Quality Assessment & Performance Improvement Report
Medical Staff and Board of Trustees

April Report

February *Data*

Aligns With	Measure	Target	Month	Calendar Year	Fiscal Year	Rolling 12-mnths
	Total fall rate ≤ 4.5 per 1,000 patient days	≤ 4.5 per 1k pt days	**2** *last 2-28-25*	**3** 12.54/1k pt days	**5** 4.89/1k pt days	**6** 4.54/1k pt days
	Prevent category D-I adverse drug events (ADEs) facility wide	0	**1** *last 1-20-25*	**1**	**1**	**1**
	ST elevation myocardial infarction (STEMI) positive EKG to transfer request within 10 minutes	Improvement from baseline (40% in 2024)	No eligible patients	**50%** 1/2		
	Documentation of risk stratification for non-ST elevation acute coronary syndrome (NSTE-ACS) patients in the emergency department	30%	No eligible patients	**0%** 0/3		

Patient Safety/Performance Improvement Activities:

- Approval of new standard operating procedure for the panic alarm buttons
- Added scripting to Call-Em-All system for prompt communication in the event of an unplanned utility outage
- Provided law enforcement with means to enter the facility in case of emergency
- Revised plain language policy to advise on paging language for an aggressive person.
- Reviewed and revised internal lockdown policy and standard work.
- Celebrated improvements (reductions) in fall and ADE rates over the past 2-3 years at Quality and Leadership Team.
- Performed facility wide SDS audit with over 400 items added to electronic SDS system
- List of actions taken/improvements made due to feedback received from employees and actual events/drills shared with leadership team. Asked that they share with their teams.

Incident Reports:

2025 February Reports

Brief Description	Investigation/Actions Taken/Improvements Made
Patient presented for outpatient labs as instructed by nurse. When they arrived there were no orders x 2 incidents	*Established process not followed. Patient was not scheduled for labs which removed the opportunity for a 'double-check' to ensure orders were entered prior to patient presenting. Department leadership reviewed with staff involved.*
Patient presented for outpatient labs. No orders.	*Patient was scheduled for labs. Prior to placing them on the schedule, the double check is to occur. This did not happen. Manager followed up with staff involved.*
Incorrect patient placed on schedule and orders scanned into incorrect chart	*Manager followed up with staff involved. Counseled on importance of accuracy.*
Patient expresses frustration in MRI scheduling process	*The order for this test was faxed during the time when our fax server was down according to documentation on the order. There was a delay in receiving this order that was not in our control as we were not expecting/waiting for it. It was discovered when the pt reached out.*
Incorrect IV fluids administered. Caught after approx 100-200 ml infused.	*Manager followed up with staff involved.*
Patient was called to schedule mobile MRI before the PA was completed	*Human error. Will track and trend.*
Birthday incorrect on order. Patient delay while awaiting new order	*Lab followed appropriate processes to resolve order error.*
Unable to read an order faxed here from external provider. Patient delay while awaiting new order	*Lab followed appropriate processes to resolve issue.*
Patient presented for an appointment and the provider had left.	*Manager followed up with staff involved and set expectation for handling this type of situation in the future.*
Prior Auth was expired when patient arrived for scheduled service.	*Manager followed up with staff involved.*
Promethazine with codeine was administered instead of the ordered promathazine without codeine. The medication wasn't verified with a scan.	*Manager followed up with staff involved. Counseled on importance of scanning medications.*
Patient last name incorrect (missing one letter) causing question if correct patient. Had to be fixed and images re-set to outside facility.	*This was patient's first visit to the facility and was registered after hours by clinical staff. All parties involved have been made aware of incident and re-education has been completed.*
Two patient falls, same patient.	*Patient was high risk for falls. They were reaching for an object during both instances. After the initial fall, the patient was placed on an alarm. After the second fall, the reacher was placed next to the patient and the alarm was pinned to dominate side. Quality discussed anticipated factors influencing fall that may have prevented this reoccurence with department manager.*
Patient had to be called back for additional blood sample due to our error.	*Causative factors revealed through investigation include: (1) Distractions- multiple areas/patients needing services at the time; (2) different staff than usual drawing labs; (3) fewer staff available than normal.*
Patient sent to waiting room for labs. Error in moving patient in Phreesia caused lab not to be notified. Patient had extended wait time.	*Primary causative factor revealed through investigation was staff who normal performs process were not available. Re-education done with current staff performing process, as well as a Teams group created for communication between departments.*
Order entry error caused need for patient to return for additional lab draw.	*One of multiple tests placed in now status while others were placed in future status. This caused tests to be missed. Leadership discussed with provider involved.*