	Employee Reimbursement				-	-	-	154.73
DR W. GREGORY MORGAN III	1099 Provider	4,766.67				4,766.67	-	-
DR. JOHN CHIAFFIETELLI	1099 Provider				-	-	-	-
F1 INFORMATION TECHNOLOGIES IN	IT Support Services				-	-	2,928.00	8,784.00
FEDEX	Postage service		24.86			24.86	-	86.65
FIRE EXTINGUISHER SALES & SERV	Plant Ops repair/maint				-	-	-	1,034.00
FIRST HEALTHCARE PRODUCTS INC	COVID Capital	7,543.00				7,543.00	-	-
FIRST NATIONAL BANK OF VINITA	premium financing				-	-	-	15,026.92
FOX BUILDING SUPPLY	Plant Ops supplies				-	-	-	-
GE PRECISION HEALTHCARE LLC	COVID Capital	971,647.76				971,647.76	-	-
GEORGE BROS TERMITE & PEST CON	Pest Control Service				-	-	-	155.00
GERAINT HARRIS	1099 Provider				-	-	-	-
GLOBAL EQUIPMENT COMPANY INC.	Minor Equipment				-	-	-	247.85
GLOBAL PAYMENTS INTEGRATED	CC processing svs	956.74				956.74	-	-
GRAINGER	Maintenance Supplies	265.06	198.12			463.18	-	-
GRAYSTONE MEDIA GROUP	Advertising				-	-	-	-
GREER COUNTY TREASURER	Property taxes				-	-	-	5,460.50
HAC INC	Dietary Supplies				-	-	329.25	223.49
HAMILTON MEDICAL INC.	Ventilator Supplies				-	-	-	-
HEALTH CARE LOGISTICS	Pharmacy Supplies	615.18	36.39			651.57	-	-
HEALTHSTREAM	Employee Training Puchased Service	841.75				841.75	-	-
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	1,000.00	2,059.69		1,000.00	4,059.69	-	-
HENGST PRINTING	Pharmacy Supplies				-	-	-	-
HENRY SCHEIN	Lab Supplies	4,466.01				4,466.01	-	13,559.97
HERC RENTALS INC	Old Rental Service				7,653.03	7,653.03	7,653.03	7,653.03
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	-				-	-	-
ICU MEDICAL SALES INC.	COVID Capital	70,983.93				70,983.93	-	-
IMEDICAL INC	Supplies				1,008.29	1,008.29	1,008.29	1,008.29
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	167.70	55.90	55.90		279.50	83.85	55.90
INSIGHT DIRECT USA INC.	COVID Capital	26,284.05				26,284.05	-	-
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	1,666.04				1,666.04	657.56	2,188.78

VENDOR	Description	0-30	31-60	61-90	Over 90	6/30/2021	5/31/2021	4/30
JNP MEDICAL SERVICES LLC	1099 Provider				-	-	-	-
KAY ELECTRIC	Repairs/maintenance				-	-	-	-
KCI USA	Supplies				9,184.67	9,184.67	9,184.67	9,184.67
KNOWBE4	COVID Capital	11,938.20				11,938.20	-	-
LABCORP	Lab purch svs				-	-	9,684.55	35,054.71
LAMPTON WELDING SUPPLY	Supplies	3,285.65				3,285.65	-	1,223.81
LINET AMERICAS, INC.	COVID Capital	15,066.00				15,066.00	-	-
LOCKE SUPPLY	Plant Ops supplies	516.63				516.63	94.73	94.73
LOWES	Supplies	1,279.11				1,279.11	-	-
LYNDA JAMES	Employee Reimbursement				-	-	67.84	-
MARK CHAPMAN	Employe Reimbursement				-	-	940.38	-
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	5,791.34	-	-		5,791.34	21,865.27	33,426.12
MEDLINE INDUSTRIES	Patient Care Supplies	8,740.73	7,706.42			16,447.15	19,518.43	39,716.52
MEDTOX DIAGNOSTICS, INC	Lab Supplies				-	-	-	1,500.00
MICROSURGICAL MST	Surgery Supplies				2,233.80	2,233.80	2,233.80	2,233.80
MID-AMERICA SURGICAL SYSTEMS	Surgery Supplies				3,607.60	3,607.60	3,607.60	3,607.60
MIMEDX GROUP, INC	Wound Care Supplies				-	-	-	2,789.00
MONARCH BROADCASTING	Advertising				-	-	-	180.00
NASCO EDUCATION LLC	COVID Capital	5,098.00				5,098.00	-	-
NATIONAL RECALL ALERT CENTER	Materials Purch svs		-			-	1,190.00	1,190.00
NEXTIVA, INC.	Phones	1,898.99			1,882.19	3,781.18	-	1,882.19
NINJA RMM	IT Service				2,625.00	2,625.00	2,625.00	2,625.00
NUSTEP LLC	COVID Capital		4,439.00			4,439.00	-	-
OHA INSURANCE AGENCY INC	Facility insurance				-	-	-	-
OK STATE BOARD OF PHARMACY	Licensure	40.00				40.00	-	-
OKLAHOMA BLOOD INSTITUTE	Lab Supplies	505.20				505.20	3,955.80	4,789.80
OKLAHOMA ELECTRICAL SUPPLY CO	COVID Capital	11,870.00				11,870.00	-	-
OKLAHOMA HOSPITAL ASSOCIATION	OHA dues				-	-	-	11,989.17
PAGE CONCEPTS, INC.	COVID Capital		46,443.60			46,443.60	-	-
PARA HEALTHCARE ANALYTICS, LLC	CMD Review	1,959.00	1,959.00	2,325.00	6,375.00	12,618.00	-	-
PHILIPS HEALTHCARE	Supplies				-	-	-	-
PHYSICIANS RECORDS COMPANY	Supplies				-	-	-	-
PITNEY BOWES GLOBAL FINANCIAL	Postage rental	347.00				347.00	-	347.00
PORT53 TECHNOLOGIES, INC.	COVID Capital	45,456.00				45,456.00	-	-
PRESS GANEY ASSOCIATES, INC	Purchased Service				-	-	2,048.28	2,048.28
RAMSEY AND GRAY, PC	Legal Fees				14,280.00	14,280.00	26,700.00	28,050.00
REYES ELECTRIC LLC	Repairs/maintenance	75,000.00				75,000.00	8,750.00	8,750.00
RUSSELL ELECTRIC & SECURITY	Repair and Maintenance	262.50				262.50	-	-
SBM MOBILE PRACTICE, INC	1099 Provider				-	-	-	-
SCHAPEN LLC	Clinic Rent	1,750.00				1,750.00	-	-
SCRUBS AND SPORTS	Employee Appreciation		62.77			62.77	-	-
SHRED-IT USA LLC	Secure Doc disposal service	247.75	125.65	124.03		497.43	436.14	555.42
SIEMENS HEALTHCARE DIAGNOSTICS	Service Contract				-	-	-	-
SIZEWISE	Swing bed purch service	210.24				210.24	735.84	315.36

VENDOR	Description	0-30	31-60	61-90	Over 90	6/30/2021	5/31/2021	4/30
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider				-	-	1,735.00	5,205.00
SOUTHWEST HOT STEAM CLEANING	Dietary Purchased Service	-				-	300.00	-
SPACELABS HEALTHCARE LLC	COVID Capital		319,546.15			319,546.15	-	-
SPARKLIGHT BUSINESS	Cable service	50.87			-	50.87	329.50	566.18
STANDLEY	Printer lease	36.12				36.12	-	-
STANDLEY SYSTEMS LLC	Printer lease				-	-	-	4,858.51
STAPLES ADVANTAGE	Office Supplies	437.73				437.73	706.90	822.52
STERICYCLE ENVIRONMENTAL SOLUT	Waste Disposal Service				-	-	-	5,839.00
STERICYCLE INC	Waste Disposal Service	3,241.58				3,241.58	4,534.94	3,329.00
STRYKER INSTRUMENTS	Surgery Supplies				31,845.65	31,845.65	31,845.65	31,845.65
STRYKER SALES CORPORATION	COVID Capital	15,723.68				15,723.68	-	-
SUNBELT RENTALS	Air Scrubber Rental - COVID				196.93	196.93	196.93	196.93
SYSMEX AMERICA INC	Lab eq svs contract				-	-	-	-
T & S LAWN SERVICES	Plant Ops purch svs				-	-	-	850.00
TECUMSEH OXYGEN & MEDICAL SUPP	Patient Supplies				-	-	-	1,500.00
TELEFLEX	Supplies				-	-	-	3,384.35
THE COMPLIANCE TEAM	Clinic Survey				2,190.00	2,190.00	2,190.00	2,190.00
TOPJET SALES, INC	Pharmacy purch svs				-	-	-	195.00
TOTAL MEDICAL PERSONNEL STAFF.	Agency Staffing	10,554.39	2,857.80			13,412.19	2,898.39	14,968.69
TOUCHPOINT MEDICAL, INC	Med Dispense Monitor Support	69,537.00				69,537.00	-	1,095.00
TSYS	CC processing svs	-	-		-	-	1,402.38	407.29
TYTOCARE INC.	COVID Capital	91,569.32				91,569.32	-	-
ULINE	COVID Minor Eq				-	-	-	248.28
ULTIMATE IT GUY LLC	Minor Eq				-	-	-	1,499.98
ULTRA-CHEM INC	Housekeeping Supplies	240.17				240.17	-	223.90
UMPQUA BANK VENDOR FINANCE	Lab Equipment				-	-	-	-
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	3,753.84	1,668.54	5,587.92	20.71	11,031.01	7,277.17	11,119.47
US MED-EQUIP LLC	Swing bed eq rental	8,823.14				8,823.14	-	6,186.51
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service			1,710.00		1,710.00	10,260.00	12,825.00
WELCH ALLYN, INC.	Supplies				(628.66)	(628.66)	(628.66)	(628.66)
WESTERN COMMERCE BANK (OHA INS	Insurance						-	-
WOLTERS KLUWER HEALTH	Clinical Education				-	-	4,866.00	4,866.00
MATT MONROE	Rent	850.00				850.00	-	-
Vendor Subtotal		**2,702,242.41**	**1,030,466.15**	**641,493.27**	**9,712,395.85**	**14,086,597.68**	**11,552,927.77**	**12,525,467.56**
Grand Total		**2,702,242.41**	**1,030,466.15**	**641,493.27**	**10,561,627.58**	**14,935,829.41**	**12,402,159.50**	**13,374,699.29**
					Conversion Variance	(13,340.32)	(13,340.32)	(463,900.48)
					AP Control	14,922,489.09	12,388,819.18	12,910,798.81
					Accrued AP	769,374.22	1,040,195.74	791,093.25
					TOTAL AP	**15,691,863.31**	**13,429,014.92**	**13,701,892.06**

Mangum Regional Medical Center
Claims List
June 2021

Check#	Ck Date	Amount	Paid To	Expense Description
15799	6/3/2021	2,025.00	ABC BIOMEDICAL	IV Pumps Rental
15852	6/17/2021	3,089.00	ADVANCE ALARMS INC	Monitoring system
15853	6/17/2021	19.00	AMBS CALL CENTER	Hotline
15800	6/3/2021	776.19	ANESTHESIA SERVICE INC	Telemetry sensors
15801	6/3/2021	3,493.30	ARAMARK	Linens - purch svs
15867	6/22/2021	1,868.04	ARAMARK	Linens - purch svs
15889	6/30/2021	5,380.11	ARAMARK	Linens - purch svs
15854	6/17/2021	3,079.13	AT&T	Fax lines
15868	6/22/2021	2,990.44	AT&T	Fax lines
15855	6/17/2021	6,405.23	BAXTER HEALTHCARE	Pharmacy Supplies
15890	6/30/2021	457.94	BAXTER HEALTHCARE	Pharmacy Supplies
15891	6/30/2021	16,000.00	BENISH AND ASSOCIATES	1099 Provider
15826	6/11/2021	1,102.35	BIO-RAD LABORATORIES INC	Lab supplies
15856	6/17/2021	2,881.34	BIO-RAD LABORATORIES INC	Lab supplies
15802	6/3/2021	1,950.00	BLUTH FAMILY MEDICINE, LLC	RHC provider
15806	6/3/2021	14,654.55	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
15857	6/17/2021	45,964.64	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
15894	6/30/2021	15,022.59	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
901058	6/18/2021	1,384.36	CENTERPOINT ENERGY ARKLA	Gas
15807	6/3/2021	831.90	CINTAS CORPORATION #628	Linen Service
15827	6/11/2021	2,649.25	CINTAS CORPORATION #628	Linen Service
15828	6/11/2021	4,629.31	CITY OF MANGUM	Utilities
15895	6/30/2021	250.00	CITY OF MANGUM	Utilities
15829	6/11/2021	30,000.00	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15869	6/22/2021	2,312.05	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15896	6/30/2021	48,036.06	COHESIVE HEALTHCARE MGMT	Mgmt and Provider Services
15830	6/11/2021	202,445.40	COHESIVE HEALTHCARE RESOURCES	Payroll Staffing
15870	6/22/2021	174,741.30	COHESIVE HEALTHCARE RESOURCES	Payroll Staffing
15897	6/30/2021	1,838.50	COHESIVE MEDIRYDE LLC	Swing bed purchase service
15871	6/22/2021	42,476.43	COHESIVE REVOPS INTEGRATION	Billing purch svs
15872	6/22/2021	68,165.59	COHESIVE STAFFING SOLUTIONS	Agency staffing
15898	6/30/2021	26,334.57	COHESIVE STAFFING SOLUTIONS	Agency staffing
15880	6/22/2021	256,625.27	CONEXUS SOLUTIONS LLC	Agency staffing
15831	6/11/2021	9,600.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
15881	6/22/2021	9,200.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
15882	6/22/2021	38,226.50	CPSI	EHR monthly support
15899	6/30/2021	23,596.00	CPSI	EHR monthly support
15900	6/30/2021	31.00	CULLIGAN WATER CONDITIONING	RHC purch svs
15883	6/22/2021	91,891.93	DELL INC	COVID Capital
15901	6/30/2021	1,809.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
15858	6/17/2021	16,016.78	DOERNER SAUNDERS DANIEL ANDERS	Legal Fees
15808	6/3/2021	4,766.67	DR W. GREGORY MORGAN III	1099 Provider
15832	6/11/2021	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider

Check#	Ck Date	Amount	Paid To	Expense Description
15884	6/22/2021	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15809	6/3/2021	2,928.00	F1 INFORMATION TECHNOLOGIES IN	Software license
15902	6/30/2021	66.23	FEDEX	Postage
15925	6/30/2021	250.00	GEORGE BROS TERMITE & PEST CON	plant ops purch svs
15885	6/22/2021	4,320.00	GERAINT HARRIS	1099 Provider
901048	6/30/2021	995.09	GLOBAL PAYMENTS INTEGRATED	CC processing
901053	6/10/2021	759.33	GLOBAL PAYMENTS INTEGRATED	CC processing
901034	6/30/2021	583.35	GLOBAL PAYMENTS INTEGRATED	CC processing
15903	6/30/2021	368.43	GRAINGER	Supplies
15833	6/11/2021	20.00	GRAYSTONE MEDIA GROUP	advertising
15810	6/3/2021	329.25	HAC INC	Dietary food
15812	6/3/2021	4,136.04	HENRY SCHEIN	Lab supplies
15905	6/30/2021	2,830.96	HILL-ROM COMPANY, INC	COVID equipment
15834	6/11/2021	3,053.75	HOLEMAN MEDIATION	Legal Fees
901050	6/2/2021	9,805.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease
15835	6/11/2021	83.85	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
15836	6/11/2021	1,290.82	JANUS SUPPLY CO	Cleaning Supplies
15906	6/30/2021	84.00	KITTY JEANENE LEWIS	Employee reimbursement
15813	6/3/2021	9,684.55	LABCORP	Lab purch svs
15907	6/30/2021	5,800.48	LABCORP	Lab purch svs
15908	6/30/2021	909.80	LAMPTON WELDING SUPPLY	Patient Supplies
15814	6/3/2021	94.73	LOCKE SUPPLY	Supplies
15815	6/3/2021	67.84	LYNDA JAMES	Employee reimbursement
15816	6/3/2021	1,716.79	MARK CHAPMAN	Employee reimbursement
15859	6/17/2021	320.00	MARY BARNES, APRN	Training clinical
15838	6/11/2021	16,393.17	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901061	6/23/2021	15,651.99	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
901065	6/28/2021	19,608.52	MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies
15821	6/3/2021	13,633.77	MEDLINE INDUSTRIES	Patient Care Supplies
901032	6/30/2021	6.00	NATIONAL DATA BANK	Credentialing
901033	6/30/2021	12.00	NATIONAL DATA BANK	Credentialing
901041	6/30/2021	6.00	NATIONAL DATA BANK	Credentialing
901051	6/2/2021	28.00	NATIONAL DATA BANK	Credentialing
901054	6/10/2021	4.00	NATIONAL DATA BANK	Credentialing
901030	6/30/2021	54.00	NATIONAL DATA BANK	Credentialing
901038	6/30/2021	8.00	NATIONAL DATA BANK	Credentialing
901042	6/30/2021	6.00	NATIONAL DATA BANK	Credentialing
15909	6/30/2021	1,190.00	NATIONAL RECALL ALERT CENTER	Central Supply purch svs
15839	6/11/2021	1,892.23	NEXTIVA, INC.	Phone svs
15910	6/30/2021	1,903.34	NEXTIVA, INC.	Phone svs
15861	6/17/2021	1,722.00	NUANCE COMMUNICATIONS INC	RHC purch svs
901056	6/14/2021	60.00	OK STATE BOARD OF MED LICENSUR	Credentialing
15841	6/11/2021	40.00	OK STATE BOARD OF PHARMACY	Licensure
15911	6/30/2021	125.00	OK STATE DEPT OF HEALTH	Licensure
15842	6/11/2021	3,955.80	OKLAHOMA BLOOD INSTITUTE	blood bank
15912	6/30/2021	505.20	OKLAHOMA BLOOD INSTITUTE	blood bank

Check#	Ck Date	Amount	Paid To	Expense Description
15886	6/22/2021	75.00	OKLAHOMA DEPARTMENT OF LABOR	Licensure
901055	6/11/2021	6,186.67	PHILADELPHIA INSURANCE COMPANY	Property Insurance
15844	6/11/2021	2,048.28	PRESS GANEY ASSOCIATES, INC	Quality purch svs
15862	6/17/2021	12,420.00	RAMSEY AND GRAY, PC	Legal Fees
15822	6/3/2021	8,750.00	REYES ELECTRIC LLC	Emergency repair COVID
15845	6/11/2021	9,667.00	SBM MOBILE PRACTICE, INC	1099 Provider
15887	6/22/2021	10,800.00	SBM MOBILE PRACTICE, INC	1099 Provider
15846	6/11/2021	436.14	SHRED-IT USA LLC	Secure Doc disposal svs
15823	6/3/2021	735.84	SIZEWISE	Equipment rentals
15847	6/11/2021	1,735.00	SMAART MEDICAL SYSTEMS INC	smaart pac rental
15913	6/30/2021	1,735.00	SMAART MEDICAL SYSTEMS INC	smaart pac rental
15914	6/30/2021	300.00	SOUTHWEST HOT STEAM CLEANING	Dietary purch service
15824	6/3/2021	278.63	SPARKLIGHT BUSINESS	Cable Service
15888	6/22/2021	412.33	SPARKLIGHT BUSINESS	Cable Service
901059	6/18/2021	7,222.11	STANDLEY SYSTEMS LLC	printer lease
15825	6/3/2021	706.90	STAPLES ADVANTAGE	Office Supplies
15864	6/17/2021	1,497.04	STAPLES ADVANTAGE	Office Supplies
15915	6/30/2021	808.09	STAPLES ADVANTAGE	Office Supplies
15918	6/30/2021	7,639.94	STERICYCLE INC	Waste Disposal Service
15865	6/17/2021	1,800.00	TECUMSEH OXYGEN & MEDICAL SUPP	Patient purch svs
15848	6/11/2021	2,898.39	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15919	6/30/2021	8,532.92	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15920	6/30/2021	345.62	ULINE	Supplies
15921	6/30/2021	335.87	ULTRA-CHEM INC	Housekeeping supplies
15849	6/11/2021	4,722.39	UMPQUA BANK VENDOR FINANCE	Note Payable Lab Equipment
15922	6/30/2021	4,722.39	UMPQUA BANK VENDOR FINANCE	Note Payable Lab Equipment
901049	6/30/2021	6,653.59	US FOODSERVICE-OKLAHOMA CITY	Dietary Food
15850	6/11/2021	6,840.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
15923	6/30/2021	1,710.00	VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purchase service
901052	6/7/2021	7,102.92	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
901057	6/15/2021	357.05	WESTERN COMMERCE BANK (OHA INS	OHA Insurance
15851	6/11/2021	4,866.00	WOLTERS KLUWER HEALTH	Clinical education
	TOTAL	**1,455,891.90**		

MONTH TO DATE PAYMENTS

Jul-21

CKS	Date	Amount	Vendor	Description
15935	7/15/2021	19.00	AMBS CALL CENTER	Hotline
15936	7/15/2021	1,036.44	ANESTHESIA SERVICE INC	Telemetry sensors
15937	7/15/2021	900.00	APEX MEDICAL GAS SYSTEMS, INC	Facility Reports
15938	7/15/2021	1,838.22	ARAMARK	Linens - purch svs
15939	7/15/2021	12,000.00	BLUESTREAM HEALTH, INC.	COVID capital
15940	7/15/2021	15,000.00	CARDINAL HEALTH 110, LLC	Pharmacy Supplies
15941	7/15/2021	94.36	CENTERPOINT ENERGY ARKLA	Gas
15942	7/15/2021	3,587.75	CINTAS CORPORATION #628	Linen Service
15943	7/15/2021	7,158.56	CITY OF MANGUM	Utilities
15929	7/7/2021	173,770.16	COHESIVE HEALTHCARE RESOURCES	Payroll Staffing
15930	7/7/2021	9,050.00	CONTEMPORARY HEALTHCARE SVCS	1099 provider
15944	7/15/2021	31,900.40	CPSI	EHR monthly support
15945	7/15/2021	160,132.00	CRITICAL ALERT	COVID capital
15946	7/15/2021	18,155.86	DELL INC	COVID Capital
15947	7/15/2021	1,809.00	DOBSON TECHNOLOGIES TRANSPORT	Internet
15931	7/7/2021	4,766.67	DR W. GREGORY MORGAN III	1099 Provider
15932	7/7/2021	9,615.38	DR. JOHN CHIAFFIETELLI	1099 Provider
15948	7/15/2021	7,543.00	FIRST HEALTHCARE PRODUCTS INC	COVID capital
15949	7/15/2021	463.18	GRAINGER	Supplies
15950	7/15/2021	3,059.69	HEARTLAND PATHOLOGY CONSULTANT	Lab purch svs
901066	7/1/2021	9,805.00	HOSPITAL EQUIPMENT RENTAL COMP	Equipment Lease
15951	7/15/2021	167.70	IMPERIAL, LLC.-LAWTON	Dietary Purchased Svs
15952	7/15/2021	26,284.05	INSIGHT DIRECT USA INC.	COVID capital
15953	7/15/2021	593.88	JANUS SUPPLY CO	Cleaning Supplies
15954	7/15/2021	11,938.20	KNOWBE4	COVID capital
15955	7/15/2021	3,285.65	LAMPTON WELDING SUPPLY	Patient Supplies
15956	7/15/2021	948.09	MARY BARNES, APRN	Training clinical
15926	7/2/2021	850.00	MATT MONROE	Rent
15933	7/7/2021	5,884.66	MEDLINE INDUSTRIES	Patient Care Supplies
15957	7/15/2021	33.47	MELISSA TUNSTALL	employee reimbursement
901067	7/2/2021	26.00	NATIONAL DATA BANK	Credentialing
15958	7/15/2021	40.00	OK STATE BOARD OF PHARMACY	Licensure
15959	7/15/2021	11,870.00	OKLAHOMA ELECTRICAL SUPPLY CO	COVID capital
15960	7/15/2021	46,443.60	PAGE CONCEPTS, INC.	COVID capital
15961	7/15/2021	45,456.00	PORT53 TECHNOLOGIES, INC.	COVID capital
15962	7/15/2021	262.50	RUSSELL ELECTRIC & SECURITY	repair and maintenance
15934	7/7/2021	8,400.00	SBM MOBILE PRACTICE, INC	1099 Provider
* 015927	7/2/2021	1,750.00	SCHAPEN LLC	RHC rent
15963	7/15/2021	620.64	SHRED-IT USA LLC	Secure Doc disposal svs
15964	7/15/2021	319,546.15	SPACELABS HEALTHCARE LLC	COVID capital
15965	7/15/2021	3,241.58	STERICYCLE INC	Waste Disposal Service
15966	7/15/2021	10,806.07	TOTAL MEDICAL PERSONNEL STAFF.	Nurse staffing agency
15967	7/15/2021	69,537.00	TOUCHPOINT MEDICAL, INC	COVID capital
* 015968	7/15/2021	91,569.32	TYTOCARE INC.	COVID capital
	TOTAL	**1,131,259.23**		

Mangum Regional Medical Center
August 2021 Estimated Claims

Vendor	Description	Estimated Amount
ABC BIOMEDICAL	IV Pump rental	7,000.00
AMERISOURCE BERGEN	Pharmacy Supplies	50,000.00
ANESTHESIA SERVICE INC	Service	5,000.00
ARAMARK	Linens purch svs	16,200.00
AT&T	Fax Service	6,000.00
BAXTER HEALTHCARE	Pharmacy Supplies	10,000.00
BENISH AND ASSOCIATES	1099 Provider	32,000.00
BLUTH FAMILY MEDICINE	1099 Provider	5,000.00
CARDINAL 110 LLC	Pharmacy Supplies	100,000.00
CENTERPOINT ENERGY ARKLA	Utilities	3,000.00
CITY OF MANGUM	Utilities	10,000.00
COHESIVE HEALTHCARE MGMT	Mgmt and provider Fees	400,000.00
COHESIVE HEALTHCARE RESOURCES	Payroll	600,000.00
COHESIVE MEDIRYDE LLC	Mgmt Transportation Service	20,000.00
COHESIVE REVOPS	Billing purch svs	70,000.00
COHESIVE STAFFING SOLUTIONS	Mgmt Staffing Service	200,000.00
COMPLIANCE CONSULTANTS	Lab Consultant	1,000.00
CONEXUS SOLUTIONS LLC	Agency Staffing	150,000.00
CONTROL SOLUTIONS	Supplies	500.00
CORRY KENDALL, ATTORNEY AT LAW	Legal Fees	5,000.00
CPSI	EHR software	100,000.00
DOBSON TECHNOLOGIES TRANSPORT	Internet	3,700.00
DOERNER SAUNDERS DANIEL ANDERS	Legal Fees	25,000.00
DR RYAN MAJOR, MD	1099 Provider	20,000.00
DR. JOHN CHIAFFIETELLI	1099 Provider	28,848.00
DR. MORGAN	1099 Provider	4,766.00
F1 INFORMATION TECHNOLOGIES IN	IT Support Services	7,500.00
FEDEX	Postage	300.00
FOX BUILDING SUPPLY	Plant Ops Supplies	2,000.00
GEORGE BROS TERMITE & PEST CON	Pest Control Service	750.00
GERAINT HARRIS	1099 Provider	30,000.00
GLOBAL EQUIPMENT COMPANY INC.	Supplies	3,500.00
GRAINGER	Maintenance Supplies	3,500.00
HAC INC	Dietary Supplies	500.00
HAMILTON MEDICAL INC.	Ventilator supplies	3,500.00
HEARTLAND PATHOLOGY CONSULTANT	Lab Consultant	2,000.00
HENGST PRINTING	Pharmacy Supplies	500.00
HENRY SCHEIN	Lab Supplies	15,000.00
HOSPITAL EQUIPMENT RENTAL COMP	Equipment rental	9,805.00
IMPERIAL, LLC.-LAWTON	Dietary Purchased Service	500.00
JANUS SUPPLY CO	Housekeeping Supplies, based in Altus	2,500.00
KCI USA	Supplies	4,000.00
LABCORP	Lab purch svs	25,000.00
LAMPTON WELDING SUPPLY	Patient Supplies	4,000.00
LOCKE SUPPLY	Plant Ops Supplies	2,500.00
MATT MONROE	Rent	850.00
MCKESSON / PSS - DALLAS	Patient Care/Lab Supplies	45,000.00

Vendor	Description	Estimated Amount
MEDLINE INDUSTRIES	Patient Care Supplies	45,000.00
MEDTOX DIAGNOSTICS, INC	Lab supplies	3,000.00
MISC EMPLOYEE REIMBURSEMENTS	To reimburse employees for travel and suppl	5,000.00
NUANCE COMMUNICATIONS INC	Supplies	600.00
ORTHO-CLINICAL DIAGNOSTICS INC	Laboratory Supplies	1,000.00
PATIENT REFUNDS	Credits due to payors	15,000.00
PHILIPS HEALTHCARE	Supplies	1,000.00
PIPETTE COM	Supplies	500.00
PRESS GANEY ASSOCIATES, INC	Purchased Service	2,048.00
RAMSEY AND GRAY, PC	Legal Fees	10,000.00
SMB MOBILE PRACTICE INC.	1099 Provider	40,000.00
SCHAPEN LLC	RHC rent	1,750.00
SHRED-IT	Secure doc disposal	2,500.00
SIZEWISE	equipment rental	7,500.00
SMAART MEDICAL SYSTEMS INC	Radiology interface/Radiologist provider	1,750.00
SOUTHWEST HOT STEAM CLEANING	Dietary Puch svs	300.00
SPARKLIGHT BUSINESS	Cable service	1,000.00
STANDLEY	Printer Lease	500.00
STANDLEY SYSTEMS LLC	Printer Lease	5,000.00
STAPLES ADVANTAGE	Office Supplies	3,000.00
STERICYCLE INC	Waste Disposal svs	10,000.00
STRYKER INSTRUMENTS	Surgery Supplies	5,000.00
TECUMSEH OXYGEN & MEDICAL SUPP	Supplies	5,000.00
THE COMPLIANCE TEAM	RHC Consultant	2,190.00
TOTAL MEDICAL PERSONNEL STAFF.	agency staffing	15,000.00
TOUCHPOINT MEDICAL, INC	pharmacy purch svs	1,500.00
TSYS	CC processing service	3,000.00
UMPQUA	Lab Eq Note	5,000.00
US FOODSERVICE-OKLAHOMA CITY	Food and supplies	12,000.00
US MED-EQUIP LLC	Swing bed eq rental	15,000.00
VITAL SYSTEMS OF OKLAHOMA, INC	Swing bed purch service	10,000.00
WETERN COMMERCE BANK	Insurance	7,100.00
CONTEMPORARY HEALTHCARE SVCS	1099 Provider	40,000.00
TELEFLEX	Supplies	2,500.00
OK STATE BOARD	Credentialing	500.00
CINTAS CORPORATION #628	Supplies	8,500.00
BIO-RAD LABORATORIES INC	Supplies	3,500.00
AMBS CALL CENTER	Hotline	200.00
APEX	COVID Capital	180,000.00
LINET	COVID Capital	15,500.00
GE HEALTHCARE	COVID Capital	1,170,000.00
Reyes Electric	COVID Capital	75,000.00
Avanan, INC	COVID Capital	16,800.00
Universal Medical	COVID Capital	2,500.00
Stryker	COVID Capital	16,000.00
Stryker	Old Surgery Supplies	6,000.00
	TOTAL Estimate	**3,810,457.00**

BKD
CPAs & Advisors

110 N. Elgin Avenue, Suite 400 | Tulsa, OK 74120-1490
918.584.2900 | Fax 918.584.2931 | bkd.com

July 15, 2021

Mr. Carson VanZant, Board Chair
Mangum Regional Hospital
1 Wickersham Street
Mangum, OK 73554

We are pleased to confirm our engagement to prepare the Medicare cost report of MANGUM REGIONAL HOSPITAL for the year ended December 31, 2020.

Our Services and Responsibilities

While cost report preparation involves assembly of information in a financial statement format, that information is solely for cost report purposes and should not be used for any other purpose. Management is responsible for the representations contained in the cost reports. That responsibility includes posting any accounting entries determined to be needed as part of the cost report preparation process.

We will use information from your accounting system and will rely on information furnished by your employees and representatives. We will not investigate or verify the accuracy or completeness of such information. Our engagement is not designed to prevent or detect and cannot be relied upon to prevent or detect fraud, abusive acts, errors and omissions, including but not limited to:

- Nonallowable costs that you have not identified or that are misclassified or combined in another account
- Insufficient underlying documentation to support the information you have provided to us
- Billing errors, including coding errors, billing for noncovered services, and improper bundling or unbundling of charges
- Insufficient medical records documentation of physician orders, medical necessity of services, or performance of services
- Inappropriate physician arrangements, including payments for referrals or contracts that do not comply with the laws commonly known as the “Stark” or “anti-kickback” laws
- Misstatements that might exist due to fraudulent financial reporting or misappropriation of assets
- Failure to comply with the Medicare and Medicaid conditions of participation
- Failure to comply with the Internal Revenue Code and related regulations

- Related-party costs that you have not disclosed to us

Our engagement will include submission of the Medicare cost report to Novitas Solutions, Inc. (Novitas) on your behalf and we have your authorization to access and submit your Medicare cost report electronically using the Medicare Cost Report e-Filing (MCReF) portal. We will not make submissions to any other third parties on your behalf unless we are separately engaged to do so.

This engagement is not intended to evaluate the effectiveness of your controls over compliance with Medicare, Medicaid, IRS, or other laws or regulations or the degree of compliance with those laws or regulations. You agree to advise us of any adverse communications from regulators or third parties, including legal counsel, which may affect compliance with laws and regulations related to your cost reports.

Cost reports are subject to review by administrative contractors and others with oversight responsibility. Professional judgment is used in resolving questions where the cost report and reimbursement rules and regulations are unclear. You understand that reviewers may choose to interpret rules and regulations in a manner different than that reflected in the cost reports, and reviewers may propose adjustments to your cost reports which could have an adverse effect on your cost report settlements.

Our engagement is not designed to nor intended to prevent or detect errors, fraud, illegal acts, or misappropriation of assets. Management is responsible for establishing and maintaining effective internal control over financial reporting and setting the proper tone; creating and maintaining a culture of honesty and high ethical standards; and establishing appropriate controls to prevent, deter, and detect fraud, illegal acts, and noncompliance with laws and regulations. Because of the limits in any internal control structure, errors, fraud, illegal acts, or instances of noncompliance may occur and not be detected. Also, in the future, procedures could become inadequate because of changes in conditions or deterioration in design or operation. Two or more people may also circumvent controls or management may override the system.

Other Services

Regulators, such as Medicare Administrative Contractors, State Medicaid Agencies, and contracted cost report auditors, make routine requests in connection with activities, such as cost report acceptance, desk reviews, settlements, and interim payment calculations. To facilitate timely responses to these routine requests, by signature on this engagement letter, you have requested that we provide information directly to the regulators. We will notify you of routine requests received directly by us from regulators. Responses to such requests will be billed separately.

Except for the responses to routine requests by regulators discussed above, our engagement will not include the submission of documentation to any third parties unless we are separately engaged to do so.

Your Responsibilities

You acknowledge that submission of the cost report and any related materials to Novitas is your responsibility. You will review the information we submit and will be solely responsible for its accuracy and completeness. You will be responsible for signing the Worksheet S certification page of the Medicare cost report. If you identify any errors or discrepancies in the submissions, it is your responsibility to notify us to discuss resolution options.

You agree to assist in establishing BKD as an authorized user to permit access to the cost reporting secure website/online portal. You agree to accept all responsibility for electronic submission of the cost report and supporting documentation. You agree to hold BKD harmless as a result of providing, maintaining and accessing the MCReF portal on your behalf.

You agree to timely notify us and, as applicable, provide copies of any correspondence received by you from regulators regarding the cost report.

Engagement Fees

We have estimated the time required by our engagement and the fees will be $13,500. In addition, you will be billed travel costs and fees for services from other professionals, if any, as well as an administrative fee of 4% to cover items such as copies; postage and other delivery charges; supplies; technology-related costs, such as computer processing, software licensing, research, and library databases; and similar expense items.

Further, our fees do not consider additional efforts related to the SARS-CoV-2 virus and the incidence of COVID-19 environment and the complexities and uncertainties involved with reimbursement reporting related to the various provisions within the new laws and the continued issuance of interpretative and procedural guidance from federal and state agencies. Such amounts will be billed based on time expended.

Our pricing for this engagement and our fee structure are based upon the expectation that our invoices will be paid promptly. We will issue progress billings during the course of our engagement, and payment of our invoices is due upon receipt. Interest will be charged on any unpaid balance after 30 days at the rate of 10% per annum, or as allowed by law at the earliest date thereafter, and highest applicable rate if less than 10%.

Our engagement fees do not include any time for postengagement consultation or assistance with your personnel or third parties, inquiries from regulators, including the submission of additional

information or response to audit or desk review adjustments, or depositions, testimony or other services involving such matters. Charges for any such services will be billed separately.

If our invoices for this or any other engagement you may have with BKD are not paid within 30 days, we may suspend or terminate our services for this or any other engagement. In the event our work is suspended or terminated as a result of nonpayment, you agree we will not be responsible for any consequences to you.

Other Engagement Matters and Limitations

Our timely completion depends on the level and timing of assistance you provide us in accumulating information and responding to our inquiries. Inaccuracies or delays in providing this information or the responses may result in an untimely cost report filing and may also impact our fees.

Our workpapers and documentation retained in any form of media for this engagement are the property of BKD. We can be compelled to provide information under legal process. In addition, we may be requested by regulatory or enforcement bodies to make certain workpapers available to them pursuant to authority granted by law or regulation. You agree that we have no legal responsibility to you in the event we provide such documents or information.

You agree to indemnify and hold harmless BKD and its personnel from any claims, liabilities, costs, and expenses relating to our services under this agreement, except to the extent resulting from the intentional or deliberate misconduct of BKD personnel.

Any liability of BKD and its personnel to you is limited to the amount of the fees you paid for this engagement as liquidated damages.

You agree that any dispute regarding this engagement will, prior to resorting to litigation, be submitted to mediation upon written request by either party. Both parties agree to try in good faith to settle the dispute in mediation. The American Arbitration Association will administer any such mediation in accordance with its Commercial Mediation Rules. The results of the mediation proceeding shall be binding only if each of us agrees to be bound. We will share any costs of mediation proceedings equally.

Either of us may terminate these services at any time. Both of us must agree, in writing, to any future modifications or extensions. If services are terminated, you agree to pay us for time expended to date. In addition, you will be billed travel costs and fees for services from other professionals, if any, as well as an administrative fee of 4% to cover items such as copies; postage and other delivery charges; supplies; technology-related costs, such as computer processing, software licensing, research, and library databases; and similar expense items.

If any provision of this agreement is declared invalid or unenforceable, no other provision of this agreement is affected and all other provisions remain in full force and effect.

This engagement letter represents the entire agreement regarding the services described herein and supersedes all prior negotiations, proposals, representations, or agreements, written or oral, regarding these services. It shall be binding on heirs, successors, and assigns of you and BKD.

If these services are determined to be within the scope and authority of Section 1861(v)(1)(I) of the Social Security Act, we agree to make available to the Secretary of Health and Human Services, or to the Comptroller General, or any of their duly authorized representatives such of our billing records as are necessary to certify the nature and extent of our services, until the expiration of four years after the furnishing of these services.

We may from time to time utilize third-party service providers, *e.g.*, domestic software processors or legal counsel, or disclose confidential information about you to third-party service providers in serving your account. We remain committed to maintaining the confidentiality and security of your information. Accordingly, we maintain internal policies, procedures, and safeguards to protect the confidentiality of your information. In addition, we will secure confidentiality agreements with all service providers to maintain the confidentiality of your information. In the event we are unable to secure an appropriate confidentiality agreement, you will be asked to provide your consent prior to the sharing of your confidential information with the third-party service provider.

You agree to assume full responsibility for maintaining your original data and records and that BKD has no responsibility to maintain this information. You agree you will not rely on BKD to provide hosting, electronic security or backup services, *e.g.*, business continuity or disaster recovery services, to you unless separately engaged to do so. You understand that your access to data, records, and information from BKD's servers, *i.e.*, BKDconnect, can be terminated at any time and you will not rely on using this to host your data and records.

We will, at our discretion or upon your request, deliver financial or other confidential information to you electronically via email or other mechanism. You recognize and accept the risk involved, particularly in email delivery as the internet is not necessarily a secure medium of communication as messages can be intercepted and read by those determined to do so.

You agree you will not modify these documents for internal use or for distribution to third parties. You also understand that we may on occasion send you documents marked as draft and understand that those are for your review purpose only, should not be distributed in any way, and should be destroyed as soon as possible.

Any time you intend to reference our firm name in any manner in any published materials, including on an electronic site, you agree to provide us with draft materials for our review and approval before publishing or posting such information.

BKD is a registered limited liability partnership under Missouri law. Under applicable professional standards, partners of **BKD, LLP** have the same responsibilities as do partners in a general accounting and consulting partnership with respect to conformance by themselves and other professionals in BKD with their professional and ethical obligations. However, unlike the partners in a general partnership, the partners in a registered limited liability partnership do not have individual civil liability, directly or indirectly, including by way of indemnification, contribution, assessment, or otherwise, for any debts, obligations, or liabilities of or chargeable to the registered limited liability partnership or each other, whether arising in tort, contract, or otherwise.

HIPAA Business Associate Agreement

We agree not to use or disclose Protected Health Information of your patients (hereinafter referred to as "PHI") obtained or produced in any form of media during the course of our work in a manner prohibited by HIPAA, as amended. We may use or disclose PHI for purposes of (a) performing our engagement, (b) management and administration of BKD, or (c) carrying out legal responsibilities of BKD. We will not further disclose information except as permitted or required by this contract or as required by law. When using or disclosing PHI in relation to this engagement, we will limit disclosures as required by HIPAA. We will not use PHI in any marketing activities in a manner that would violate HIPAA. We represent to you that we have implemented what we consider to be appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of your PHI as required for us as a business associate to comply with HIPAA.

With respect to your PHI, we will report to you any breach (as defined in 45 CFR 164.402), material security incident or use or disclosure not authorized by this agreement and, to the extent practical, assist you in mitigating any harmful effects caused by breaches, material security incidents, or unauthorized uses or disclosures of which we become aware. To assist you in fulfilling your responsibility to notify impacted individuals and others of a breach involving unsecured PHI (as required under 45 CFR 164.400 et seq.), in this report we will identify to you, to the extent reasonably possible:

1. Each individual whose unsecured PHI was subject to the breach.

2. Any other available information you are required to include in your notification to such individual(s) or others under 45 CFR 164.404(c).

We agree that any material violation of these confidentiality provisions by us entitles you to terminate this engagement. Similarly, if we become aware of a violation of HIPAA by you that cannot be or is not timely cured, we may be obligated to terminate this engagement.

BKD agrees to:

1. Upon their request, make available to the Secretary of Health and Human Services (HHS) our internal practices and books and records relating to the use and disclosure of PHI for purposes of determining your compliance with the Security and Privacy Rule, subject to any applicable legal privileges.

2. Make available information necessary for you to make an accounting of disclosures of PHI about an individual.

3. To the extent we maintain information that is part of a Designated Record Set, make available information necessary for you to respond to requests by individuals for access to PHI that is not in your possession but is considered part of a Designated Record Set.

4. Upon receipt of a written request from you, incorporate any amendments or corrections to PHI contained in our workpapers in accordance with the Security and Privacy Rule to the extent such PHI is considered part of a Designated Record Set.

For purposes of this agreement, the term "Security and Privacy Rule" refers to the final rules published to implement the Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996*, specifically 45 CFR Parts 160 and 164. The terms "Protected Health Information" and "Designated Record Set" have the same meaning as defined in the Security and Privacy Rule.

At the conclusion or termination of this engagement, any PHI retained by us will be subject to the same safeguards as for active engagements.

We will obtain from any agents, including subcontractors, to whom we provide PHI received from you, or created or received by us on behalf of you, an agreement to the same restrictions and conditions that apply to us with respect to such PHI.

To the extent that any relevant provision of HIPAA is eliminated or held to be invalid by a court of competent jurisdiction, the corresponding portion of this agreement shall be deemed of no force and effect for any purpose. To the extent that any relevant provision of HIPAA is materially amended in a manner that changes the obligations of business associates or covered entities that are embodied in term(s) of this engagement, the Parties agree to negotiate in good faith appropriate amendment(s) to this engagement to give effect to such revised obligations. In addition, the terms of this engagement should be construed in light of any interpretation and/or guidance on HIPAA issued by HHS from time to time.

We will be pleased to discuss this letter with you and look forward to serving you. If the above arrangements are acceptable to you, please sign the enclosed copy of this letter and return it to us. If the signed copy you return to us is in electronic form, you agree that such copy shall be legally treated as a "duplicate original" of this agreement.

BKD, LLP

BKD, LLP

The services and arrangements described in this letter are in accordance with our understanding and are acceptable to us:

MANGUM REGIONAL HOSPITAL

By: _____
(Name and Title)

Date: _____

SCS/TCW/ajl

AM: 1183982

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

HOSPITAL NAME

Respiratory Protection Program Evaluation Summary for 2021

Purpose: The evaluation of the Respiratory Protection Program (RPP) is conducted to ensure that all aspects of the program meet the requirements of the OSHA Respiratory Protection standard. Any procedural changes that are implemented as a result of the program evaluation will be communicated to the employees and reinforced by their supervisors. The evaluation shall be submitted to the following committees:

- Infection Control & Prevention
- Environment of Care & Safety
- Quality
- Med Staff
- Governing Board

Program Evaluation for 2021

1. Appointment of Respiratory Program Administrator
    a. Karli Bowles, RN
    b. 7/15/2021

2. The hospital has a written operational policy in place which acknowledges employer responsibility for providing a safe and healthful workplace. The policy of this hospital is designed to protect the health and safety of its employees by eliminating hazardous exposures where feasible; using engineering and administrative controls to minimize hazardous exposures that cannot be eliminated; and using respiratory protection and other personal protective equipment when the frequency and duration of exposures cannot be substantially reduced or eliminated.

3. The written Respiratory Protection Program has met the required elements for the Respiratory Protection Program for 2021.
    a. Written designation of a program administrator.
    b. An evaluation of hazards and identification of appropriate respirators for specific job classifications and/or tasks.
    c. Procedures for medical evaluation of employees required to use respirators.
    d. Fit testing procedures: annual fit tests completed on 6/23/2021.
    e. Procedures for proper use of respirators has been accomplished by:
        - Respiratory Education and training of staff.
        - Observation of staff using respirators to ensure correct technique.
        - Assessing staff knowledge of respirators.
        - Fit testing.

f. Procedures for storage and inspection of respirators has been accomplished by:
    - Education to staff on storing and inspecting respirators during fit testing procedures.
    - Respiratory Education and training of staff.

g. Procedures for training employees regarding the respiratory protection program has been accomplished using oral and written education, and one-on-one training during fit testing.

h. The training curriculum includes the following elements:
    - General requirements of the OSHA Respiratory Protection standard.
    - Specific circumstances under which respirators are to be used.
    - Respiratory hazards to which employees are potentially exposed during routine and emergency situations.
    - Respirator necessity, proper fit, usage, maintenance.
    - Limitations and capabilities of the respirators that will be used.
    - How to inspect respirator, donning and doffing respirator, user seal checks.
    - Maintenance and care of respirators.
    - Recognition of medical signs and symptoms that may limit or prevent the effective use of respirators.
    - How and when to decontaminate or safely dispose of a respirator that has been contaminated with chemicals or hazardous/infectious biological materials.

i. The RPA has conducted an evaluation of the RPP to ensure that all aspects of the program meet the requirements of the OSHA Respiratory Protection standard. Program evaluation included:
    - A review of the written program:
      The hospital has developed and approved of the RPP policy. Karli Bowles, RN will be appointed to the RPPA.
    - Completion of a program evaluation checklist based on observations of workplace practices:
        - Evaluation complete and no recommendations made at this time.
    - A review of feedback from employees (including: respirator fit, selection, use, and maintenance/wearer issues, availability) collected during the annual training session or utilization during periods of use:
        - Masks were uncomfortable. Instructed to cluster activities and limit use.

4. The written program is readily available to any employee included in the program and/or OSHA representative.

5. Changes or improvements to the Respiratory Protection Program for 2021.

    a. NA

_____ _____/_____/_____

Respiratory Program Administrator *Date*

_____ _____/_____/_____

Medical Director *Date*

_____ _____/_____/_____

Governing Board Member *Date*

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Respiratory Program Administrator

Appointment Form

The Mangum Regional Medical Center administrative staff has appointed and granted full authority to the Respiratory Program Administrator to make the necessary decisions to ensure its success. The individual designated as the RPA has been determined to serve in this role by appropriate training or experience that is commensurate with the complexity of the program per the OSHA standard. In addition, the RPA has demonstrated an understanding of the principles of respiratory protection and of the requirements of the OSHA Respiratory standard (29 CFR 1910.134). This authority includes, but is not limited to:

a) Conducting hazard assessments for selecting appropriate respiratory protection;
b) Purchasing the necessary equipment and supplies;
c) Developing and implementing policies and procedures for the Respiratory Protection Program;
d) Ensuring records are maintained and secured in a confidential manner;
e) Retain oversight of the Respirator Fit Test Program;
f) Providing respirator education and training to the hospital's staff;
g) Conducting a periodic evaluation of the Respiratory Protection Program

Karli Bowles, RN, BSN has been appointed as the Respiratory Program Administrator for Mangum Regional Medical Center

_____ _____/_____/_____

Respiratory Program Administrator *Date*

_____ _____/_____/_____

Medical Director *Date*

_____ _____/_____/_____

Governing Board Member *Date*