PERFORMANCE IMPROVEMENT

Sample Plan for a Surgical Facility

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GUIDELINES FOR MINUTES

Center Advisory Steering Committee

General Business

By individual physician, any credentialing and privileging activities

Report from Performance Improvement Activities

Specific mention of approval of the following:

By category or topic, approval of policies and procedures: new and annual reviews

By personnel, approval of any appointments to the position of administrator and medical records' custodian

Performance Review

Patient Questionnaire Results

Present summary of patient questionnaire results .Individual physicians will review their patient responses. Patient satisfaction results are reviewed during recredentialling process. If there is a particular question or trend that shows lower than desired performance, document what you plan to do about it.

Pharmacy Report

If there were any particular concerns, note them.

Risk Management Report

Include a summation of the "Variance reports" in the minutes.

Infection Control Report

Give the percentage of infections, if there were any. Make statement about findings of other monitors; e.g., all O.K. Include a summation of the "Variance reports" in the minutes.

Pathology Review Report

Advise the physicians if return of pathology reports is within day limit established by policy.
Pathology reporting results are reviewed during the recredentialling process Advise if any pre and post procedure diagnoses differed.

Monitoring important aspects of care

Always monitor medical record for rate based indicator complications. Complete summation of complications, actions will be documented through the peer review process and or variance reports. Attach the summary(s) of monitoring activities. Keep the record review worksheets with the patient logs.

Performance Improvement Studies

Tell about any study you have done or any you are doing. Write it up in the performance improvement study form at and attach it to the minutes.

Minutes are sent to the Governing Body for review and recommendations.

MINUTES TEMPLATE
PERFORMANCE IMPROVEMENT/ CENTER ADVISORY STEERING COMMITTEE
Date:
Present: _____

General Business

_____

Peer Review

_____

Credentialing

_____

Performance Review:
Patient Questionnaire Results

_____

Pharmacy Report

_____

Variance "Risk Management" Report

_____

Environmental/Safety Report

_____

Infection Control Report

_____

Pathology Review Report

_____

Rate Based Indicator Complications "Important Aspects of Care"

_____

Performance Improvement Studies

_____

Contracts

_____

Policy/Form New and Revised

_____

New Hires/Educational Activities

_____

PERFORMANCE IMPROVEMENT PLAN

SUBJECT: PERFORMANCE IMPROVEMENT

The Center 's management and staff are committed to developing and carrying out an ongoing performance improvement program. Experience has proven that quality cannot be assured, but it can be monitored continuously and improved effectively through a concerted effort by all individuals caring for the patient. Performance Improvement is a dynamic process that focuses on the evaluation of patient outcomes to determine methods of improving care.

An emphasis on performance improvement is a link among all medical and clinical personnel providing patient care and the numerous individuals involved in the care to achieve a standard of excellence in an objective and comprehensive manner that will benefit patients.

GLOSSARY:

Aspects of care:	Clinical activities that involve a high volume of patients entail a high degree of risk for patients or tend to produce problems for staff or patients.
Concurrent:	A study that begins with a current manifestation and links this effect to occurrences at the same point in time, related to care in progress
High risk:	Patients at risk if the aspect of care is not provided correctly and in a timely manner
High volume:	The aspect of care that occurs frequently or affects a large number of patients
Indicator:	Well-defined measurable objective statements related to the structure, process or outcomes of care
Occurrence screens:	Data that are utilized to identify individual variations in care which are reviewed and confirmed by peer review and used to identify trends/patterns
Outcomes:	The intended or realistically expected correction of the patient's problem by a certain point in time
Standard:	A criterion used by general agreement to determine whether something is as it should be. An agreed upon level of excellence. An established norm determined by opinion, authority, research and/or theory
Threshold:	Pre-established level or point at which intensive evaluation of care or practice is indicated for the monitoring activity for the purpose of setting realistic goals for performance improvement.

OBJECTIVES

Objectives of the program are

1. To improve overall patient care and services through systematic monitoring and evaluation;
2. To ensure continuing improvement by putting into effect an ongoing, comprehensive, and a workable program;
3. To involve all levels of staff in the improvement process;
4. To provide higher quality care and services at lower costs;
5. To utilize indicators and related thresholds;
6. To routinely collect data related to the indicators and compare the level of performance with the

thresholds for evaluation;
7. To collect data on sentinel and rate-based indicators based on important aspects of care and/or services that reflect structure, process and outcomes;
8. To monitor and evaluate important aspects of care when the thresholds for evaluation have been reached; and,
9. To ensure identification and solution of problems.

Center Advisory Steering Committee shall be established which shall meet at least once per calendar quarter. Documentation of the committee activities will be presented to the Governing Body for review.

PURPOSE

The purpose of the committee is as follows:

1. Develop mechanisms necessary to detect and identify performance that is inconsistent with the standards of the Center ;
2. Collect data to determine that standards are being met;
3. Recommend corrective action which will bring performance into compliance with standards; and
4. Plan follow-up studies to evaluate the effectiveness of corrective actions.

MEMBERSHIP

The committee members shall include:

Medical Director
Ambulatory XXXXXXXXXXXX Business Nurse Manager
At least one other physician
Center personnel as desired and appropriate

RESPONSIBILITIES

The Governing Body has the overall responsibility for developing, maintaining and supporting the ongoing, comprehensive program. The Medical Director is responsible for monitoring the program.

The committee is charged with the following quality assurance and performance improvement activities:

1. Assures the provision of quality patient care by requiring and supporting the establishment and maintenance of an effective Performance Improvement program
2. Monitors, coordinates and integrates all committee activities and ensures participation of all disciplines. The committee receives all reports regarding but not limited to, infection control, patient transfers, tissue review, medical records review, safety and fire, medication handling and storage, risk management.
3. Monitors and evaluates the quality and appropriateness of patient care and clinical performance and identifies variances or problems to be assessed. The Center Advisory Steering Committee recommends actions to be taken for correction and follow up or directs the appropriate committee or individual(s) to take necessary action. Actions taken are then reported back to the Committee.
4. Reports at least quarterly to the Governing Body. The Center manager is responsible for providing the Committee report/minutes to the Governing Body.

COMMITTEE MEMBER FUNCTIONS

Functions of Committee Members

1. The Medical Director and Center Nurse Manager have the following functions and responsibilities:

a. Develops and ensures implementation of the Performance Improvement Program using input from all levels of staff;
b. Participates with the clinical director in the identification of clinical functions and indicators and in the establishment of thresholds for evaluation;
c. Serves as primary coordinator and director of the program, accepting full responsibility and accountability for the following:
   - assists with monitoring of the program
   - recommends corrective actions
   - oversees actions taken
   - provides status reports to the Medical Advisory Committee
   - assists in developing new policies and procedures
   - changes staffing and environment as needed
   - assists in developing educational programs for the employees and staff
   - ensures support of the Performance Improvement program

2. The Center Nurse Manager or designee has the following functions and responsibilities:
   a. Shares in the overall responsibility for developing and ensuring implementation of the Performance Improvement program in clinical areas;
   b. Participates with the Medical Director and other managers in the identification of clinical functions and ensures the following:
      - identification of indicators
      - establishment of thresholds for evaluation
      - identification of the yearly monitoring calendar which specifies clinical functions and frequencies for monitoring activities
      - identification of clinical staff for data collection and evaluation
      - implementation of appropriate action(s) and
      - evaluation of the impact of actions taken;
   c. Ensures clinical staff involvement by promoting team spirit and participation in the program;
   d. Communicates results of findings and actions with all staff members;
   e. Conducts regular meetings to allow for staff involvement and to elicit staff ideas and feedback regarding improvement of patient care and services;
   f. Determines corrective action in collaboration with the staff, interdisciplinary team members and the Medical Director and Center Advisory Committee;
   g. Assists in the collection and analysis of data on important aspects of care and/or services; and
   h. Reports to the Medical Director on a quarterly basis, the monitoring activities, results, actions and recommendations for further action.

AREAS FOR REVIEW

Areas and activities for routine review include the following:

1. variance reports
2. medical record review
3. infection control reports
4. follow up patient phone calls
5. patient satisfaction surveys
6. communication from physicians/employees
7. cancellations on the day of scheduled appointment
8. patient morbidity/mortality

The medical staff shall conduct ongoing comprehensive self-assessment of the quality of care provided, including the appropriateness of care. Physicians will perform peer review. Center staff with the medical staff reviewing information may conduct all other reviews.

Areas of review may address the following:

1. History and Physical done on each patient prior to admission '.2. Appropriateness of treatment in accordance with history
3. Appropriate lab and X-ray tests based on history, physical, and planned procedure
4. Drug usage reviews
5. Review of patient care services from contracted sources
6. Infection control reports
7. Review of services provided including the availability of services; e.g., under use, overuse, timeliness of scheduling, etc.
8. Timely procedure reports written or dictated immediately following the procedure and signed by the physician

There shall be no limit as to the number of studies, that can be conducted, a minimum of three will be performed annually.

ASPECTS OF CARE

Aspects of care to review may include:

1. High volume aspects: Procedures that occur frequently Nursing activities frequently performed
   Nursing care that affects large number of patients

2. High risk aspects: Areas that carry potential for liability and/or patient injury
   Care delivered inconsistent with standards
   Acts of omission/commission
   Failure to recognize cardiac arrhythmias
   Failure to perform aseptic techniques
   Failure to provide patient education

3. Problem prone aspects: Procedures that cause patient/staff anxiety Activities needing improved efficiency

INDICATORS

Indicators will focus on the patient, the staff, and the system and relate to the structure, process or outcome of care/service. All serious clinical events such as sentinel events and complications and unexpected changes in patient health status (infection, nerve damage, altered skin integrity) will be reviewed. See attached forms

THRESHOLDS

All indicators are monitored and reported to committee. Each event is sent for peer review to determine appropriateness of care. This information is then used to determine the potential need for quality improvement study implementation, policy creation and or revision, personnel performance review, as well as review at time of medical staff reappointment.

Sources of Data may include the following, in addition to other sources:

Rate Based Indicator Complication Form
review of licensing/certification/accreditation findings

- variance reports
- patient satisfaction surveys
- medical records reviews
- personnel credentialing/in-service records

- post-procedure phone calls
- direct observation of staff
- review of physician orders
- patient complaints

Sample size of data all complications, infections and sentinel events. Randomly at least *5 charts per month*.

Analysis and evaluation identifies trends or patterns of care. Action plans/solutions are then developed and enacted to solve the problems or improve care. The effectiveness of these actions are assessed through continuous monitoring. If the action/solution is ineffective, another plan is developed. A time limit shall be set for reevaluation.

PERFORMANCE MEASURES

Specific areas identified by quality improvement activities and or member concerns are agreed upon annually and measured. These measures are reported quarterly. A minimum of three areas are to be monitored.

COMMUNICATION

Relevant information from the Performance Improvement program will be disseminated as necessary to the affected individuals and groups in the following ways:

1. Written and/or oral reports
2. Performance Improvement review meetings at least quarterly
3. Quarterly reports to Governing Board

The Center Advisory Steering Committee will evaluate the objectives, scope of the organization and effectiveness of the Center annually.

PROBLEM IDENTIFICATION - RESOLUTION PROCESS

The following steps are utilized in the problem-solving process:

1. Problem identification
2. Priority setting
3. Problem assessment
4. Problem correction
5. Problem correction monitoring

Problem Identification: Problems may be identified from the following sources: Committee members, Center staff members, patient satisfaction surveys, patient record audits, regulatory agency survey reports, consultation reports, environmental services reports, procedure logs and records, and variance reports. The Problem Identification and Assessment Form may be used. All staff is encouraged to bring problems to the Nurse Manager.

Problem Priority Setting: Priority will be given to those problems that have the potential of the highest negative impact on patient care if not resolved. A letter code will be given to each problem, from A to C, letter A having the highest priority.

Problem Assessment: Some Problems may be resolved immediately; others will require the use of pre-established, clinically valid written criteria to investigate the extent and probable cause(s) of the problem. Criteria may include standards of practice, policies and/or procedures, and regulatory agency standards. A time frame must be established for each problem to be assessed.

Problem Resolution: The Committee shall take appropriate action to eliminate or reduce the identified problems through designated mechanisms, which shall include: in-service or other educational programs; new or reviewed policies and procedures; staffing changes; equipment or facility modification; adjustments in clinical privileges.

Problem Monitoring: The Committee is responsible for determining that a problem remains resolved or reduced to an acceptable level. This will be accomplished through periodic monitoring of corrective action. If a problem has not been satisfactorily resolved, it will be re-evaluated for appropriate resolution. The Quality Improvement Log will be utilized to provide continuity of all Quality Improvement activities.

- review of physician orders
- patient complaints

CONTRACTED SERVICES REVIEW

Services provided by outside resources shall be monitored on an on-going basis for Quality. Quality concerns of the Center and/or Outside Service will be reported to the Medical Advisory Committee via Problem Identification forms. Corrective actions and resolutions to concerns will be noted on the Problem Identification Form and in the Medical Advisory Committee minutes. A copy of the Problem Identification Form will be kept with the contracted service agreement and will be reviewed by the Governing Body annually, and considered at time of agreement renewal for continuation of services.

CONFIDENTIALITY

Quality Improvement activities are confidential matters and the Committee records are not subject to subpoena. When appropriate, codes or ID numbers may be used to protect patient or staff identity.

ANNUAL EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The Medical Advisory Committee will annually evaluate the effectiveness of the Quality Improvement plan and revise it accordingly as to:

1. Comprehensiveness
2. Assessment of clinical performance
3. Improvement in patient care
4. Cost effectiveness
5. Ongoing activity

The result of this evaluation will be disseminated in writing to the Governing Body and staff.

Reviewed and Approved:	Clinic	Ambulatory XXXXXXXXXXXX Business Center
_____	_____	_____.
Date	Nurse Manager	Nurse Manager
Date	_____ Medical Director	_____ Medical Director
_____	_____	
Date	Representative of the Governing Body	

STATEMENT OF CONFIDENTIALITY

POLICY/FORM

As a member of a Medical Advisory Steering Committee involved in the evaluation and improvement of the quality of care rendered in XXXXXXXXXXXX Business CENTER . I recognize that confidentiality is vital to the free and candid discussion necessary to effective medical staff peer review activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of XXXXXXXXXXXX Business CENTER affairs.

I,_____do hereby agree to hold all contents of the XXXXXXXXXXXX Business CENTER Medical Advisory Steering Committee meetings confidential and not to discuss matters pertaining to:

- Quality Improvement/Peer Review issues
- Risk Management factors
- Condition of Equipment or Facilities
- Physicians, staff or employee of the Center who may be under peer review, probation status or disciplinary proceedings

OR

To disclose to parties outside of the committee any names of individuals, contractual services or companies brought before the committee in an effort to improve productivity or performance.

I understand that by discussing any of the aforementioned factors, information provided by myself to unauthorized parties outside the auspices of the XXXXXXXXXXXX Business CENTER Medical Advisory Committee meeting may be subpoenaed under the "information discovery" rules and ultimately used against the Center , or any individual so identified, in a court of law.

Signature:_____

Printed Name:_____

Date:_____

PERFORMANCE IMPROVEMENT STUDIES

POLICY
Performance Improvement studies should occur at least once a quarter. Performance Improvement studies can come from (l) Events or Occurrences, (2) Findings from Monitors, (3) Suggestions Evaluated For Adjustment to Provision of Care or Management of Center

PERFORMANCE IMPROVEMENT PROJECT

1. State the problem or concern and how it was identified.

2. Define whom, how, and what was affected by this problem. Use a numerical calculation if possible.

3. Findings

4. List corrective measures implemented to resolve the problem.

5. Outline the plan to re-evaluate to determine whether corrective measures were successful, how the effectiveness will be measured, and when the problem will be re-evaluated.

6. List to whom the results will be reported.

A valuable study has the following characteristics:

- an important problem or concern in the care of patients is identified
- the frequency, severity, and source of the suspected problems or concerns are evaluated
- corrective measures were implemented to resolve the problem
- the problem is re-evaluated to determine whether corrective action is successful
- if the problem remains, alternative measures are taken to resolve the problem
- participation and communication throughout the organization: all employees know what is being reviewed so they can have input and they have feedback on the outcome of the study and results.

The goal of the study is an improvement in patient care or an improvement in the organizational process.

PERFORMANCE IMPROVEMENT PROJECT Date: _____

1. State the problem or concern and how it was identified:

_____
_____
_____
_____

2. Define who, how, and what was affected by this problem. Use a numerical calculation if possible.

_____
_____
_____
_____

3. Findings.

_____
_____
_____
_____

4. List corrective measures implemented to resolve the problem.

_____
_____
_____
_____

5. Outline the plan to re-evaluate to determine whether corrective measures were successful, how the effectiveness will be measured, and when the problem will be re-evaluated.

_____
_____
_____
_____

6. List to whom the results will be reported.

_____
_____
_____

PERFORMANCE IMPROVEMENT
ACTIVITIES SUMMARY CHART

POLICY

The following are examples of performance improvement activities. Begin with the activities that must be continuously reviewed such as infection control, drug management, fire/disaster drills, risk management, and patient questionnaires. As performance improvement opportunities present, determine which ones will be a performance improvement study. Implement other monitors periodically. **Examples follow.** If a monitor shows 100% compliance over a period of time, routine monitoring should end. Every measurement activity is not required each month. Activities that should always occur to document compliance to state and federal regulations and standards of care are noted with an **ASTERISK.**

When a monitor is accomplished through chart review, the review can include monitoring on all the aspects of care that use chart review as a method. One can randomly select 10% of the charts and audit for assessment, effectiveness of anesthesia care, assessment of condition and progress of patient, return to pre-procedure status and discharge, and therapeutic measures per doctor's orders. Again, these monitors should be performed periodically to assess compliance to standards of care. Results that indicate need for concentrated review to improve performance should be evaluated for possible selection as a detailed performance improvement study. Monitors that indicate compliance should be performed only periodically to check continued compliance.

The statistical information and the review of problems, investigation, action, results, and improvement are summarized and reported to the Center Advisory Committee. The committee approves the report and can make recommendations. If recommendations are made, action steps are developed and implemented. After a period of time, there is a review to determine if the changes improved the results.

The Center Advisory Steering Committee minutes are presented to the Governing Body. The Governing Body approves the report and recommendations or makes suggestions. If suggestions or governing body recommendations are made, this is communicated to the medical advisory committee and appropriate staff for review, implementation, and follow-up.

ACTIVITIES SUMMARY CHART

ACTIVITY	METHOD	USUAL FREQUENCY
*Minutes	Write up information in consistent format	At least quarterly
*Performance Improvement Study	Document using Study Format	Three per year
*Performance Improvement Study	National Benchmarked Study	Annually
Indicators	Nursing Audit Rate Based Indicator Tool	Every Chart, all the time
Performance Measures	Inspection and Chart Review	Quarterly
*Completeness and Content of Record	Chart Review	Every Chart, all the time
* Physician Peer Review	Random Chart Review ~ .	15 charts quarterly All complications
*Review of the Environment of Care	Observation, logs, maintenance records	Monthly Environmental Inspection Biomedical Biannual Generator Monthly
*Infection Control	Physician Questionnaire	Monthly
*Pathology Reports	Logs	Quarterly
Staff Meetings	Meetings	Monthly
*Pharmacy Review of ordering, storing, handling of drugs	Direct Observation, Review of Documentation	Supply and Outdate Monthly Pharmacist Inspection Q 2 months
*Fire Drills	Drills, Review	Quarterly
*Disaster Drills	Drills, Review	Annually
*Code Blue	Drills Review	Biannual
*Malignant Hyperthermia	Drills Review	Annually
*Risk Management	Variance Reporting	Quarterly
Patient Questionnaires	Questionnaire, Summary, Complaint Investigation	Quarterly

PERFORMANCE INDICATORS

POLICY

Indicators are measurable objective statements related to the structure, process, or outcomes of care.
Indicators are used to target review of the structure, process, and outcomes. Indicators should be chosen to target high volume, high risk, and problem prone areas.

High volume procedures would be targeted because they represent the majority of procedures performed.
High risk areas may include items which if done wrong create patient injuries, financial losses, **and** damage to the reputation of the Center. These include proper informed consent, medication administration, and medication handling and storage.

~ **Problem prone** areas would be found based on variance reports, patient questionnaire responses, infection control reports, and other tools used to measure adherence to standards or desired outcome.

- **Cost of care** areas could be found based on the cost to perform certain functions or procedures, differences in cost for same procedure by different attending physicians, the type of material management activities and the cost of the supply inventory.

Some indicators are always checked. For example, medical records are always reviewed to check that all required forms and signatures are present. This is required to know if the chart is ready to file as completed. For example, when a chart does not contain a procedural report, it is determined to be incomplete and stored in a separate file section. Once the procedural report is received and signed, the chart would be ready to be stored in the file section for completed medical records. When there has been an extended period of time without a chart being completed, the medical director may have to be notified of the incomplete status and the person responsible for completion contacted. If a chart cannot be completed, it must be taken to the Governing Body for approval to file it in the completed medical record section. An example of when a chart cannot be completed is when it is missing a signature or a dictated report and the person responsible has moved away from the area, stopped practicing or working at the Center, and will not or cannot come to the Center to complete the record.
A percentage of records are reviewed periodically for content on the forms. How often this is reviewed is based on results of the review. When results show need for improvement, methods to improve are determined and implemented. Later, another review occurs to see if the implemented method did result in improvement.
Some indicators are checked monthly. An example would be a monthly review of the medication storage and handling.
When there is good compliance some indicators can be reviewed only once a quarter or once every six months, or once a year.
There are some reviews that may not recur unless a problem is found and then the review would begin again to learn how to get it back on track. New personnel, new procedures, a change in one process that impacts another process and similar factors can cause an indicator to come back for review.
The important activity is to measure what is important. When there is deviation in performance, determining what should be done and implementing a structure or process is conducted. If there is not a deviation or problem, then other indicators would be measured.
The Performance Improvement Data Collection Forms may be used as a starting point for the program. Not all indicators must be checked concurrently. As the findings are reviewed, decisions will be made whether to drop an indicator, measure it less often, or change the way it is measured. Quarterly, the findings are reviewed. The Center Advisory Steering Committee will provide input on whether indicators or measurements should change. There will also be an annual appraisal of the performance improvement plan and indicators selected for review.

PERFORMANCE INDICATORS FORM

XXXXXXXXXXXX BUSINESS. P.A.

RATE BASED COMPLICATIONS AND SENTINEL EVENTS

Objective: **To review event occurrence and enable collection of rate as well compliance to policy.**

a. Inform the Advisory Committee **b. Tool to Compliment the Peer Review Process**

c. Facilitate Root Cause Analysis **d. Accomplish Performance Improvement Goals**

Variance/Sentinel Event	CODE	**RATE**
> 4 hours **PACU** care	CI	
>2 hr. to reach **ALDRETE** score >8	C2	
ANGINA OR EKG EVIDENCE OF ISCHEMIA MI/or Congestive Heart Failure/or Cardiac Arrest,	C3	
ARRHYTHMIA (Requiring medications)	C4	
ASPIRATION: Induction, Emergence, Other	C5	
BLOOD PRESSURE Rise or Drop of 30 mm from baseline Systolic >180 or <85 for 10-15 **MINUTES** or more	C6	
BRONCHOSPASM/LARYNGOSPASM/Pneumothorax, Unplanned tracheotomy	C7	
EQUIPMENT FAILURE	C8	
FAILED MAC ANESTHETIC	C9	
HEART RATE >120 or below 50 (unless pre-existing) 10-15" or more	C10	
INTUBATION Difficult or Impossible Intubation, Unplanned Extubation/Re-intubation, Esophageal	C11	
Lack of follow up of **ABNORMAL TEST RESULTS**	C12	
Major **PERMANENT LOSS OF FUNCTION** that is not present when the patient is admitted to the healthcare facility.	C13	
MEDICATION Error	C14	
MISDIAGNOSIS, or "normal result"	C15	
MORTALITY During or After Anesthesia	C16	
NAUSEA and/or vomiting req. anti-emetic	C17	
Near **MISTAKE** if revealed	C18	
OP TIME =or > 90 minutes	C19	
PACU BLEEDING requiring active treatment	C20	
PACU remained **INTUBATED** >30 minutes	C21	
PATIENT INJURY (i.e.: Teeth, Eyes, Other)	C22	
Post op **SEVERE SORE** throat req. treatment	C23	
RADIATION EXPOSURE limit exceeds recommended max dose/ Radiology film retakes	C24	
RESPIRATORY RATE +/- 6 from resting rate (in pts. w/compromised respiratory system)	C25	
SEIZURE	C26	
TEMPERATURE increase (1 hour of 2.5 degrees) 102 degrees or more or 95 degrees or less	C27	
UNEXPECTED APNEA/hypoventilation	C28	
Unplanned **TRANSFER** to outside care facility	C29	
Use of **VOLUME EXPANDING** intravenous fluids	C30	
WRONG SITE XXXXXXXXXXXX BUSINESS	C31	
INFECTION		

PERFORMANCE MEASURES FORM

PERFORMANCE MEASURES	THRESHOLD BENCHMARK	RESPONSIBLE PARTY	***SAMPLE SIZE***	DATA SOURCE
Procedures performed with no intra-op or post-op complications	90%	Physician	All Patients	Complications Peer Review Forms
Patients free from post-op infection	90%	Nursing Staff Physician	All Patients	Infection Report Forms
History & Physical completed within 30 days of procedures (with absence or presence of changes noted within 24 hours of procedure)	100%	Physician	15 cases per month	Medical Records
Informed consent and right side right site consent provided and signed	100%	Nursing Staff Physician	15 cases per month	Medical Records
Documentation of MD evaluation of patient prior to discharge	100%	Physician	15 cases per month	Medical Records
Patient Assessment follow-up phone call documented within 72 hours	100%	Nursing Staff	15 cases per month	Medical Records

PERFORMANCE MEASURES-TRENDING SHEET

PERFORMANCE MEASURES	THRESHOLD/ BENCHMARK	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Procedures performed with no intra-op or post-op complications	90%				
Patients free from post-op infection	90%				
History & Physical completed within 30 days of procedures (with absence or presence of changes noted within 24 hours of procedure)	100%				
Informed consent and right side and right site consent provided and signed	100%				
Documentation of MD evaluation of patient prior to discharge	100%				
Patient Assessment follow-up telephone calls no later than 72 hours	100%				

MEDICAL RECORDS

POLICY

The Medical Record should be completed within 30 days.

Every chart is reviewed for the containment of the forms in the chart. See the form for Completeness of the Medical Record review of the chart to determine whether it is ready to file as completed.

A percentage of charts may be reviewed periodically using the Performance Improvement Data Collection Form for Content of the Medical Record.

The form contains room for six charts. The person checks in the box when the item complies. Blank boxes or "X" in the box means the chart does not comply with that item.

If other indicators are to be reviewed that involve chart documentation, these same charts can be reviewed for the other indicators. For example, at the beginning of the program a sample of charts may be reviewed on indicators as a baseline. Then, based on results, the one area with the most need for improvement would be reviewed, a plan of correction developed and implemented, and a recheck performed to see if corrective measures resulted in improvements.

After the reviews, there will be a tally of compliance. The score will be reported in summary form to the Center Advisory Committee. They will accept the report and can make recommendations. This will be documented in the minutes.

The governing body will approve the summary report and any recommendations from the Center Advisory Committee. Any suggestions made by governing body members will be communicated to the Center Advisory Committee and Center Nurse Manager.

COMPLETENESS OF MEDICAL RECORD CHECKLIST

The schedule and the XXXXXXXXXXXX Business log are checked to assure there is a chart for each patient having a procedure in the XXXXXXXXXXXX Business Center. The chart is filed as complete once all items and signatures are present. Place this checklist in the front of each chart. Complete the checklist and assure each chart is complete before filing.

	Compliant to Policy **+ = Compliant** **0 = Noncompliant**	**Op Report** **Date filed**	**Pathology** **Date filed**	**Comments**
ALLERGY STICKER				
SUMMATION PAGE				
PHYSICIANS PRE OP ORDERS				
DEMOGRAPHIC				
PRE-OP CHECKLIST				
PRE-OP CALL				
PRE-OP INSTRUCTIONS				
CONSENT				
XXXXXXXXXXXX BUSINESS HAND WRITTEN HISTORY AND PHYSICAL AND OR DICTATED				
LAST OFFICE NOTE				
HEALTH INFORMATION SHEET (All Pages)				
OPERATIVE REPORT				
OPERATIVE PHOTOS				
PATHOLOGY REPORT	Y N			
INTRAOPERTIVE NURSING RECORD WITH OR WITHOUT ANESTHESIA GRAPH				
TIME OUT CHECKLIST				
RECOVERY ROOM RECORD				
ANESTHESIA ORDERS				
ANESTHESIA GRAPHIC				
ANESTHESIA HISTORY AND PHYSICAL				
ANESTHESIA CONSENT & CONSULT				
DISCHARGE INSTRUCTIONS				
PHYSICIAN POST OP INSTRUCTIONS				
EKG				
ALL BLOOD WORK				
IMAGING REPORTS				
COPY OF PRESCRIPTION				
POST OP CALL				
POST OP PHONE CALL		Unable to speak to patient Yes No	Copy of first post op visit in chart Yes No	Complication Noted on visit Y N

Recovery Nurse, please complete audit of record, complications and peer review <u>on the back side of this form,</u> you are required to perform this task involving pt's you have recovered before you leave for the day. Thank you. Nurse Manager

PEER REVIEW

POLICY

This is an example of a review of the expected documentation, physician evaluation, physician plan of care, and performance of the plan. It is also a review of any complications.

This peer review is performed automatically when the following occur:

patient is transferred to the hospital from the XXXXXXXXXXXX Business Center patient reports a dissatisfaction with the medical care provided and remains dissatisfied patient requires resuscitation

patient requires resuscitation

At least quarterly, a sample of cases/charts of each physician on staff should be reviewed. If an adequate sample is not reached through review of the above occurrences, then charts are selected randomly to reach the minimum number.

This review involves chart review.

Suggestions for completing this review include:

Review of any complications, transfers, infections, patient injuries, or cases involving a patient who complained about the medical care without resolution of the complaint.

Throughout the month, the Center Manager can keep a list of those cases that should be reviewed. Others are pulled at random. These charts are reviewed by the physicians before the quarterly committee meetings, allowing time for investigation and research to clear up questions before the meeting. A physician does not review his own chart or patient.

MEDICAL RECORD/NURSING PEER REVIEW WORKSHEET

XXXXXXXXXXXX BUSINESS, P.A.

PEER REVIEW

PROCEDURE PERFORMED:

RECORD NUMBER:

DATE OF SERVICE:

COMPLICATION

Clinical Staff Peer Review			
Pre-op, patient instructions given and documented on chart (Consideration given to cultural, ethical and learning needs, physical limitations)	Yes	No	N/A
Allergies and/or abnormal drug reactions documented, Sticker on chart			
Pre-op record and nursing assessment complete and signed by nurse (Validation of current medication present, objective document to support the correct site, side and procedure performed present,)			
Evidence of informed consent, complete and signed by patient surgeon and witness			
Pre-op diagnostic studies on chart noted dated and timed by a nurse and MD (if abnormal, addressed)			
H&P on chart and signed by attending surgeon/or anesthesiologist (follow policy-time frame for assessment pre and post procedure)			
All entries completed with appropriate signatures, dated and authenticated if needed (Pre-op, intra-op and post-op) Admission, Intraoperative and Postoperative Orders noted. Verbal orders written as such and noted within 24 hrs by MD			
If patient involved in research, clinical trials or experimentation-documentation of benefits, risks, alternatives and right to refuse present, consent for visitor in OR			
Patient response to treatment documented, when giving medications and/or palliative care pt status post care documented- when desired result not achieved documentation of next action present.			
If tissue removed, documentation of specimen, requisition form present , specimen sent to lab and final pathology report signed by surgeon and in chart			
Peri-Operative nursing record complete and signed by nurse			
Recovery Records complete, Signed			
Anesthesia Record Graphic, H & P, Consent, and Consult if done complete			
Patient discharged from PACU by physician order and policy of patient status for discharge met			
Patient Discharge instructions signed by person caring for pt post op are in chart			
Post-op telephone contact documented and form complete (If unable to contact, document in record the date and time calls attempted and MD informed of difficulty reaching patient)			

Comments:

Recommendations:

Reviewer:_____ Date:_____

ANESTHESIA PEER REVIEW WORKSHEET

XXXXXXXXXXXX BUSINESS, P.A.

PEER REVIEW

PROCEDURE PERFORMED:

RECORD NUMBER:

DATE OF SERVICE:

COMPLICATION

ANESTHESIOLOGIST PEER REVIEW		
	Yes	No
Anesthetist pre-op note ADEQUATE: preoperative discussion of risk and benefits of anesthesia discussed, possible wakefulness discussed. Assessment immediately prior to procedure noted.		
Choice of anesthesia APPROPRIATE		
Evidence of patient re-evaluation post induction		
Anesthesia record complete, reflects appropriate monitoring		
Required signatures of Anesthetist present and dated for assessments, orders and end of intraoperative note.		
Procedure completed without intra-op or postoperative complications related to anesthesia		
APPROPRIATE management of intra-op complications (only if #6 is no)		
Discharge note/order present and sufficient		
LAB REVIEW: Abnormal lab values addressed in anesthetist's notes		

Comments:

Recommendations:

Reviewer:_____ Date:_____

SURGEON PEER REVIEW WORKSHEET

XXXXXXXXXXXX BUSINESS, P.A.

PEER REVIEW

PROCEDURE PERFORMED:

RECORD NUMBER:

DATE OF SERVICE:

COMPLICATION

SURGEON PERFORMANCE REVIEW		
	Yes	No
Surgeon's pre-op note includes diagnosis and sufficient indication for XXXXXXXXXXXX Business		
Surgeon's pre-op note includes medications including dose and frequency		
Surgeon's operative report sufficiently describes procedure and patient status		
Procedure completed without surgeon related complication		
APPROPRIATE management of complications		
APPROPRIATE setting for this XXXXXXXXXXXX Business		
APPROPRIATE lab/x-ray		
PATHOLOGY: Pathologist and surgeon diagnosis are compatible/agree		

Suggestion:

Recommendations:

Reviewer:_____ Date:_____

PEER REVIEW REPORTING FORM

Period of Review: Quarter
Procedures:
Number of Charts Reviewed:
Number of Complications:
Objective:

1. To review and report surgeon peer review
2. Inform the Governing and Medical Executive Board of review reporting
3. Facilitate Root Cause Analysis and Corrective Action
4. Accomplish Performance Improvement Goals

MD	C #	MR #	Procedure Performed

Period of Review: Quarter
Procedures:
Number of Charts Reviewed: Random Selected Number:

Objective:

1. To review and report surgeon peer review
2. Inform the Governing and Medical Executive Board of review reporting
3. Facilitate Root Cause Analysis and Corrective Action
4. Accomplish Performance Improvement Goals

MD	C #	MR #	Procedure Performed

This form should be given to the Nurse Manager

MEDICAL NECESSITY

POLICY

During the peer review process, medical necessity is reviewed to assure that documentation about the medical necessary of the procedure is included in the medical record.

Medical necessity is not reviewed on every case. It is reviewed periodically on high volume procedures, procedures that are a focus of review by insurers or Medicare, or when a physician is new to the XXXXXXXXXXXX Business Center or Center .

For example, in an orthopaedic XXXXXXXXXXXX Business Center, a frequent procedure performed may be arthroscopy. Orthopaedic journals or governmental quality review agencies may have criteria about the type of assessment and treatment a patient should have prior to the decision to have XXXXXXXXXXXX Business. The physicians would review the literature and develop a list of information that should be documented to assure there is appropriate documentation of medical necessity. The medical record of patients undergoing that procedure would be checked against the criteria and the physicians informed of the compliance with the appropriate documentation. The physicians would determine what corrective measures, if any, are needed to improve the documentation of medical necessity.

VARIANCE EVENT

POLICY
The internal risk management program shall include the use of a Variance form to be filed with the Ambulatory Center Nurse Manager. The Nurse Manager will review the reports for the appropriateness of actions taken to reduce risks of injuries and adverse variances.

Variance forms shall be completed by Ambulatory Center staff to record potential and actual injuries or adverse variances to patients. All unusual events shall be documented on a variance form.

Variance forms shall be used to develop categories of variances that identify problem areas. Once problem areas are identified, procedures shall be adjusted or developed and procedures implemented and enforced to correct the problem areas. All Variance Events will be reported at the quarterly Advisory Committee Meeting to provide focus for Ambulatory Center staff education, training, and performance improvement activities.

The Variance forms are part of the work papers of the attorney defending the Ambulatory Center in litigation related to the Ambulatory Center and are subject to discovery, but are not admissible as evidence in court. Any person completing a Variance form is not subject to civil suit by virtue of such form.

All employees hall participate in the completion of Variance forms. All occurrences that are not consistent with routine care and treatment of a patient of the Ambulatory Center are to be reported as an Variance Event.
Procedure

1. Any Ambulatory Center employee or medical staff member who discovers, is directly involved in, or is responding to a variance, is to complete or direct the completion of the Variance form.

2. All completed Variance form will be submitted to the Ambulatory Center Nurse Manager as soon as possible after the event occurs.

3. The Variance Events that involve patient care issue will trigger peer review and reporting to the Advisory Committee.

4. The problem description should be precise, concise and accurate. All areas of the Variance form are to be completed..

5. The Ambulatory Center Nurse Manager will review all Variance form.

    a. All Variance forms shall be reviewed by the Advisory Committee. Review and action shall be recorded in committee minutes.
    b. The Variance form is a confidential document and must be handled as such. It is not part of the patient's record.
    c. The Ambulatory Center Nurse Manager will report variances to the Center Administrator as soon as possible.

VARIANCE EVENT FORM

This form is confidential, and is ***NOT PART OF THE MEDICAL RECORD***

_____ _____
Name of Person Involved Date of Birth

❒ Patient ❒ Visitor ❒ Employee

Staff Person Completing Form: **Witness:**

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Age: _____ Sex: M F

Place of Occurrence: ❒ OR ❒ RR ❒ Other area _____

Date of Occurrence: _____ Time _____ AM PM

Brief description of occurrence. Name the equipment, drug, treatment or procedure involved and disposition.

_____

_____

_____

_____

Check **one** box in each of the following groups:

A. Nature of Variance

- ❒ Fall
- ❒ Fire
- ❒ Medication Error
- ❒ IV/Anesthesia technique
- ❒ Treatment/Procedure technique
- ❒ Equipment malfunction
- ❒ Infection within 30 days post procedure
- ❒ Left Center against Medical Advice
- ❒ Light headedness/loss of consciousness in XXXXXXXXXXXX BUSINESS Medical Clinic
- ❒ Other _____

VARIANCE EVENT FORM PAGE -2-

B. Nature of Injury

- ❒ Aspiration – foreign matter
- ❒ Cardiac arrest
- ❒ Death
- ❒ Drug reaction or toxic effect
- ❒ Fracture
- ❒ Laceration
- ❒ Injection site injury
- ❒ None
- ❒ Other: _____

C. Severity of Injury

- ❒ No apparent injury
- ❒ Minor
- ❒ Moderate
- ❒ Severe
- ❒ Not applicable

D. Corrective Action

Policy/Procedure

- ❒ Chance
- ❒ In-service
- ❒ Facility/Equipment Change

E. How could this have been prevented?

_____

_____

_____

_____

Date of Report: _____

This form should be given to the Nurse Manager

SENTINEL EVENT

DEFINITION:

Any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. Sentinel Events include but are not limited to XXXXXXXXXXXX Business on the wrong patient or wrong body part, unanticipated death – see reporting form.

POLICY:

Upon identification, this facility will respond appropriately to all Sentinel Events occurring or associated with services/actions rendered. Appropriate response includes a thorough and credible root cause analysis, implementation of improvements to reduce risk and monitoring of the effectiveness of those improvements.

PROCEDURE:

1. Facility staff shall notify the Nurse Manger immediately and complete a Variance form as soon as practical.
2. The Nurse Manager shall immediately notify Medical Director, Administrator and Steering Committee. The Administrator shall notify the Risk Manager of the malpractice carrier within 24 hours.
3. The Nurse Manager will be assigned as team leader to keep the focus on the event sequence.
4. The facilitator and/or team leader shall identify any data or materials that should be secured as evidence. The Mandatory Reporting of Sentinel Events form is t*o be submitted or called to the* Maine Department of Health & Human Services Division of Licensing and Certification *by the next business day after the sentinel event occurred or the next business day after the Center determines that an event occurred.*
5. In preparation for the first emergency Advisory Committee meeting, every staff person involved in the event shall prepare a written account of their observations and sequence of events, including any potential contributing factors.
6. At the first meeting, the accounts of team members will be compared and combined to generate a thorough detailed list of the sequence of events. The Nurse Manager or designee shall document the sequence of events and immediate corrective actions taken on the Root Cause Analysis Report.
7. The team shall then identify factors that contributed to the event and mark those items on the sequence of events that could potentially be contributory to the event. Each event in the sequence will be analyzed by the team until it is determined whether it was "contributory", "non contributory" and "incidental finding" or that there is "insufficient data".
8. Contributory factors shall be further analyzed by the team until the root cause is identified. l findings that are important but non-contributory to the sentinel event shall be topics for future quality improvement studies.
9. Once the root cause is identified, the team shall develop an "Action Plan" that includes a corrective or improvement action for each root cause or root contributor and a responsible party assigned. A timetable shall be established for implementation of each corrective action.
10. A Summation of the event shall be written on the State Narrative Report within 45 days of the event and submitted to the Maine Department of Health & Human Services Division of Licensing and Certification.
11. The Nurse Manager determines the evaluation method of the corrective action and the date it will be evaluated.
12. The Nurse Manager is responsible for reporting team activities to the Administrator. The Administrator is responsible for communicating team activities to the Medical Steering Committee.
13. The Action Plan is monitored at the quarterly Medical Advisory Committee until the Committee deems the issue resolved.

S orting Form

Section I

This information is protected from public disclosure.

This form is required to meet the regulations pursuant to Section 1, 22 MRSA, Chapter 1684, Sentinel Events Reporting, § 8756
Regulations for Governing the Licensing of Ambulatory Surgical Facilities, Chapter 4.B. Compliance Requirements-Mandatory Reporting of Sentinel Events; the Licensing of General and Specialty Hospitals, Chapter VI.T. Governing Board-Mandatory Reporting of Sentinel Events; Critical Access Hospitals, Chapter XXVII C.1.b) (4); the Licensing of End Stage Renal Disease Units/Facilities, Chapter 4.F. Administration-Mandatory Reporting of Sentinel Events; the Licensing and Functioning of Intermediate Care Facilities for Persons with Mental Retardation, Chapter 5.D.11 Mandatory Reporting of Sentinel Events

I. Each facility (general acute hospital, critical access, and specialty hospital, ambulatory surgical facility, end stage renal disease, intermediate care for mental retardation) shall report (to the Division) all patient sentinel events.

II. Patient Sentinel Events include:

a. One of the following that is determined to be unrelated to the natural course of the patient's illness or underlying condition or proper treatment of that illness or underlying condition that results from the elopement of a patient who lacks the capacity, as defined in Title 18-A, section 5-801, paragraph C, to make decisions:

1) An unanticipated death; or
2) Major loss of physical or mental function not related to the natural course of the patient's illness or underlying condition.

b. XXXXXXXXXXXX Business on the wrong patient or body part;
c. Hemolytic transfusion reaction involving the administration of blood or blood products having major blood group incompatibilities;
d. Infant abduction or discharge to the wrong family;
e. Rape of a patient;
f. Suicide of a patient in a healthcare facility where the patient receives inpatient care.

Section II

Part I: *To be submitted or called to the Division by the next business day after the sentinel event occurred or the next business day after the hospital determines that an event occurred.*

Name of facility	
Type of Sentinel Event	
Date of Event	
Time of Event	
Date of Detection (Date event identified by facility)	
Date of this Report	
Patient's Age	
Patient's Gender	
Admitting Diagnosis	
Name, title and contact information of person submitting report (Phone and email)	

Part II: Narrative Report *To be submitted in writing forty-five (45) days from the date the event was reported to the Division. (**May include attachments if all information is provided.**)*

Name of facility and address	
Name, title and contact information of person submitting report (phone and email)	
Date and time of event	
Type of event	
Detailed Narrative Report to include:	1. Description of event 2. Clinical or organizational systems or processes that may have contributed to the sentinel event 3. Identification of changes to reduce the risk of reoccurrence, corrective actions taken or planned 4. Signature of the Chief Executive Officer/Administrator of the hospital

Detailed Narrative Report

Please submit via fax to 207-287-3251, e-mail (roberta.jolda@maine.gov or carole.kennally@maine.gov), or mail (suggest Return Requested)

Confidential to Roberta Jolda RN, HSC

or

Carole Kennally RN, HSC
Maine Department of Health & Human Services
Division of Licensing and Certification
11 State House Station
442 Civic Center Drive
Augusta, Maine 04333-0011

INFECTION CONTROL

POLICY
Every month an infection survey form will be reviewed and signed by each M.D. on all their individual cases.

There will be a tracking form in the Center nurses office which will be completed by the Center Manager on patients with suspected post-procedure infections.

The infection rate will be presented quarterly to the Advisory Board. This report should include the following:

- Number of procedures performed per MD
- Number of procedures with a post-procedure infection.
- Percent of procedures wit a post-procedure infection.
- Type of procedures with infection.

After the Center Nurse Manager reviews the summarization, a review will be completed of infection and complications to determine if action is required.

Further investigation would be indicated if:

1) There is a high infection rate
2) There is a trend in the type of infections

Once investigations have been accomplished, the Medical Director and ASU Nurse Manager will determine what action to take and when to evaluate the result of the action taken to determine if the action produced improvement in outcome.

The statistical information and the review of problems, investigation, action, results and improvement are reported to the Center Advisory Committee. The committee approves the report and can make recommendations. If recommendations are made, managers are made aware of them and confer with the Medical Director for action steps to take. This report will be presented at the Center Advisory Steering Committee meeting, where it is documented in minutes that are reviewed by the Governing Body

INFECTION TRACKING FORM

To be completed by Center Nurse Manager *Date:* _____

Definition of Infection:

Multiplication of bacteria in the body characterized by local pus formation.

Patient Name/ DOB:_____ MD:_____

DOS**:**_____ OR Room:_____ RN: _____

Allergies:_____ Anesthesia Type:_____

Anesthesiologist:_____ Procedure Length: _____

Procedure: (1)_____ (2) _____

Pre-Op / Intra-Op Meds: _____

Wound Classification:_____ Skin Prep Used: _____

Hospital: _____

Please Check All Applicable Boxes Below:

Clinical Findings:

Abscess (not suture related)
Fever (>38°C or 100.4°F)
Pain / Tenderness at Wound Site
Purulent Drainage (not suture related)
Swelling / Redness

Were Instruments Flashed? Y N
Do Test Strips for Sterilizer Indicate Problem? Y N

☐ Admitted/Date: _____
☐ Antibiotics Initiated-/Date/Drug_____
_____
☐ Wound Cultures Submitted: Y N
☐ Wound Opened Y N
Risk Factors (i.e., diabetes, smoker, age, or non-compliance)

Summary / Investigation:

_____
_____
_____
_____

Date Resolved: _____

M.D. Signature: _____ Date: _____

EXAMPLE OF INFECTION AND POST PROCEDURE COMPLICATIONS LETTER TO SURGEON

XXXXXXXXXXXX BUSINESS, CENTER Infection Control Survey
XXXXXXXXXXXX Business date: 11/14/00

Surgeon: ALL

Surgeon	Patient	Case	D.O.B	Post-Op Infection?		Complications?		Hospitalization		Resolved
Date	Assist	Procedure qc	Description	Yes	No	Yes	No	Yes	No	

BROWN, DAVID (DGB)

XXXX, xxxxx / 27193010270 / 11/14/2007 ____ ____ ____ ____ ____ ____ ____

____
ACL RECONSTRUCTION ARTHROSCOPICALLY
AIDED ANTERIOR CRUCIATE LIGAMENT
REPAIR/AUGMENTATION OR RECONSTRUCTION

Other Surgeons related to this case:
Comment:
Number of surgeries: 1 Surgeon's Signature: Date:

CAIN, PAUL (PRC)

XXXXX, xxxxxxx / 120921 03/09/89
10246 / 11/14/2007 ARTHROSCOPY ____ ____ ____ ____ ____ ____
____ ____
L KNEE SCOPE-REP.PAT.LIG.
ARTHROSCOPY, KNEE, SURGICAL;
WITH MENISCECTOMY (MEDIAL OR LATERAL,
INCLUDING ANY MENISCAL SHAVING)

XXXXX xxxxxxxx/ 100361 10/01/91
10228 / 11/14/2007 REMOVAL OF ____ ____ ____ ____ ____ ____
____ ____
HARDWARE REM L KNEE
REMOVAL OF IMPLANT; DEEP (EG, BURIED
WIRE, PIN, SCREW, METAL BAND, NAIL, ROD OR PLATE)

Other Surgeons related to this case:
Comment:

Number of surgeries: 2 Surgeon's Signature: Date:

TIMONEY, JAMES (JMT)

Xxxx,xxxx / 69455 12/10/47
10160 / 11/14/2007 ARTHROSCOPY ____ ____ ____ ____ ____ ____
____ ____
ARTHROSCOPY, SHOULDER, DIAGNOSTIC,
WITH OR WITHOUT SYNOVIAL BIOPSY

Other Surgeons related to this case:
Xxxx,xxxxx / 22387 07/27/38
10247 / 11/14/2007 REMOVAL OF ____ ____ ____ ____ ____ ____
____ ____
DX SCOPE-HDWRE REM L ANKLE
REMOVAL OF IMPLANT; DEEP (EG, BURIED
WIRE, PIN, SCREW, METAL BAND,
NAIL, ROD OR PLATE)

Number of surgeries: 3 Surgeon's Signature: Date:

TRENDING INFECTION LOG

Review Date: _____

Patient Name	Date	Post-Op Diagnosis	Culture Results	Treatment Given:

DISEASES/INFECTIONS MANDATORY REPORTING

NOTIFIABLE CONDITIONS LIST

MAINE DEPARTMENT OF HUMAN SERVICES, BUREAU OF HEALTH

Category 1: Reportable immediately by telephone on the day of recognition or strong suspicion of disease:	**Category 2: Reportable within 48 hours of recognition or strong suspicion:**	**Laboratory Specimen Submission:**
Chickenpox (varicella) ▪ Admission to hospital, any age ▪ Adults >18 years, any clinical setting Diphtheria Hepatitis A, B, and C (acute) Hepatitis, acute (etiologic tests pending or etiology unknown) Measles (rubeola) Meningococcal disease Outbreaks ▪ Foodborne (involving 2 or more persons); waterborne; and respiratory ▪ Institutional ▪ Unusual disease or illness Pertussis Poliomyelitis Rabies (human and animal) Rubella (including congenital) *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin Tuberculosis (active and presumptive cases) Category 1 Diseases that are possible indicators of bioterrorism: Anthrax Botulism Brucellosis Gram positive rod septicemia or meningitis, growth within 72 hours of inoculation in laboratory Outbreaks of unusual disease or illness Plague Q fever Ricin Poisoning Smallpox Staphylococcal enterotoxin B pulmonary poisoning Tularemia Venezuelan equine encephalitis	Acquired Immunodeficiency Syndrome (AIDS) Babesiosis Campylobacteriosis CD4 lymphocyte counts <200/ul or <14% of total lymphocytes Chancroid Chlamydia (*c. trachomatis*) (all sites) Chickenpox Chickenpox-related death Creutzfeldt-Jacob disease, <55 years of age Cryptosporidiosis Cyclosporiasis Ehrlichiosis Encephalitis, arboviral *Escherichia coli* 0157:H7 (and all other hemorrhagic *E. coli* enteritis, shiga producing *E. coli* strains) Giardiasis Gonorrhea *Haemophilus influenzae* disease, invasive, all serotypes Hantavirus pulmonary syndrome Hemolytic-uremic syndrome (post-diarrheal) Hepatitis B (chronic, prenatal) Hepatitis C (chronic) Human Immunodeficiency virus (HIV) infection* Influenza-like illness outbreaks Legionellosis Listeriosis Lyme Disease Malaria Meningitis, bacterial Meningococcal invasive disease Methicillin-resistant *Staphylococcus aureus* suspected to be community-acquired Mumps Psittacosis Salmonellosis Shiga toxin-related disease (gastroenteritis) Shigellosis Streptococcal disease, invasive Groups A and B *Streptococcus pneumoniae*, invasive disease Severe Acute Respiratory Syndrome (SARS) Syphilis Tetanus Toxoplasmosis Trichinosis Vancomycin-resistant *Staphylococcus aureus* *Vibrio* species, including Cholera West Nile virus infection Yellow Fever *Soundex patient identifier or patient name required	**Directors of Laboratories are to submit cultures of the following organisms to the Maine Health and Environmental Testing Laboratory for confirmation, typing, and/or antibiotic sensitivity including but not limited to:** *Bordetella pertussis* *Clostridium botulinum* *Clostridium tetani* *Corynebacterium diphtheria* *Escherichia coli* 0157:H7 *Francisella* species *Haemophilus influenzae,* invasive *Legionella* species *Listeria* species *Mycobacterium* species (TB complex only) *Neisseria meningitidis* *Salmonella* species, including *S. typhi* *Shigella* species *Streptococcus,* Group A, invasive only *Streptococcus pneumoniae,* invasive only *Vibrio* specie *Yersinia pestis* **Antibiotic-resistant Diseases in Special Category:** Other diseases caused by selected antiobiotic-resistant organisms are to be reported semiannually (twice each year) in aggregate form by clinical laboratories. These include: ▪ Invasive disease caused by methicillin-resistant *Staphylococcus aureus* (MRSA) ▪ Invasive disease caused by vancomycin-resistant Enterococcal species ▪ Invasive disease caused by penicillin-resistant *Streptococcus pneumoniae*

Who must report:

Health Care Providers, Medical Laboratories, Health Care Facilities, Administrators, Health Officers, Veterinarians

When to report:

- Category 1 diseases are reportable immediately by telephone on recognition or strong suspicion of disease
- Category 2 diseases are reportable by telephone, fax, or mail within 48 hours of recognition or strong suspicion of disease

What to report:

Disease reports must include as much of the following as is known:

- Disease or condition diagnosed or suspected
- Case's name, date of birth, address, phone number, occupation and race
- Diagnostic laboratory findings and dates of test relevant to the notifiable condition
- Health care provider name, address and phone number
- Name and phone number of person making the report

Complete Rules for the Control of Notifiable Conditions at

HOW TO REPORT:

TELEPHONE: ***OR*** FAX:
1-800-821-5821 1-800-293-7534
(24 hours a day) (24 hours a day)

The Department of Human Services
Bureau of Health

CANCER REPORTING

POLICY

Under Maine code of regulations, Chapter 225,Cancer

Section **§1402** All hospitals and other health care facilities providing screening, diagnostic or therapeutic services with respect to cancer shall report to the Department of Human Services all persons diagnosed as having a malignant tumor or certain benign tumors as determined by rule no later than 6 months from the date of diagnosis. The report must include information on the person's usual occupation and industry of employment and other elements determined by rule to be appropriate. The Commissioner of Human Services shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [2003, c. 421, §11 (amd).]
A physician, surgeon or other health care practitioner who diagnoses or provides treatment for cancer patients, upon notification by the Department of Human Services, shall report to the department any further information requested by the department concerning any person now or formerly under the health care practitioner's care, diagnosed as having or having had a malignant tumor. A physician, surgeon or other health care practitioner who diagnoses or provides treatment for cancer patients is required to report any newly diagnosed cancer case to the department when that patient will not be referred to a reporting facility for diagnosis or treatment. [1995, c. 292, §1 (amd).]
A facility or individual complying with the reporting requirements of this section is not liable for any civil damages as a result of such acts. [1995, c. 292, §1 (amd).]

MAINE CANCER REGISTRY, Maine Center for Disease Control, DHHS
286 Water Street, 4th Floor, 11 State House Station, Augusta, ME 04333
TEL: (207) 287-4742 FAX: (207) 287-4631

PHYSICIAN REPORTING FORM INSTRUCTION SHEET

GENERAL INSTRUCTIONS

The Physician Reporting Form is to be used to document cases of cancer that are diagnosed and treated in the physician's office or other non-hospital setting. It is not meant for cases in which the patient was also admitted to a Maine hospital for either diagnostic procedures or treatment of the cancer. The following cases are reportable to the Maine Cancer Registry:

All neoplasms classified as in-situ or malignant (behavior codes 2 or 3), **except**
- carcinoma in-situ of the cervix;
- basal and squamous cell carcinomas of all skin sites other than genital sites

All benign or uncertain neoplasms (behavior codes 0 or 1) of the meninges, brain, and central nervous system.

Report only newly diagnosed cases. Cases of recurrent cancer are not reportable. Report cancer only for its site of origin (primary site). Metastatic cancer is reportable in lieu of a primary cancer only if the primary site is unknown. If the patient was diagnosed in your practice prior to 1995, this particular cancer is not reportable, and the Physician Reporting Form is not required. If you are uncertain whether or not you should report a case of cancer, please contact the Maine Cancer Registry (MCR) for advice.

The MCR appreciates that not all data items will apply to every case and that information will be lacking in some cases. Each required data item is explained below. Information is ordered as it appears on the form.

1. PHYSICIAN INFORMATION

Physician's Name: Enter the name of the patient's physician in this practice.
License Number: Enter the Maine license number of the patient's physician in this practice.
Physician Address: Enter the address of the office location where correspondence should be sent.

2. PATIENT INFORMATION

Last Name, First Name, Middle Name, Maiden Name, and Suffix: Enter the patient's last name, first name, middle name, maiden name if known, and suffix.
Date of Birth: Enter the patient's date of birth. Use this format: mm/dd/yyyy.
Social Security Number: Enter the patient's social security number.
Sex: Identify the physical sex of the patient.
Race: Identify the patient's race.
Hispanic: Identify the patient's Hispanic ethnicity if known.
Occupation/Industry: Enter the occupation and industry of the patient during most of his/her working life prior to the diagnosis of this cancer, even if the patient is currently retired (e.g., teacher, retired/high school).
Address at Diagnosis (Street Address, City, State, Zip): Enter the patient's permanent address at diagnosis. Use street address rather than PO Box or rural delivery numbers where possible. Town of residence is preferred over town of postal address.
Current Address (Street Address, City, State, Zip): Enter the patient's current address if different from the address at diagnosis.

3. CANCER INFORMATION

Date of Diagnosis: Enter the date this cancer was first diagnosed. The first positive statement by a physician of *cancer or malignancy* is acceptable, including radiology reports, clinical diagnosis, direct visualization (endoscopy), or cytology and pathology reports. Use this format: mm/dd/yyyy.
Date 1st seen for this cancer: Enter the date that the patient was first seen at this practice for this cancer. Use

mm/dd/yyyy.

Primary Site: Enter the primary site (origin) of this cancer. If the origin of the cancer is not known (e.g. "metastatic adenocarcinoma in T4 vertebra"), enter "unknown primary" or, in the case of melanoma, enter "skin, NOS."

Histology or Morphology: Enter the histologic type of this cancer (e.g., adenocarcinoma).

Laterality: Circle which side of the organ the cancer was diagnosed at (if known) for paired organs.

Grade Code: If known, indicate the histologic grade (e.g., moderately differentiated).

Behavior Code: If known, indicate whether the tumor is benign, uncertain, in-situ, or malignant.

What number cancer is this?: Indicate if the current cancer is the first, second, third, etc. cancer this patient has been diagnosed with.

STAGING INFORMATION: If this cancer has been staged by the physician, please record the information in the following fields. The MCR recognizes that cancer is not always staged in the office setting. The MCR will attempt to stage the cancer based on the diagnostic and treatment information provided on this form.

- **Stage Description:** Provide a text description regarding the stage/extent of disease at diagnosis.

Tumor Size: Indicate the largest dimension or diameter of the primary tumor in centimeters.

Tumor Extension/Depth of Invasion: Indicate the farthest documented extension of the primary tumor either clinically or pathologically. Do not include discontinuous metastasis to distant site(s). (eg., for melanoma include Clark's Level and Breslow's depth of invasion. For prostate cancer include information regarding direct extension beyond the prostate gland.)

Number of Regional Lymph Nodes (LN) Examined: Indicate the total number of regional lymph nodes removed and examined by a pathologist.

Number of Regional Lymph Nodes (LN) Positive: Indicate the exact number of regional lymph nodes examined by a pathologist and found to contain tumor.

Identify Regional Lymph Nodes (LN) Involved: Identify the specific regional lymph node chain farthest from the primary site that is involved by tumor either clinically or pathologically.

Site(s) of Distant Metastases: List sites of distant metastases.

- **General Summary Stage Code:** Select stage code according to the SEER Summary Staging Manual 2000. If staging manual is not available, please provide text to substantiate the stage at diagnosis.
- **Pathologic/Clinical TNM, AJCC Stage:** Assign the appropriate T, N, M, and Stage Group Code according to the AJCC TNM Staging Manual. If staging manual is not available, please provide text to substantiate the stage of disease at diagnosis.

4. DIAGNOSTIC INFORMATION (Methods of Diagnosis -- Type of Test, Date and Result)

Histology (Tissue Sample)
Cytology (FNA, Spun Cells)
Radiology/Scans/Ultrasound
Visualization (e.g., Endoscopy)
Clinical (inc. Phys. Exam)

Select "YES" or "NO" under each category of test. If the patient had any of these tests, give the date of the test and a very brief summary of the result (e.g., "10/12/98 CT brain-metastatic carcinoma in lt. frontal lobe." Or "12/30/98 skin lt. forearm-malignant melanoma, Clark's Level II, Breslow's depth 0.60 mm., margins negative.")

5. FIRST COURSE OF TREATMENT INFORMATION (Date and Description)

Cancer Directed XXXXXXXXXXXX Business
Radiation Therapy
Chemotherapy
Hormone Therapy
Biological Response Modifier or Other

Select "YES" or "NO" under each category of treatment. If the patient had any of these treatments, give the date of

treatment and a very brief summary of the procedure (e.g., "12/30/98 Excisional bx of suspicious skin lesion, left forearm." Or "05/09/97 Tamoxifen started.")

6. FOLLOW UP INFORMATION

Vital Status: Circle the appropriate vital status.

Date of Death or Last Contact: If the patient is deceased, this will be the date of death. If the patient is still living, this date will be the last time the patient was seen by your practice. Use this format: mm/dd/yyyy.

Tumor Status: Select the appropriate disease status, regardless of whether the patient is living or deceased.

ICD-9-CM Code for Cancer Related Cause of Death: Provide the appropriate ICD-9 code describing the cause of death. Please provide text if code unknown.

If Deceased, was there an Autopsy?: Select Yes, No, or Unknown.

Following Physician's Name: Provide name of physician who is currently responsible for the patient's medical care.

Managing Physician's Name: Provide name of physician who is responsible for the overall management of the patient during diagnosis and/or treatment for this cancer.

Referring Physician's Name: Provide name of physician who referred this patient.

Patient referred from: For this cancer, if the patient was referred to this practice by another facility or physician, enter the information here.

Patient referred to: For this cancer, if the patient was referred elsewhere for further diagnostics or treatment, enter the information here.

MAINE CANCER REGISTRYPHYSICIAN REPORT FORM (06/05)

Please submit form to: DAWN NICOLAIDES, CTR
MAINE CANCER REGISTRY
286 WATER STREET, 4TH FLOOR
11 STATE HOUSE STATION
AUGUSTA, ME 04333-0011
PHONE: 207-287-4742

PHYSICIAN NAME
PHYSICIAN LICENSE #
PHYSICIAN ADDRESS

PATIENT INFORMATION

LAST name	FIRST NAME	MIDDLE NAME	MAIDEN NAME
NAME SUFFIX (SR. JR, III ETC)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	Sex ☐ 1 Male ☐ 2 Female ☐ 3 Other ☐ 4 Transexual ☐ 9 Unknown

Race	Hispanic	Usual Occupation – text
☐ 1 White ☐ 2 Black ☐ 3 Native American ☐ 96 Asian ☐ 9 Unknown ☐ Other _____	☐ 1 Yes ; If yes, ethnicity_____ ☐ 2 No ☐ 9 Unknown	_____ Usual Industry – text _____

Address at diagnosis

Street City State Zip

Current address, if different from above

Street City State Zip

CANCER INFORMATION

Date of Diagnosis (mm-dd-yyyy) Date first seen for this cancer (mm-dd-yyyy)	Primary Site (text description)	Histology or Morphology (text)	
Laterality (check one) ☐ 0 N/A ☐ 1 Right ☐ 2 Left ☐ 3 One side, unknown which ☐ 4 Bilateral ☐ 9 Paired organ, no information re laterality	Grade Code ☐ 1 Well differentiated ☐ 5 T-Cell ☐ 2 Moderately well differentiated ☐ 6 B-Cell ☐ 3 Poorly differentiated ☐ 7 Null Cell ☐ 4 Undifferentiated, Anaplastic ☐ 9 Unknown or N/A	Behavior Code ☐ 0 = Benign ☐ 1 = Uncertain ☐ 2 = In - situ ☐ 3 = Malignant	What number cancer is this (1st, 2nd, 3rd, etc)?

Stage Description (complete all applicable fields)	General Summary Stage	Pathologic TNM, AJCC Stage
Tumor Size_____ Tumor Extension/Invasion_____ # Regional Lymph Nodes (LN) Examined_____# Regional LN Positive _____ Identify Regional LN Involved ____ _____ Site(s) of Distant Metastasis _____	☐ In Situ ☐ Localized ☐ Regional by Direct Extension ☐ Regional Lymph Nodes ☐ Distant	T_____N_____M_____Group _____ Clinical TNM, AJCC Stage T_____N_____M_____Group _____

DIAGNOSTIC INFORMATION

HISTOLOGY (TISSUE SAMPLE) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	
CYTOLOGY (FNA, SPUN CELLS) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	
RADIOLOGY, SCANS, ULTRA SOUND ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

VISUALIZATION (E.G. ENDOSCOPY) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	
CLINICAL (INC. PHYS. EXAM) ☐ YES ☐ NO	DATE
TEXT DESCRIPTION	

PHYSICIAN NAME

PATIENT INFORMATION,

LAST name	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

FIRST COURSE OF TREATMENT INFORMATION COMPLETE ONLY THE FOLLOWING WHICH APPLY TO THIS PATIENT

CANCER DIRECTED XXXXXXXXXXX BUSINESS ☐ YES ☐ NO	DATE OF CANCER DIRECTED XXXXXXXXXXX BUSINESS
SURGICAL PROCEDURE TEXT	

RADIATION THERAPY ☐ YES ☐ NO	DATE OF RADIATION THERAPY
RADIATION THERAPY TEXT	

CHEMOTHERAPY ☐ YES ☐ NO	DATE OF CHEMOTHERAPY
CHEMOTHERAPY TEXT	

HORMONE THERAPY ☐ YES ☐ NO	DATE OF HORMONE THERAPY
HORMONE THERAPY TEXT	

BIOLOGICAL RESPONSE MODIFIER ☐ YES ☐ NO	DATE OF BRM
BRM TEXT	

OTHER TREATMENT ☐ YES ☐ NO	DATE OF OTHER TREATMENT
OTHER TREATMENT TEXT	

FOLLOW UP INFORMATION

' ITAL STATUS 1 Alive ☐ 0 Dead	l ATE OF DEATH OR LAST FOLLOW-UP	' UMOR STATUS ☐ 1 No evidence of this Cancer ☐ 2 Evidence of this Cancer 9 Unknown
lCD-9-CM CODE FOR CANCER RELATED CAUSE OF l TH:	l F DECEASED, WAS THERE AN AUTOPSY? 1 YES ☐ 2 NO ☐ UNKNOWN	
l OLLOWING PHYSICIAN'S NAME	l ANAGING PHYSICIAN'S NAME	' URGEON'S NAME
l EFERRING PHYSICIAN'S NAME	INSTITUTION REFERRED FROM	INSTITUTION REFERRED TO
COMMENTS:		

CENTER QUARTERLY REPORT
QUARTER/ANNUAL

1. Analysis Of Procedures

1st Quarter cases performed	QTD_____	
2nd Quarter cases performed	QTD_____	YTD_____
3rd Quarter cases performed	QTD_____	YTD_____
4th Quarter cases performed	QTD_____	YTD_____

2. Patient Satisfaction Surveys

1st Quarter survey	QTD_____	Satisfaction Rate___%
2nd Quarter survey	QTD_____	Satisfaction Rate___%
3rd Quarter survey	QTD_____	Satisfaction Rate___%
4th Quarter survey	QTD_____	Satisfaction Rate___%
	YTD_____	Response Rate_____%

3. Risk Management
Safety
 # Variance Reports

1st Quarter	QTD_____
2nd Quarter	QTD_____
3rd Quarter	QTD_____
4th Quarter	QTD_____
	YTD_____Rate_____%

 # Sentinel Event YTD____0_____

 # Complications

Rate Based Indicator Complication

1st Quarter	QTD_____
2nd Quarter	QTD_____
3rd Quarter	QTD_____
4th Quarter	QTD_____
	YTD_____Rate___%

Hospital Involvement

1st Quarter	QTD_____
2nd Quarter	QTD_____
3rd Quarter	QTD_____
4th Quarter	QTD_____
	YTD_____Rate %

 # Infections

1st Quarter	QTD_____
2nd Quarter	QTD_____
3rd Quarter	QTD_____
4th Quarter	QTD_____
	YTD_____Rate_____%

 # Environmental/Safety Monitoring Deficiencies

1st Quarter QTD_____
2nd Quarter QTD_____
3rd Quarter QTD_____
4th Quarter QTD_____
YTD_____Rate_____%

Hospital Transfers

1st Quarter QTD_____
2nd Quarter QTD_____
3rd Quarter QTD_____
4th Quarter QTD_____
YTD_____Rate_____%

Tissue Cases (Pathology)

1st Quarter 2007# of Tissue Cases QTD_____
2nd Quarter 2007# of Tissue Cases QTD_____3rd
Quarter 2007# of Tissue Cases QTD_____
4th Quarter 2007# of Tissue Cases QTD_____YTD_____

Medical Records Deficiencies

1st Quarter QTD_____0_____
2nd Quarter QTD_____0_____
3rd Quarter QTD_____0_____
4th Quarter QTD_____0_____
YTD_____Rate_____%

Pharmacy

Outdates/Consultant Report

1st Quarter QTD_____0_____
2nd Quarter QTD_____0_____
3rd Quarter QTD_____0_____
4th Quarter QTD_____0_____
YTD_____Rate_____%

Cancellation

1st Quarter QTD_____0_____
2nd Quarter QTD_____0_____
3rd Quarter QTD_____0_____
4th Quarter QTD_____0_____
YTD_____Rate_____%

Radiation

Exceed Exposure Limit Summation of All:

1st Quarter QTD_____0_____
2nd Quarter QTD_____0_____
3rd Quarter QTD_____0_____
4th Quarter QTD_____0_____
YTD_____Rate_____%

PROBLEM RESOLUTION/QUALITY IMPROVEMENT LOG

Date to Committee	Problem # & Priority	Problem Title	Person Responsible	Date Corrected	Date Monitored

PROBLEM IDENTIFICATION AND ASSESSMENT

Problem #:_____ Priority: A B C Date: _____

Problem Description: _____

_____

_____

_____

Individual Assigned: _____

Assessment: _____

_____

_____

_____

Corrective Action Taken: _____

_____

_____

_____

_____

Follow Up Activity or Date: _____

_____

Completion Date (no further follow-up necessary): _____

_____

PROBLEM IDENTIFICATION AND ASSESSMENT FOLLOW-UP FORM

Brief Description of Problem: _____

Follow-up Action Results: _____

_____

SIGNATURE

CENTER NO SHOW

PURPOSE: In the event a patient does not show for the following types of appointments: referral, initial office visit, post op visit, follow up visits involving interpretation of diagnostic testing and XXXXXXXXXXXX Business inpatient, outpatient or CENTER .

POLICY: The Center will document the steps taken in following up on the patients that fail to show for these types of appointments in order to minimize risks to both the patient and physicians.

PROCEDURE:

1. The Center will contact via telephone a minimum of twice. Speaking directly with the patient is the best way to ensure a accurate understanding of why the no show occurred. A notation of the calls will be entered into the patient recorded.
2. The Center will send all patients (whether they are reached by phone or not) a letter informing the patients of the importance of contacting the office. A copy of the letter will be entered into the chart.
3. Documentation of calls and letter sent will be logged into the cancellation log.
4. A letter will be sent to the referring physician of the patient's decision not to show for the appointment.
5. The letter is scanned into the electronic medical record as documentation of attempts to reach patient.

EXAMPLE LETTER

Date

John Doe
10 Flag St.
Anytown, ME 04111

Dear John Doe,

Your appointment was scheduled for January 1, 2000. You did not arrive for this appointment, therefore we request that you call your physician's office at 207-783-1328 to reschedule your appointment at a more convenient date.

Please call even if you do not plan to reschedule your appointment.

Thank you,

XXXXXXXXXXX Business

CANCELLATIONS TRACKING (Within 72 hours of XXXXXXXXXXXX Business)

DATE	*PATIENT NAME*	*REASON FOR CANCELLATION*

CANCELLATION SUMMARY

# Cancellations	Reason For Cancellation
	Illness
	Insurance doesn't cover
	Transportation problems
	Family or work emergency
	Changed mind
	No Show

PATHOLOGY REPORTS

POLICY
A log is maintained of each specimen sent to a pathologist
The log is checked regularly to determine if results have been returned within one week. There will be

a follow up phone call to the pathology lab if results are not back within one week. When the pathology report is received, the log will be marked.

It will be confirmed that the doctor has seen each pathology report by initializing. If there is no conflict between the pre-procedure and post-procedure findings and no further action is needed, the pathology report will be filed in the medical record. If conflict exists, peer review will occur.

A summary is prepared each month:

- Number of specimens sent
- Number of reports that were returned more than one week after the specimens were sent.
- Number of conflicts.

This report will be presented at the Center Advisory Steering Committee meeting where it is documented in minutes that the Governing Body reviews.

PATHOLOGY REPORTING LOG

_____Quarter_____Year
Procedures: _____
Number of Pathology Specimens: _____

Objective:

a) To review and report pathology
b) Inform the Advisory Committee of review reporting
c) Accomplish Performance Improvement Goals

Total	MD #	Pre op Diagnosis	MR #	Pathology Report Diagnosis
1	22	Excision Cyst Long Finger		Compatible with ganglion cyst, NO ATYPIA
2	24	Ganglion Cyst		Ganglion cyst
3	22	Volar Retinacular Cyst		Ganglion , NO ATYPIA
4	22	Volar ganglion Cyst		Ganglion Cyst, NO ATYPIA
5		Compartment Tendinitis		Compatible with focal chronic Synovitis
6	22	Volar Ganglion		Ganglion Cyst , NO ATYPIA
7	2	Synovial Cyst		Synovial Cyst
8	15	Recurrent Skin Lesion		Cellular dermatofibroma Mayo Clinic consult confirmed, tumor cells staining for Factor XIIIa, scattered s-100
9	24	PIP joint Swelling		Nonspecific chronic inflammation
10	2	Lipoma left shoulder		Compatible with Lipoma
11	22	Synovitis MP JT		Mild chronic Synovitis NO ATYPIA
12	24	Dorsal Carpal Ganglion		Ganglion cyst
13	22	Excision Mass Finger		Giant Cell Tumor NO UNDUE CYTOLOGIC ATYPIA
14	24	Tenosynovium wrist		Chronic Synovitis compatible with juvenile rheumatoid arthritis
15	24	Shoulder Mass		Mature fat consistent with Lipoma , NO ATYPIA
16	24	Mucus Cyst		Mucinous cyst
17	22	Mass left forearm		Thrombosed Vessel
18	22	Excision Ganglion L Wrist		Ganglion
19	22	Mass Palm		Skin showing capillary hemangioma- NO EVIDENCE OF MALIGNANT CHANGE
20	15	Meniscal tear loose bodies		Segments of bone from osteophyte of the left knee , NO ATYPIA
21	22	Benign skin lesion hand		Benign non specific acanthoma
22	44	Dupuytrens disease hand		Palmar Fibromatosis , NO ATYPIA
23	44	1. Mass finger 2. Chronic Synovitis		1. Foreign body granulomatous reaction 2. Rheumatoid nodules
24	44	Volar Ganglion Cyst		Ruptured Ganglion Cyst
25	31	Post Subacromial Decompression 9 mos		Non specific focal superficial ulceration with dermal inflammation NO ATYPIA
26	22	Mass upper arm		Chronic and granulomatous inflammation with fibrosis, Acid Fast and Fungal stain negative.
27	24	Mass forearm arm		Myxoid neurofibroma NO MALIGNANCY
28	22	Mass finger		FB with granulomatous reaction NEGATIVE FOR NEOPLASM
29	31	Torn medial meniscus Knee		Benign Synovial tissue with mild Synovial proliferation, NO ATYPIA
30	24	Retinacular Cyst		Nonspecific chronic inflammation and fibrosis
31	22	Mass finger		Hemangioma WITHOUT ATYPIA
32	31	Patellofemoral chrondromalacia		Ganglion cyst NO MALIGNANCY
33	22	Mass Finger		Capillary Hemangioma NO MALIGNANCY
34	22	Ganglion Cyst		Ganglion NO ATYPIA SEEN
35	22	Ganglion Cyst Wrist		Ganglion NO ATYPIA SEEN

No Malignancies Reported, all diagnosis consistent with pathology.

Recommended Action/Follow Up:

_____ _____

Signature of the Advisory Committee Chairman ***Date Signed***

STAFF COMMUNICATIONS

POLICY

At least once a month, staff is informed, through meetings or written communication, of the following:

1. Policies and procedures changed.

2. Infection control and complications report so the staff is aware of patient infections and complications and given an opportunity to provide input on ways to control these outcomes.

3. Findings from performance improvement monitors; e.g., documentation of care concerns, risk management variance reports, employee injuries, selected monitors.

The staff communications must be detailed enough so that anyone who is not present at a meeting due to illness or work assignments can read the communications and learn what was discussed. Particular attention should be paid to the closure of the information loop so all employees are aware of performance improvement activities.

Attendance of employees at staff meetings should be recorded. Those unable to attend, but later read the minutes, will sign off that the information has been read. When information is communicated through memos, the staff will sign that the information has been read.

A summary of staff meeting activities, changes, and suggestions will be reported as necessary to the Center Advisory Committee. The Center Advisory Steering Committee minutes document any comments or summary information. These Center Advisory Steering Committee minutes are presented to the Governing Body.

PHARMACY

POLICY

At least monthly, a review of the ordering, storage, and handling and outdates of drugs will be conducted. The audit will be performed by the purchasing agent and the consulting pharmacist.

The audit results will be provided to the Center Manager who will determine if there are problems or concerns requiring action.

The pharmacist will review a minimum of four charts every two months to reconcile the narcotic log as well as the medical record content in regards to medication utilization.

The reports will be presented in summary form to the Center Advisory Committee. The Center Advisory Steering Committee will accept the report and. can make recommendations. The Center Nurse Manager should be made aware of any recommendations and confer with the Medical Director, as appropriate.

The report is documented in the minutes of the Center Advisory Steering Committee and these minutes, as a whole, are presented to the Governing Body.

PHARMACY INSPECTION FORM

A. **REFRIGERATOR**	Yes	No	**B. STOCK MEDICATION: Check stock in med room and cart(s).**	Yes	No
1. Is there a thermometer in the refrigerator? The Temp is now (Range is 36°-46°F).			1. Is the stock medication area properly secured?		
2. Is only medication stored in the refrigerator?			2. Are stock containers properly and legibly labeled and in good condition?		
3. Are only drugs requiring refrigeration stored in the refrigerator?	—		3. Are all open vials dated as to date opened and initialed?		
4. . Are all open vials stored in the refrigerator dated as to date opened and initialed?			4. Are appropriate PAR levels maintained?		
5. Is there only one container of the same medication opened?			*5.* Is there only one container of the same medication?		
C. OTHER	**Yes**	**No**	**D. OTHER**	**Yes**	**No**
Is crash cart locked and lock checked daily?			6. Is the narcotic cabinet properly locked?		
2. Is the crash cart locked and with a current list of expiration dates available for review?			7. Are allergies written on the patient medical records in a prominent, consistent place?		
3. Locks for cart kept in narcotics cabinet?			8. Prescription pads are stored in a secured place?	.	
4. Are poison control numbers posted?			9. Do staff know and practice policies against prior prepared doses or pre-drawn unlabeled syringes?		
5. Are policy and procedures manual and drug references available?			10. Was the staff notified of drug recall and recall medications separated for return?		
ADDITIONAL COMMENTS, FINDINGS, RECOMMENDATIONS:					

Inspected by:

PHARMACIST CHART REVIEW

Medical Record Number:
Date of Service:

Objective:

d) To review and report provided as well as documentation throughout the continuum of care in relation to medications
e) Inform Advisory Committee of Review
f) Facilitate Root Cause Analysis and Corrective Action
g) Accomplish Performance Improvement Goals

PERFORMANCE REVIEW			
	Yes	No	
Pre op review and documentation of medication patient is currently on			
Evaluation of allergies and documentation at each transfer for care			
Documentation of physician order according to policy			
Anesthesia record legible, reflects medications used			
Physician medication orders appropriate to care required, orders noted			
Recovery Care reflects medications used with response to treatment			
Discharge instructions advise patient when and how to use medications at home			

Recommended Action/Follow up:

_____ _____

Pharmacist Date

FIRE/DISASTER DRILLS

POLICY
Quarterly fire drills exercise all primary elements of the fire plan listed below. Annually a disaster drill will be performed. At least 50% of the required drills are unannounced. All personnel of all shifts in all areas of every building where patients are housed or treated shall participate in drills. All fire drills are critiqued for the purpose of identifying deficiencies and opportunities for improvement. All personnel are trained in fire response according to the facility fire plan. The effectiveness of this training shall be evaluated at least annually. The training shall include general facility protocols and all aspects of response that may unique to the individual's duties and work site.

Fire drills test staff knowledge of:

a. use and functioning of fire alarm systems (where such alarms are available);

b. transmission of alarms (where such alarms are available);

c. containment of smoke and fire;

d. transfer to areas of refuge, including from one to another smoke compartment;

e. fire extinguishment;

f. specific fire-response duties; and

g. preparation for building evacuation.

Note: Actual patient transfer or transport and building evacuation are not required. Properly documented actual or false alarms may be used for 50% of required drills for each shift, if all elements of the fire plan were implemented

Two times a year, there will be a disaster drill, one of which must be for an external disaster. An internal disaster drill can be a fire drill, bomb threat, lack of power with a generator malfunction, etc. An external disaster can be a fire at the adjacent building and threat of spread to the Center or an explosion in a nearby building or street. A combination fire drill and a disaster drill performed at the same time can be used to meet one of the four fire drills and one of the two disaster drills per year.

The employees' actions during the drill will be documented. The actions will be summarized to determine if individual counseling/education is required or if there are general overall educational needs.

The report of the drill will be presented at the Center Advisory Steering Committee and documented in the minutes. These minutes, as a whole, are presented to the Governing Body.

Central Maine Orthopaedics, P.A.

XXXXXXXXXXXX Business, P.A.
ENCY / DISASTER RESPONSE EVALUATION FORM

Date:_____Scenario & Circumstances: _____

Type of Drill: ☐ Fire ☐ Bomb Threat

Areas for Review	OK	Improve	Comments
I. Communications			
1. Alarm monitoring company notified of drill before and after completion (800-310-0107 acct# 110-6521)			
2. Alarm activated by employee			
3. Timely response by Charge person			
4. Accurate identification of location of alarm			
5. Emergency Response Agency (911) notified (simulated during drill)			
II. Staff Participation			
1. Each staff member aware of duties and assignments			
2. All staff members responded to alarm and began assigned duties.			
3. Charge person assumed responsibility and directed staff in a calm manner following assigned duties.			
4. Staff communicated necessary information to visitors.			
III. Containment			
1. RACE procedure utilized appropriately.			
2. Doors closed			
3. Areas secured			
IV. Patient /Visitor/Staff Safety			
1. Exit corridors clear.			
2. Removal of person(s) from hazardous area(s).			
3. Evacuation procedure followed.			
4. Grouping area outside the involved area established.			
V. Equipment & Supplies			
1. O2/suction/anesthesia gasses turned off			
2. ASU staff simulated and can list emergency equipment taken to safe area.			
3. Patient information ready for transport with patient (simulated during drill).			
4. Used fire extinguishers replaced within 8 hrs.			

VI. Protection of Supplies			
1. Narcotic cupboards locked			
2. Current patient records gathered (simulated during drill).			
Personnel Present:			
Comments/Critique:			
Action Plans for Improvement:			
Signature: Date:			

ENVIRONMENT OF CARE, REVIEW OF SAFETY ISSUES, AND LOGS

POLICY
Logs are maintained for generator, extinguisher certification, smoke detectors, equipment maintenance, sterilizers, refrigerators, air handlers, and defibrillator checks.

Each month, the logs are reviewed to assure they are being properly maintained and to identify any trends in the results of the routine checks and maintenance findings.

Any negative trends will be addressed with an action plan.

A review of the safety issues and the environment should be conducted periodically, at least once each six months. This task can be assigned to various personnel to help them learn which safety issues are reviewed. This review requires a walk around the XXXXXXXXXXX Business Center and spot checks of maintenance records.

Findings are reported at the Center Advisory Steering Committee meeting, documented in the minutes, and those minutes are reviewed by the Governing Body.

ENVIRONMENTAL ROUNDS
INFECTION CONTROL

POLICY
Environmental rounds will be done at least monthly.

PURPOSE

To assure a safe environment for patients and staff. To identify potential problems for early intervention and/or correction.

PROCEDURE
The nurse manager is responsible for assuring that the environmental rounds are completed monthly or more frequently as needed.

The nurse manager may complete the process herself or delegate the responsibility to another qualified individual.

Findings and any corrective actions indicated will be documented on the checklist.

If corrective actions cannot be done immediately, a 14 day time limit will be observed unless circumstances dictate otherwise. Such circumstances must be fully documented and issues resolved as soon as feasible.

Any problems deemed "urgent" by the survey person or team must be resolved immediately or within 2 days post identification. If unable to resolve in the 2 day limit, such circumstances must be fully documented and issues resolved as soon as feasible.

Any problem that poses a state of jeopardy (i.e. danger of harm from either use or lack of proper function) for a patient or staff must be rectified immediately or other arrangements must be made to assure safety. Process must be documented.

The nurse manager must be notified immediately if an immediate danger is identified.

The nurse manager will notify the Administrator and the Medical Director immediately.

Infection Control Environmental Rounds Checklist will be kept on file in the nurse manager office.

The Nursing Manager will report findings to the Medical Advisory Committee quarterly or more frequently as circumstances require.

ENVIRONMENTAL ROUNDS
INFECTION CONTROL FORM

Month Year Person Completing Survey:_____

Focus **Compliance Status** **Findings & Corrective Action Recommended** **Resolve**

Area Surveyed	**Yes**	**No**	**NK** *	**NA** **	*Specify if any follow-up required to comply*	**Date/Initial**
A. General Condition of Areas This includes Nursing Area, Patient Areas, and entire Unit where not otherwise documented						
• Is the area clean, safe, and in good repair?						
• Is the area free of trip hazards?						
• Are electrical cords intact without fraying or damage evident?						
• Have electrical appliances/equipment been safety-inspected within the last 12 months?						
• Are the air vents free of dust/dirt?						
• Do the fire doors close properly and are the doors free of obstacles?						
• Fire extinguishers are available and staff knows how to use them?						
• The fire extinguishers have current inspection tag.						
• Are the exits free of obstructions?						
• Are the exit signs clearly visible and lights functional?						
• Are sinks, soap, running water, and hand towels readily available for handwashing?						
• Are dispensers for soap appropriately labeled?						
• Are the drinking water dispensers visibly clean and draining appropriately?						
• Are used drinking cups disposed of properly and not left on top of dispenser?						
• Are food and drinks found only in approved designated areas and not in areas with potential for contamination?						
• Are wall hangings secured?						
• Are ceilings and walls in good repair without staining, cracking, or water damage evident?						
• Is the area above the cabinets free of objects that are closer than 18" from the ceiling?						
• Are free-standing shelves secured to wall to prevent toppling in event of earthquake?						
• Is the area free from danger of falling objects from shelves,						

cabinet tops, etc. in case of earthquake?						
• Are the counter drawers closed to avoid injury?						
• Are patients' personal items kept separated and labeled?						
• Do only authorized persons have access to the area?						
• The staff knows appropriate procedure to report safety and/or hazardous incidents?						
• The staff knows the protocol to follow in case of fire. (RACE)						
• Infection Control information (disease prevention) is included in patient education.						
• Patient care equipment is clean (free of visible contamination) and undamaged (e.g. BP cuffs, thermometers, glucose testing devices, other multi-patient use items)						
• Safety needle devices are available, used by staff, and disposed of properly?						
• Are appropriate sharps containers available, inaccessible by unauthorized staff and patients, and not overfilled?						
• Are sharps appropriately disposed of?						
• If recapping is necessary, is it done according to policy and without risk of needlestick?						
• Medication carts are locked and only accessible by authorized persons.						
• No outdated medications are found.						
• No clean or sterile supplies are found under the sinks (in all areas of Unit).						
• Personal Protective Equipment (PPE) is available, staff knows location, appropriate use and disposal observed (includes use of gloves for IV insertions						
• Standard Precautions are followed by staff. (Observed or knowledge indicated when asked)						
• Staff handles specimens appropriately.						
• Only facility approved cleaning chemicals are found on Unit and MSDS is available.						
• Staff knows what MSDS is and how/when to use it.						
• Biohazardous Waste is appropriately disposed of in red bags in appropriate container with closed lid and proper labeling						
• Waste containers are not overfilled.						
• Staff knows the proper protocol for cleaning up and disposing of broken glass.						
• The staff knows the appropriate protocol for cleaning up a						

"blood spill".						
• Refrigerators for patient food and medications have thermometers						
• Medication refrigerator is locked						
• No food is kept in the medication refrigerator.						
• No open milk container, unlabeled or undated perishable food found in food refrigerators.						
• Refrigerators, microwaves, other appliances for food prep are clean.						
• Staff uses appropriate Standard Precautions when handling soiled linen.						
• Soiled linen is not placed on the floor.						
• Soiled linen is placed in appropriate bag, bag is not overfilled, and hamper lid is closed.						
• Clean linen is kept separated from soiled linen.						
• Clean linen is stored in a covered cart with zippers closed unless restocking or accessing						
• Linen appears clean, not stained, or torn.						
• Ice machines are visibly clean, not leaking water, and maintenance logs available.						
• There is separation of clean and dirty items in the designated utility rooms.						
• No outdated supplies found						
• Supplies are stored in a clean, dry area and no outdated supplies are found.						
• Appropriate signage is in place for Biohazardous Waste collection points.						
B. Patient Areas						
• Area is clean and without obvious hazards.						
• The bathrooms are clean, soap, paper towels, waste container, chair available.						
• Personal items are not shared among patients.						
• Patients are given information on good hygiene, proper handwashing and proper waste disposal and observed by staff for compliance.						
• Patient mattresses are not torn, soiled, or otherwise damaged requiring replacement.						
C. XXXXXXXXXXX Business Rooms and Areas						
• Accessible to appropriate persons only						
• No trip hazards noted						
• Filters checked, cleaned or changed per protocol						
• Area free of visible soil and dust						

• XXXXXXXXXXXX Business specific PPE available, used and disposed of appropriately						
• All equipment functioning properly without frayed cords noted and without apparent rust and or oxidation of finish						
• Equipment PM documentation up-to-date and available for review						
• *Separation of clean and dirty maintained*						
• *All items/packs sterilized in-house have sterilization date and load control numbers*						
• *All used or opened single-use items are disposed of properly and never reprocessed or resterilized*						
D. Log Documentation Complete						
• Refrigerator temperature logs are maintained.						
• OR temperature and humidity logs completed						
• Crash cart checklist completed except for days Center not open						
• Malignant Hypertension Cart available and checked						
• Steris Unit functioning logs completed and appropriate measures taken if problems identified						
• Autoclave functioning logs completed and appropriate measures taken if problems identified						
• Biohazardous Waste disposal tracking records maintained						
•						
•						
•						
•						

***NK Not known** ****NA Not applicable**

_____Yes_____No Were any "urgent" issues identified?
_____Yes_____No Were any "immediate danger" issues identified?
_____Yes_____No Have all issues been resolved? If not, explain remaining issues and estimated date of resolution.

Instructions:
1. **Checklist is to be completed by the Nursing Manager or designee**
2. **Documentation should be recorded on the original form. If more space is needed, use the back of the form.**
3. **Documentation will be kept on file in the Nursing Office**
4. **All corrective actions must either be finished or a written explanation of why not completed within 7 days of survey unless deemed "urgent" by the survey person or team. Urgent issues must be resolved within 2 days.**
5. **A report documenting findings will be presented to the Medical Advisory Steering Committee quarterly.**

RISK MANAGEMENT

POLICY
A quarterly report will be prepared for the Center Advisory Steering Committee to provide information about the variances and any actions taken, staff training, and program changes. All accidental events regarding patients, visitors and personnel will be investigated and corrective action taken will be reviewed. The committee may make recommendations. This will be documented in the minutes of the meeting.

The report for the Governing Body will contain a summary and a trend report. The Governing Body may make recommendations. This will be documented in the minutes of the meeting.

Any recommendations made by the Center Advisory Steering Committee and Governing Body will be reviewed and implemented as appropriate.

PATIENT QUESTIONNAIRES

POLICY
Questionnaires are randomly given to patients each day. The questionnaire will be coded with the patient's identification number and the initials of the MD thus enabling staff to track the completed questionnaire should research need to occur. When low ratings or negative comments are received, a review will be made to determine what could have been done differently or what corrective action needs to be taken to increase patient satisfaction.

As they are returned, the Center Nurse Manager or designee will gather the questionnaires and all results (negative and positive) will be noted, tallied, and presented in summary form to the monthly meeting of the Center Advisory Committee.

QUALITY IMPROVEMENT ANNUAL EVALUATION

Yes	No	NA	
___	___	___	Did the Center monitor and evaluate the quality, appropriateness and outcomes of patient care?
___	___	___	Were all "important aspects" of care or services evaluated?
___	___	___	Did the monitoring identify any problems or opportunities to improve care/services?
___	___	___	If problem were identified, were they resolved?
___	___	___	Are these monitors still effective in evaluating care/services?

Briefly state the impact of the Center 's Q.I. Program on improved service and patient care:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What changes are you planning to make in the Q.I. Program next year?

_____

_____

_____

_____

NURSE MANAGER: _____

NURSE MANAGER: _____

DATE OF REPORT: _____

PERIOD OF EVALUATION: _____

SUBMITTED BY: _____