Facility Name:	Policy And Procedure Guideline Name:	Policy Number:
Durango Outpatient Surgery Center	Performance Improvement Plan (Improving Organizational Performance)	PI 100
	Subject Category:	Effective Date: 2008
	Improving Organizational Performance	Revised Date: 12/2020
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Policy:
It is the policy of the center to follow a planned systematic approach to improving organizational performance. A FOCUS-PDCA model will be utilized for the framework for improvement.

Purpose:
The purpose of the Quality Assessment and Performance Improvement Plan is to ensure the facility's ability to carry out the mission and vision. The Quality Assessment and Performance Improvement program has been developed utilizing the EDGE tools and other facility specific monitoring to be an ongoing data driven process. The EDGE program utilizes systems approaches which assess both systems and processes. The overall goals include, but are not limited to, demonstration of measurable improvement in patient outcomes and improvement in patient safety by using quality indicators associated with improved health outcomes and by identification and reduction of medical errors.

Procedure Guidelines:

The Performance Improvement Plan at Durango Outpatient Surgery Center is a customer driven, facility-wide process and philosophy of improving both the quality of patient care and productivity at the lowest cost. It is an integrated effort in which the entire organization works to provide optimum healthcare, patient satisfaction, risk reduction, and proper utilization of resources by competent healthcare practitioners, business office and other support staff.

SECTION I. MISSION AND VISION OF (insert facility name)

Our Mission

The mission of the (insert facility name) is to provide first class surgical services for the local community in a safe, comfortable and welcoming environment; one in which we would be happy to treat our own families.

Our Vision

The (insert facility name) through the combined efforts of our physicians, Governing Board, and our staff, shall provide healthcare services that shall be recognized in the local community as the optimal standard of excellence for the services we provide.

Our Value Statement

In pursuit of our mission, we believe the following value statements are essential and timeless.

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion, kindness, and dignity.
- We conduct all of our business in an ethical and honest manner.
- We recognize our colleagues and partners as valuable members of our healthcare organization, and pledge to treat each other with loyalty, dignity, and respect.

QUALITY DEFINITION

At (insert facility name), the pursuit of quality is the never-ending process of evaluation with intent to improve the services, which shall ultimately meet and exceed the expectations of our customers. Quality shall be measured by the feedback received through our customers (internal and external), and through recognized regulatory and accrediting agencies.

PERFORMANCE IMPROVEMENT DEFINITION

PI is embracing a continual organizational wide effort to find new and better ways of doing things.

SECTION II. PHILOSOPHY/OBJECTIVES/SCOPE OF SERVICES

1. PHILOSOPHY of the PERFORMANCE IMPROVEMENT PROGRAM

A. Utilizes principles of quality measurement based on data collection, objective analysis, and results dissemination (EDGE™ processes).

I. Components of EDGE include:

- Today's Proven Process (TPP)
  - Evidence based action steps or best practices that when put in place for every patient improves results.
- Measures-Focus Studies
  - Measures are the data gathered at the facility to access how well the processes are working or where improvements may be needed. Because we cannot manage what we cannot measure, Audit tools have been created to assist in proactively collecting data to determine if key elements of a process are in place.
- Risk Incidents and Close Calls/Good Catches

- Risk incident reporting provides a tool to enhance Patient Safety by providing a confidential, uniform, electronic method of reporting outcomes and close calls. Presenting standard data for learning, benchmarking, and performance improvement.

- Patient Relations- Complaints and Compliments
  - Patient relations reporting provides a tool to track and trend patient relation occurrences such as grievance or compliments.
- Patient Satisfaction Measurements
  - Seeks feedback from our primary customer allowing for improvement.

II. Today's Proven Process (TPP) includes the following areas:

- Keep a Safe Environment
- Know and Provide Surgeon preferences
- Medication Safety
- Prevent Surgical Site Infections
- Prevent Wrong Site- Universal Protocol
- Schedule My First Choice/Handle My First Call
- Start My Cases on Time/Minimize Turnover Time

Measure/Focus Studies are as follows:

Measure	Timing	Qualification for Reporting
Prevent Wrong Site	Each Month	5% of case volume
ASCQC • Inappropriate Hair Removal • Prophylactic IV Antibiotic Timing • VTE Risk Assessment	Each Month	Report only on those patients who qualified but did not receive appropriate treatment
Prevent Injury- Pre-Operative and Post Operative Calls	Each Month	Report only those patients not contacted per the facility policy
Prevent Surgical Site Infections	Each Month	5% of case volume
Start My Cases on Time/Minimize My Turnover Time	Each Month	Report only those patients with times outside the facility's average
Patient Satisfaction	Each Month	Complete audit tool and data enter information into EDGE system.
Know and Provide Surgeon Preferences	1st Quarter	Only cases surgeon preferences not provided
Prevent Surgical Fires	1st Quarter	5% of case volume

Prevent Injury- Prevent Burns	2nd Quarter	5% of case volume
Prevent Injury-Laser Safety	2nd Quarter	5% of case volume
Schedule My First Choice/Handle My First Call	2nd Quarter	Only scheduling calls that went to voicemail
Prevent Infection Hand Hygiene	2nd Month of Each Quarter	30 Personnel Audits
Keep a Safe Environment	Last Month of Each Quarter	Completed audit tools and data enter information into EDGE system
Prevent Medication Variances-Medication Safety	3rd Quarter	5% of case volume
Prevent Injury- Safe Positioning	3rd	5% of case volume
Prevent Injury- Prevent Falls	4th	5% of case volume

Other areas for ongoing monitoring:

Process	Frequency
Operative and other invasive procedures that place patients at risk.	Quarterly
All significant discrepancies between pre-operative and post-operative diagnoses, including pathologic diagnoses.	Quarterly
Documentation in the Medical Record of the medical necessity for the procedure/treatment, and appropriateness of care provided.	Quarterly
Adverse events related to using moderate or deep sedation of anesthesia. (identified via Risk Incident Reports)	Quarterly
Medication errors/adverse drug reactions, medication labeling errors or inappropriate labeling (identified via Risk Incident Reports)	Quarterly
Blood and blood component usage	Quarterly
All confirmed blood transfusion reactions.	Quarterly
Risk assessment and management activities	Quarterly
Employee Satisfaction Survey to include: Staff opinions and needs Staff perception of risk to individuals Staff suggestions for improving patient safety* Staff willingness to report adverse events	Annually

*Employees may make suggestions for improving patient safety at anytime.

B. Offers physicians and staff objective information, which they can use for purposes of review, patient management, and quality measurement.

C. Is grounded in the concept of continuous quality improvement, through regular feedback of information on performance and clinical / environmental risk assessment.

D. Promotes integration and communication between facility departments, medical staff, and administration to continuously improve processes which affect patient care.

2. OBJECTIVES

A. Continually evaluate clinical and operational processes to identify opportunities for improvement.

B. Identify, focus, analyze, and correct processes or systems which have the potential to impede quality patient care.

C. Integrate and coordinate all organizational performance improvement activities in order to increase effectiveness, eliminate duplication of efforts, and promote proper utilization of staff and resources.

D. Comply with standards of practice and meet all requirements of the accrediting body, state/federal agencies, and other regulatory bodies.

E. Eliminate unnecessary risks and hazards within the facility.

These objectives are accomplished by:

I. The employment of qualified and effectively supervised personnel for patient care, utilizing clear channels of supervision, responsibility, and accountability.

II. Patient care, which is appropriate to the ages and needs of patients, is delivered as follows:

- In a timely manner.
- Within the range of available resources.
- In a cost-efficient manner as possible.
- Consistent with achievable goals.
- Properly documented to facilitate evaluation.
- Continuously evaluated and improved.

III. A system in which one level of care is provided to all patients and is subject to periodic review prospective or concurrent with the use of pre-established objective indicators and documentation of findings.

IV. A system in which the findings of patient care monitoring and evaluation are utilized by the facility in concrete ways to fulfill the objectives of the performance improvement program.

V. The maintenance of a continuing education program utilizing, in part, results of patient care monitoring and evaluation.

VI. Continuous evaluation and improvement of customer satisfaction (patients, physicians, employees, family and community).

3. SCOPE OF SERVICES

A. The scope of the performance improvement program of Durango Outpatient Surgery Center includes monitoring and evaluation of activities, which addresses patients of age groups of pediatric to geriatrics served by the facility. All staff employees and physicians on staff are responsible for utilizing the concepts of the PI program to assist in the delivery of quality care considering the following concepts:

I. Emphasis on the safe, timely delivery of services to identified customers.

II. Delivery of services accomplished within a range of available resources.

III. Care and services provided in the most cost efficient manner.

IV. Services planned or provided are consistent with achievable goals.

V. All care delivery and business transactions are properly documented to facilitate effective evaluation.

VI. Aspects of identified care practices are continuously evaluated with opportunities for improvement identified and implemented when deemed appropriate. This process is facilitated through peer review and education regarding cases requiring Root Cause Analysis.

VII. Efforts are guided by standards established through leadership, accrediting agency and state, federal and other regulatory bodies.

VIII. On-going and organized education initiatives designed to educate all staff, physicians and leaders in Performance Improvement and patient safety concepts and to facilitate their participation in the process through department meetings and facility wide.

SECTION III. LEADERSHIP'S ROLE AND RESPONSIBILITY FOR PERFORMANCE IMPROVEMENT

Leadership plays a central role in performance improvement. At Durango Outpatient Surgery Center Leadership includes the Governing Board, elected officers of the medical staff, the medical director, the Medical Executive Committee, the Performance Improvement Committee, the facility Administrator and senior management of the facility, and department managers. The leaders set expectations, develop plans and manage processes to measure, analyze, and improve the quality of facility's governance, management, clinical and support activities. The leaders are responsible for adopting an approach to performance improvement, which is utilized in reporting and team activities. The leaders are responsible for setting priorities and reprioritizing in response to sentinel events, risk assessments, unexpected or unusual occurrences, patient safety concerns, and expressed opportunities for improvement by internal and external customers served.

Leaders are responsible for establishing a policy and procedure for sentinel events, educating staff on sentinel events and responding appropriately when they occur. The policy shall include a process for conducting a timely root cause analysis (RCA) that focuses on processes, systems and development of risk reduction strategies, as well as an action plan, which includes evaluating the effectiveness of actions taken.

Leaders set a positive performance improvement and safety culture in the organization through planning, education, providing support, such as time and resources, and empowering staff as appropriate. Leaders also actively participate in interdisciplinary performance improvement activities, as appropriate.

The performance improvement program is the shared responsibility of the Governing Board, the medical staff, and the administration of the facility with specific areas of the program delegated to each. The program involves the Board, medical and other professional staff, administrative, technical and all support services, and includes education concerning the approaches and methods of performance improvement. PI teams/ committees may include both management and non-management staff from all departments in the problem solving process.

1. GOVERNING BOARD

The Governing Board shall review and evaluate facility activities to assess, preserve and improve the overall quality and efficiency of patient care in the facility. While maintaining overall responsibility, the board delegates operational authority of this function to the Medical Executive Committee and Administrator. In exercising its supervisory responsibility, the board shall:

A. Receive, review and accept or reject periodic reports related to outcomes.

B. Assess the program's effectiveness and efficiency and require modification in organizational structure and systems where necessary to improve program performance.

C. Provide for allocation of resources and support systems for performance improvement and functions related to patient care and safety.

D. Verify that the overall goal of patient care enhancement is being achieved.

E. Require a process designed to assure that all individuals responsible for the assessment, treatment or care of patients are competent.

F. Receive and review minimally an annual report regarding the facility contracts to ensure compliance with regulatory requirements and patient safety and quality of care. The Board shall receive the report from the Medical Executive Committee and Administrator.

2. MEDICAL EXECUTIVE COMMITTEE

A. The Medical Executive Committee (MEC) of the medical staff is accountable to the Governing Board for oversight of the monitoring and evaluation functions to determine that safe and quality driven medical care is rendered to all patients in the facility through performance improvement monitoring, actions taken when indicated, and by reporting these activities to the Governing Board.

B. The MEC delegates the responsibility for the operations of the monitoring and evaluation functions to the medical director, Performance Improvement Committee (PIC) and appropriate medical staff committees. The MEC is responsible for functional oversight of key areas of operations to include but not limited to:

I. Pharmacy: Coordinates periodic review of the processes related to medication management to include procurement, efficacy of use, dispensing and adverse drug events.

II. Environment of Care: Monitors environmental safety, security infection control, and disaster preparedness issues.

III. Credentialing of medical staff: Reports on credentials issues for licensed independent providers and allied health professionals assigned to the medical staff. Function includes evaluation of the results of monitoring and evaluation functions at the time of initial, ongoing and reappointment to the medical staff.

IV. Contract Services: The MEC shall receive from the Administrator minimally annually a report regarding the quality and safety of the services provided by contract. More frequent reports will be provided on an as needed or as requested basis. The MEC will review the services and make

recommendation to the Governing Board to continue, modify, or cancel the contract based on quality of services and patient safety.

C. The Medical Executive Committee (MEC) supports and acts upon recommendations of the PIC; include the investigation of variances, implementation of actions, monitoring of results, and approval/revision of policies. The medical director presents the performance improvement report to MEC which includes, but is not limited to, a quarterly summary of PI project activity and a quarterly trending of house-wide indicators.

D. The Medical Executive Committee is the oversight body of the sentinel event process.

3. ADMINISTRATION

Administration, through the facility Administrator is accountable to the Governing Board for the quality of care and performance of all staff. The facility Administrator coordinates efforts to:

A. Promote the participation of the appropriate members of professionals and technical staffs and departments in the program through interdisciplinary monitoring and evaluation of patient care and important facility functions through Performance Improvement Committee.

B. Establish and maintain operational linkages between the functions of risk management, quality management and performance improvement.

C. Assure that sufficient resource, and personnel are provided to support continuous performance improvement activities.

D. Assure staff are provided adequate time to participate in performance improvement activities.

E. Participates on Governing Board, Medical Executive Committee, and Performance Improvement Committee.

Other administration staff includes the Chief Nursing Officer and Business Office Manager. Both of these individuals participate in facility committees as assigned.

1. QUALITY MANAGEMENT NURSE

Administration shall provide adequate resources to the medical staff and facility departments to conduct performance improvement functions. The assigned QM Nurse shall facilitate the following services and functions:

A. Orientation and training on performance improvement functions.

B. Reports of changes in regulations, laws, and JC standards to the medical staff, clinical and non-clinical departments

C. Facilitate data retrieval functions from the various departments. Coordinates data collection and submission for accrediting purposes, USPI's EDGE™ data and other regulatory data collection requirements as assigned by facility administrator.

D. Aggregate performance improvement findings for presentation to Medical Staff and Professional Activities Committee.

E. The Nurse Quality Manager shall facilitate that appropriate actions from PI findings are implemented, and within established time frames, as directed by the Performance Improvement Committee.

F. The Quality Management Nurse shall attend meetings of the Performance Improvement Committee, facilitate performance improvement subcommittees, and present data to the MEC and Governing Board for communication of performance improvement activities as designated.

G. Leadership provides opportunities for training to assist the Quality Management Nurse in efforts to stay informed on current accreditation requirements, local, state and national health care regulatory requirements and reports change to the Medical staff and facility leadership.

2. EVALUATION OF LEADERS EFFECTIVENESS

At least annually, the Quality Management Nurse shall prepare an annual appraisal of the performance improvement program. The facility leaders, through the Performance Improvement Committee shall evaluate the effectiveness of the performance improvement program through annual appraisal. In addition, the leaders shall perform a self-evaluation of their effectiveness in participating in the PI program.

The leaders shall ultimately evaluate their effectiveness by accomplishment of goals and improvements through performance improvement monitoring and PI teams. If the goals and objectives are found to be ineffective, new actions may be taken or new teams may be formed.

SECTION IV: PLAN

Durango Outpatient Surgery Center participates in facility-wide interdisciplinary monitoring of important functions. Performance improvement activities include how the facility designs, measures, assesses, and improves important processes. All PI activities are incorporated into a systematic, organization-wide approach through integrated monitoring and performance improvement teams.

1. METHODOLOGY

A variety of methods exists that can be utilized by a facility to assist in identification, trending and monitoring quality processes. The methodology utilized by USPI's EDGE™ process is simplistic with the underlying purpose being to help staff exceed customer expectations in the clinical, service and financial areas of the organization. The EDGE™ process is outlined in the following table:

1. What is the problem?	Record and analyze data to find areas where improvement is needed. Unlike many other PI programs, USPI's EDGE™ utilizes process measures to serve as warnings that a bad outcome might be pending
2. What is the Solution?	Use USPI's EDGE™ Today's Proven Processes as a springboard for solutions that could work for your facilities problem areas identified
3. How do we implement change?	Change is tough, and we need to think out of the box in order to implement Today's Proven Processes
4. How do we know if it worked?	Continue to report process and outcome measures, so you can see if your implemented solutions worked. This is a question to continually ask and is asked consistently by accreditation agencies

The FOCUS-PDCA methodology is an adjunct method for staff to utilize in conjunction with the EDGE process to assist in establishing a systematic method for teams to address issues within the organization. It should be stressed that there is no one method for creating a culture of continuous quality improvement. In fact, a variety of methodologies should be benchmarked and utilized by staff to assist in developing and monitoring processes within the organization.

Sampling Size (recommended by Joint Commission) for performance improvement shall be as follows:

- For a population of fewer than 30 cases, sample size 100% of available cases
- For a population of 30 – 100 cases, sample size 30 cases
- For a population of 101 – 500 cases, sample size 50 cases
- For a population size greater than 500 cases, sample size 70 cases

STEP	FUNCTION	TEAM TOOLS
F	FIND A PROCESS TO IMPROVE	• Data from customer concerns, staff observation, occurrence reports, Physician input.
O	ORGANIZE A TEAM THAT KNOWS THE PROCESS	• Department/Administrative Level teams. • Quality Management Committee established teams.
C	CLARIFY CURRENT KNOWLEDGE OF PROCESS	• Review current data related to process. • Review EDGE Proven Processes. • Ask questions/Brain storm ideas. • Flow chart current process. • Consider benchmarking for evidenced based and best practices.
U	UNDERSTAND CAUSES OF VARIATION	• Data collection/analysis. • Display with graphs, run charts, control chart, histogram, scatter diagram, pareto diagram.
S	SELECT THE PROCESS IMPROVEMENT	• Define the process in simplistic terms. • Examine criteria related to the process. • Present data to leadership for support.
P	PLAN THE IMPROVEMENT AND CONTINUED DATA COLLECTION	• Planning Matrix. • Responsibility Matri. • Who/What/When/Where? EDGE™ Requirement owners.
D	DO THE IMPROVEMENT, DATA COLLECTION AND ANALYSIS	• QM audit tools/EDGE™ DATA. • Discuss in Unit team meeting. • Educate staff on the process.
C	CHECK THE RESULTS AND LESSONS LEARNED FROM THE TEAM EFFORT	• Data Collection Analysis. • Same QM tools used in (U). • Document in Department & committee reports to leadership. • Celebrate accomplishments of staff.

A	ACT TO HOLD THE GAIN AND TO CONTINUE TO IMPROVE THE PROCESS	• Data reporting to leadership. • Track & Trend at Unit level. • Utilize QM tools to assist (U & C). • Revise policy & procedures if needed. • Staff /Physician Education Customer Education.

2. ONE LEVEL OF CARE

The Governing Board, through the medical staff and administration, shall ensure that mechanisms are in place to provide a uniform level of care to all patients with the same health needs. The following mechanisms shall be utilized to ensure consistent compliance:

A. Access to and appropriateness of care and treatment does not depend on the patient's ability to pay or source of payment.

B. Acuity of the patient's condition determines resources allocated to meet patient's needs.

C. The level of care provided to patients who have been administered anesthesia in areas outside the operating room is comparable to that provided in the operating room.

D. Patients with the same nursing care needs receive comparable levels of nursing care throughout the facility departments.

3. FACILITY-WIDE PRIORITIES

Priorities for facility-wide performance improvement activities at (insert facility name) shall be designed to improve patient outcomes. These priorities shall be developed by the Performance Improvement Committee with participation of all facility disciplines, and approved by the Medical Executive Committee and Governing Board. Priorities that relate to improving patient outcomes may include but are not limited to:

A. High risk patient issues.

B. High volume patient issues.

C. Problem prone patient issues.

4. DASHBOARD BENCHMARKS

The assigned Quality Manager and/or member of the Administrative Leadership Team provides a Quality Management report to the Governing Board on a quarterly basis

and may include but is not limited to customer service satisfaction measures, patient safety indicators (including the National Patient Safety Goals), environment of care issues, employee safety, regulatory measures of success, data from USPI's EDGE™ reporting measures and other outcome indicators prioritized as significant quality management issues. The report to the Governing Board provides a snap shot of priority areas. The dashboard may be utilized to provide performance information as measures of success within the organization and comparison to external entities as determined.

5. **REPRIORITIZING:** Priorities to focus on may be recalled in response to unusual or urgent events such as those identified through PI monitoring and evaluation, changing regulatory requirements, significant patient/staff needs; changes in patient population; changes in the environment of care; changes in the community, or in response to sentinel events.

   These priorities shall be reviewed and approved by the facility administrative leaders, Chief of Medical Staff, and Governing Board in the approval of the facility-wide performance improvement plan.

SECTION V: DESIGN

When a need or opportunity to establish new services, extend product lines, or significantly change existing functions or processes, the following factors shall be considered:

1. The process shall be consistent with the facility's mission, vision, values and plans.
2. The needs and expectations of patients, staff, medical staff, and others served, shall be considered in the design of the process.
3. The design shall be clinically sound and current (by use of appropriate practice guidelines and clinical nursing and medical standards as deemed necessary)
4. The process shall be consistent with sound business practices.
5. It shall incorporate available information from other organizations about the occurrence of sentinel events to reduce the risk of similar sentinel events.
6. The design should incorporate results of performance improvement activities.

Consideration of these factors shall provide basic performance expectations that can be measured, assessed, and improved, targeting sustained over time. All disciplines, which shall be involved in the new service, product line, function, or process, shall be included in the design.

SECTION VI. MEASURE

Measurement is the basis for determining the level of performance of existing processes and

the outcomes resulting from these processes. Measures shall be used to help identify areas for more focused or targeted data collection. Continuous and ongoing measurement activities may include:

- Measures of both processes and outcomes.
- Measurement of high volume, high risk and problem prone issues.
- Identification for focused or targeted data collection.
- Establish a performance baseline.
- Comparison of outcomes to internal and external databases, when available, as appropriate.
- Measures shall focus on sustaining improvement.

The sampling shall consist of a minimum of 30 patients per quarter or 100% for population size of fewer than 30 cases. Method of sampling for each measure shall be determined by the Performance Improvement Committee or PI team that has identified a process study.

1. **MONITORING OF IMPORTANT FACILITY FUNCTIONS**

   In addition to participation in Performance Improvement Committee, facility departments shall participate in monitoring of important facility functions (as appropriate). Indicators shall be prioritized for the following functions:

FUNCTIONS	RATIONALE		
	High Risk	**High Volume**	**Problem Prone**
1. Rights And Responsibilities Of The Individual			#
2. Provision Of Care, Treatment And Services	#	#	#
3. Medication Management	#	#	#
4. Performance Improvement	#	#	#
5. Leadership			#
6. Environment Of Care	#	#	#
7. Human Resources			#
8. Information Management		#	#
9. Infection Prevention And Control	#	#	#

10. Emergency Management	#		#
11. Record of Care, Treatment, And Services		#	#
13. Life Safety	#		#
14. Waived Testing		#	#

All monitoring and evaluation of facility functions shall include identifying the processes, which make up the key facility functions and identifying indicators (and appropriate clinical criteria) for monitoring the important facility functions.

Results of the monitoring, along with the Performance Improvement Committee and subcommittee's conclusions, recommendations, actions, and evaluation shall be communicated to all departments/services and to the medical staff, Medical Executive Committee and Governing Board.

2. PI MONITORING ACTIVITIES

The following Quality Management activities are targeted for monitoring through a variety of methods to include monthly monitoring through USPI's proven processes accessible in EDGE™ Online.

A. Operative/other invasive procedures.

B. Anesthesia adverse outcomes sedation outcomes.

C. Medication errors/adverse drug reaction rate, medication labeling.

D. Blood usage.

E. Customer satisfaction.

F. Autopsies and results.

G. Risk assessment and management activities.

H. Medical staff assessment & treatment of patients, efficiency of clinical practice patterns, significant departures from established clinical practice patterns, education of patients and families, and coordination of patient care with other disciplines.

I. Patient health record review.

J. Infection prevention surveillance results.

K. Environment of care/safety performance standards.

L. Resuscitation outcomes.

M. Appropriateness and effectiveness of pain management.

N. National patient safety goals.

3. MEDICAL STAFF MONITORING AND EVALUATION

A. Medical staff is responsible for involving members of the medical staff in interdisciplinary monitoring and evaluation activities. Medical staff responsibilities include:

I. Identify indicators, collect data for each indicator, reach conclusions, make recommendations and initiate actions.

II. Communicate findings, conclusions, recommendations and actions, effectiveness of actions taken to Medical Executive Committee.

III. Assess the effectiveness of actions and document improvement in patient care.

IV. Make recommendations related to credentialing for clinical privileges.

V. Participate on performance improvement teams.

VI. Review and evaluate the findings of:

- Operative and other invasive and non-invasive procedures.
- Blood and blood components review.
- Medical record review for clinical pertinence.
- Medical record timeliness and delinquency review.
- Mortality.
- Infection prevention.
- Resource/case management.
- Resuscitation outcomes.
- Appropriateness and effectiveness of pain management.
- Risk management assessment and risk reduction activities .
- Restrain usage.

- Assessment and treatment of patients.
- Efficiency of clinical practice patterns.
- Significant departures from established clinical practice patterns.
- Education of patients and family.
- Coordination of patient care with other disciplines .

B. All medical staff PI activities shall be reported to the Medical Executive Committee. The medical staff is responsible for participating in and evaluation of PI activities. All PI activities are reported to the governing board.

SECTION VII. AGGREGATE AND ANALYZE

1. AGGREGATE AND ANALYZATION PROCESS

Aggregating and analyzing data allows the organization to use this information to draw conclusions about its performance of a process or outcome. The organization shall also compare its performance over time and with other sources of information.

A. Performance compared internally over time (patterns/trends).

B. Performance compared with similar processes in other organizations.

C. Performance compared to up-to-date external sources (benchmarking).

D. Control limits established for expected variation.

E. Data analysis is interdisciplinary when appropriate.

2. INTENSIVE ANALYSIS

Intensive analysis shall be conducted when the following factors are identified:

A. Single events, performance, and patterns or trends vary significantly from expectations.

B. Performance varies significantly and undesirably from other USPI facilities.

C. Performance varies significantly and undesirably from recognized standards.

D. Sentinel event has occurred.

3. ANALYSIS OF FINDINGS RELEVANT TO INDIVIDUAL PERFORMANCE

When the findings of the analysis process are relevant to an individual's performance, the following process shall be followed:

A. Medical Staff
Peer review process shall be utilized for individual medical staff performance. The case shall be referred to the Medical Executive Committee and reviewed by a peer physician. Final determination shall be made at the Medical Executive Committee and an improvement strategy, such as education determined as necessary. The Quality Manager maintains peer review findings in individual medical staff PI Files. The peer review findings are used in consideration for reappointment to the medical staff, and could result in modification of clinical privileges.

B. Facility Staff
The Department Manager shall review information relevant to individual staff performance and an improvement strategy, such as education, determined as necessary. Documentation of this action shall be maintained in individual personnel files of the manager and utilized in the performance evaluation process as appropriate.

4. USE OF DIMENSIONS OF PERFORMANCE AND SCIENTIFIC TOOLS

These definitions of dimensions of performance are utilized in assessing how performance was improved:

DIMENSIONS OF PERFORMANCE
I. Doing The Right Thing
· The **efficacy** of the procedure or treatment in relation to the patient's condition. Efficacy is the degree to which the care/intervention for the patient has been shown to accomplish the desired/projected outcome (s).
· The **appropriateness** of a specific test, procedure, or service to meet a patient's needs. Appropriateness is the degree to which the care/intervention provided is relevant to the patient's clinical needs, given the current state of knowledge.
II. Doing The Right Thing Well
· The **availability** of a needed test, procedure, treatment, or service to the patient who needs it. Availability is the degree to which appropriate care/intervention is available to meet the patient's needs.
· The **timeliness** with which a needed test, procedure, treatment, or service is provided to the patient. Timeliness is the degree to which the care/intervention is

provided to the patient at the most beneficial or necessary time.

- The **effectiveness** with which tests, procedures, treatment, or service is provided to the patient. Effectiveness is the degree to which care/intervention is provided in the correct manner, given the current state of knowledge, in order to achieve the desired/projected outcome for the patient.

- The **continuity** of the services provided to a patient with respect to other services, practitioners, and providers, and over time. Continuity is the degree to which care/intervention for the patient is coordinated among practitioners, among organizations, and over time.

- The **safety** of the patient (and others) to whom the services are provided. Safety is the degree to which the risk of an intervention and risk in the care environment are reduced for the patient and others, including the health care provider.

- The **efficiency** with which services are provided. Efficiency is the relationship between the outcomes (results of care) and the resources used to deliver patient care.

- The **respect and caring** with which services are provided. Respect and caring is reflected by the degree to which the patient or a designee is involved in his/her own care decisions and to which those providing services do so with sensitivity and respect for patients' needs, expectations, and individual differences.

Various scientific tools may be used to assist in assessment, including flowcharts, Pareto charts (bar graphs), histograms, cause-and-effect diagrams (fishbone diagram), and run charts.

5. REFERENCE DATABASES

The facility may use InfoSource to compare performance in cost per case with other peer facilities. In addition the EDGE system will be used to benchmark clinical outcomes with peer facilities. All facilities using EDGE will benchmark with the external data base for ASQC.

SECTION VIII. IMPROVE

Monitoring activities identify a variety of opportunities for improvement. These include improving existing processes, designing new processes, and/or reducing variation or eliminating undesirable variation in processes or outcomes. Improved changes, which are made, shall be implemented into standard operating procedures and monitored for sustained improvement. Staff shall be educated about redesigned processes or changes. The following reporting structure is utilized for performance improvement reporting:

1. PERFORMANCE IMPROVEMENT COMMITTEE STRUCTURE

Performance Improvement Committee

The Performance Improvement Committee meets at least quarterly for the purpose of overseeing functional process improvement activities. The chairperson is the facility medical director. The committee serves to evaluate the results of monitoring and evaluation of facility functions conducted by departments, prioritize projects, approve new PI teams and review the progress of the current PI teams. Findings, conclusions, recommendations, and actions taken are communicated to medical staff members. This committee reports activities to the facility leadership, medical staff, Medical Executive Committee and the Governing Board.

2. DECISIONS FOR IMPROVEMENTS

Decisions for making improvements are made by the Performance Improvement Committee based on the following factors:

A. Opportunities to improve processes within the important functions.

B. Results of risk management activities and quality control activities.

C. Resources needed to improve, such as staffing, facilities, training, equipment, etc.

D. Organization's mission and priorities.

Opportunities to improve care may be referred to the Performance Improvement Committee from the following sources:

E. Patients and families.

F. Governing Board.

G. Medical staff.

H. Employees.

I. Administration.

J. JV Partners of the facility.

K. Quality/Risk Manager.

L. Safety Officer.

M. Infection Control Practitioner.

N. PI team.

3. ACTIONS FOR IMPROVEMENT

Once results have been evaluated and the decision is made that improvement is necessary, the performance improvement teams may determine actions to be implemented for the improvement. These actions are reported to the Performance Improvement Committee, which oversees process improvement activities. When action is taken to improve a process:

A. The action may be tested on a trial basis.

B. The action's effectiveness is evaluated using the dimensions of performance.

C. When the initial action is not effective, a new action may be taken and may include the continuation or formation of a PI team, if appropriate.

D. Successful actions are implemented.

4. REPORTING CHANNELS

Reports of findings, conclusions, recommendations and actions shall be reported to the Performance Improvement Committee, the Medical Executive Committee, and the Governing Board.

5. PERFORMANCE IMPROVEMENT TEAMS

The facility utilizes Performance improvement teams (PI teams) to study processes, which occur in the facility, design new processes, and to make improvements in these processes utilizing the PDCA model. The processes may be studied because a problem was determined or because the process can be improved even if a problem has not been identified. The PI teams are interdisciplinary and include members of management and non-management from all involved departments and medical staff members, as necessary.

The following factors may be utilized in determining when to use a team approach:

TEAM DECISION	INDIVIDUAL MANAGER'S DECISION
The need exists to combine old and new information-requires brainstorming, data-gathering, and innovation. The situation doesn't require an immediate solution. Consensus is needed to make the solution work When the problem is a process problem When the process crosses departmental	No need for extensive data-gathering. Quick decision is required. Consensus is not needed. When the problem is a people or performance problem.

boundaries. When the process seems to be very complex	

The Performance improvement teams are groups of people who work together for a common objective. The teams identify processes or problems needing improvement, and then study the processes methodically to improve them by eliminating root causes of problems. The Performance Improvement Committee shall approve all new PI teams. Team meetings shall be conducted as often as determined necessary by the team to work on the process. Each team shall have a team leader and a facilitator. Department managers shall encourage employees to serve on performance improvement teams as needed for performance improvement functions.

6. DESIGN TEAMS

A design team may be formed anytime a new service is added or expanded. Design teams may be approved by the Performance Improvement Committee as another PI team. These teams are called design teams to differentiate them from other PI teams focused on processes. All design teams shall consider the following factors in the development or expansion of new services:

A. Consistent with the facility's mission, vision, and other plans.

B. Meets the needs of individuals served, staff, and others.

C. Clinically sound and current, using nursing and medical clinical standards and considering practice guidelines.

D. Incorporate available information about sentinel events to reduce risk.

E. Incorporate results of performance improvement activities.

The PI representative shall meet with each new team, as indicated, to offer or provide continuous performance improvement education on the purpose of teams, the PDCA model, and the most common CPI tools which may be used. Minutes of all team meetings should be maintained and shall include the members who are present, purpose of the meeting, summary of items discussed, any actions to be taken, and any follow-up. A copy of all team minutes is to be forwarded to the Quality Manager. A summary of the design teams' activities shall be presented at the Performance Improvement Committee, Medical Executive Committee, and the Governing Board meetings.

7. Reporting Schedule:

REPORTING SCHEDULE (Minimum Reporting Requirements)

DATA	WHEN & WHERE REPORTED	
Performance Improvement	Every Quarter	QC/MEC/GB
Environment of Care (Form B)	Every Quarter	QC/MEC/GB
Safety/Risk Management	Every Quarter	QC/MEC/GB
Infection Control	Every Quarter	QC/MEC/GB
Patient Satisfaction	Every Quarter	QC/MEC/GB
Medical Staff Reports & Appointment	Every Quarter	MEC/GB
Financial Review	Every Quarter	GB
Report from any review/survey, licensure or accreditation	Every Quarter	MEC/GB
Medical Records Review	Every Quarter	QC/MEC/GB
Privacy Officer Report	Every Quarter	QC/MEC/GB
Compliance Officer Report	Every Quarter	MEC/GB
Human Resource Report to GB (form C)	1st Quarter	GB
Review of Employee Competency (Form D)	1st Quarter	GB
Review of Human Resource Policies	1st Quarter	GB
Evaluation of Administrator	1st Quarter	GB
Review of Contracts (Form E)	2nd Quarter	MEC/GB
Review the Organizational Chart	2nd Quarter	GB
Review Conflict of Interest & Indemnification Liability	3rd Quarter	GB
Evaluate MEC Performance in PI (Form F)	3rd Quarter	MEC
Evaluate GB Performance (Form G)	3rd Quarter	GB
Review Information Management Plan, PI Plan, Scope of Services, Leadership Plan, Environment of Care Plans, Infection Control Plan, Patient Rights and Responsibilities Policy	3rd Quarter	GB
Review Operating Agreement, Purpose of GB and MEC	4th Quarter	MEC/GB

QC = Quality Council MEC = Medical Executive Committee GB = Governing Board

PI = Performance Improvement

SECTION IX. SENTINEL EVENTS

Definition: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Leaders of the organization shall be responsible for defining the policy and procedure for responding to a sentinel event. If a sentinel event occurs in the facility, the facility shall form a PI team, composed of persons close to the involved process, to review the incident and conduct a credible root-cause analysis to determine if there was either:

1. Special cause variation – human error.

2. Common cause variation – underlying system or process issue.

Once the root cause analysis has been conducted, the team shall develop an appropriate action plan to address any variations identified and establish measures for any changes made. The action plan shall be presented to the Performance Improvement Committee for approval. Periodic progress reports shall be reported to the Performance Improvement Committee until the issue is determined to be resolved. Once resolved, PI indicators may be continued to ensure that the problem remains corrected.

SECTION X. ANNUAL APPRAISAL

At least annually the Performance Improvement Committee, Medical Executive Committee and Governing Board shall be responsible for review of the performance improvement plan and the evaluation of improvements made in patient care and facility functions. The review shall include an evaluation of the performance improvement program and the impact of patient care through direct and indirect improvements and an evaluation of leadership's PI contributions. A summary report shall be prepared by the quality manager and facility administrator evaluating the individual components and overall effectiveness of the program. The department leaders, Performance Improvement Committee, the Medical Executive Committee, and the Governing Board shall review the summary.

References:

- Joint Commission Standards for Ambulatory Surgery Centers 2020
- CMS Conditions of Overage, State Operations Manual

Attachments:

Form A Sample Quality Council Agenda
Form B Governing Board Report for Environment of Care
Form C Human Resources Report to Governing Board
Form D Review of Employee Competency
Form E Annual Contracts Review

Form F	Medical Staff Leadership Effectiveness
Form G	Governing Board Self Evaluation
Form H	Governing Board Annual Performance Improvement Evaluation
Form I	Quality/Performance Improvement Form
Form J	Sample Pathology PI-QA Study
Form K	Sample Performance Improvement Priority Key
Form L	Sample Medical Record Review
Form M	Sample Chart Audit

Facility Name:	Policy And Procedure Guideline Name:	Policy Number:
Durango Outpatient Surgery Center	**Patient Safety + Quality Improvement Program** **(Environment Of Care)**	**SAFE 104**
	Subject Category: **SAFETY**	**Effective Date: 10/01/2016** **Revised Date: 1/15/20** **Page 1 Of 6**

Policy: Durango Surgery Center shall provide guidelines and implement proactive practices, which provide a safe environment of care in relation to property, equipment, patients, personnel and the public. The facility and each OR must be designed and maintained so that all types of surgery can be performed in a manner that protects the lives and assures the physical safety of all individuals.

Purpose: This plan is action oriented and solution focused. The purpose of this plan is to address patient safety related concerns, environment, challenges and revise the program to better serve the patients and their families. To this end, Durango Surgery Center has developed this Patient Safety + Quality Improvement Plan.

Our plan focuses on the process rather than the individual, and recognizes both internal and external customers, as well as facilitates the need of analyzing and improving processes.

Mission Vision and Value: As we seek to improve the quality of our patients' lives, to serve our communities, to provide an exceptional environment for our employees and physicians. We are guided by:

- Quality: is at the core of everything we do and every decision we make.
- Integrity: We manage our business with integrity and the highest ethical standards. Preservation of dignity and value for each patient, family member, employee, and other healthcare providers.
- Service: We have a culture of service that values teamwork and focuses on the needs of others. We operate with transparency by measuring our results.
- Collaboration of healthcare, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high quality healthcare.

- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the patient safety priorities.

Procedure Guidelines:

Responsibility:
This committee will be comprised of at least: Safety Officer, Infection Control Officer, Pharmacy, Executive Member, and Medical Director

1. Durango Surgery Center leadership takes action to minimize identified safety risks in the physical environment. Employees are responsible for:

   A. Intervention when, safety conditions pose a threat to life or health, or threaten damage to equipment or buildings.

   B. The continuing maintenance of the facility property, eliminating hazards upon discovery.

   C. Reporting equipment or maintenance problems and incidents of property damage to the Administrator/ Clinical Director upon discovery.

   D. Reporting injuries and illness to the Administrator/Clinical Director.

   E. Obtaining the information necessary to perform tasks in a manner that prevents injury to themselves, patients and others.

2. The Administrator/Clinical Director, and Safety Officer, as agents of the Quality Assurance Committee are responsible for:

   A. Patient safety + Environment of Care development, implementation and monitoring.

   B. Report of Safety Surveillance and activities to the Quality Assurance Committee/PI committee.

   C. Every 12 months the organization evaluates the Environment of Care Plan for objectives, scope, performance and effectiveness.

Maintenance and Supervision:

1. Comply with the NFPA 101®, Life Safety Code® (LSC) for maintaining and supervising the facility grounds, buildings and equipment.

2. Maintain equipment and utilities following a preventative maintenance schedule.

3. Maintain sufficient light in the parking and entrance areas to reduce the potential for falls and security concerns.

4. Maintain signs and emergency systems to meet the needs of the visual and hearing impaired.

5. Maintain smoke free environment.

6. Provide facility cleaning, maintenance, and inspection, following a schedule for daily, weekly, monthly, semi-annual and annual activities.

7. Construction and Renovation (Interim Life Safety Plan):

   A. Meet the existing ambulatory health care occupancy health code requirements for construction or renovation.

   B. Train staff in alternative safety processes including the use of new specialized equipment and space.

   C. Train staff to compensate for changes in Life Safety Plan.

   D. Provide increased facility safety monitoring with construction and renovation included reference to the NFPA 101®, Life Safety Code® (LSC).

   E. Inspect and monitor components of Life Safety Plan weekly or more frequently if indicated.

Risk Assessment:

1. Provide risk assessment and hazard surveillance to evaluate the impact of the center building, grounds, equipment, occupants, and internal physical systems on patient, employee and public safety.

   A. Assign a Safety Officer to maintain risk and hazard surveillance.

   B. Record Hazard surveillance.

   C. Report environmental hazard and safety surveillance to the Quality Assurance Committee. Provide follow-up to staff concerning safety issue recommendations.

2. Report and document patient, personnel or visitor injury, and occupational illness. Document incidents on a Variance Report, Occurrence Report, or Incident Report.

   A. Investigate and evaluate each report for opportunities to improve performance using: **Root Cause Analysis Framework**:

Root Cause Analysis (RCA) Team Responsibilities

Root Cause interviews, analysis, investigation, and corrective action plan implementations. Participates in the RCA meetings and discussions. Communicate honestly and openly about only data and facts to the team members and their supervisors/leaders. Include injuries and occupational illness in the report to the Quality Assurance Committee.

B. Patient Safety QA Committee Responsibilities (based on NRS 439.875 and NRS 439.877)

   i. Monitor and document the effectiveness of the patient identification policy.

ii. Clinical Director will supervise the reporting of all sentinel events alleged to have occurred at the facility, including, without limitation, performing the duties required pursuant to NRS 439.835. Each year, submit a report to the Director of the Legislative Counsel Bureau for development, revision and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to NRS 439.877(4)(b).

iii. Receive reports from the patient safety officer pursuant to NRS 439.870.

iv. Based on NRS 439.865, the patient safety plan must also include an infection control program see: infection control policies.

v. Review and evaluate the quality of measures carried out by the facility to improve the safety of patients who receive treatment.

vi. Review and evaluate the quality of measures carried out by the facility to prevent and control infections.

vii. At least once each calendar month (or quarter), report to the executive or governing body of the facility by way of Administrator or Clinical Director regarding:

1. The number of sentinel events that occurred at the medical facility during the preceding calendar month (or quarter);
2. The number and severity of infections that occurred at the facility during the preceding calendar month or quarter; with recommendations to reduce such events.

The Patient Safety Committee will meet monthly (or quarterly) to accomplish the following:

Monthly	Quarterly	Annually
1) Sentinel event monthly report 2) Severity of infection report 3) RCA assessment	1) Sentinel event quarterly report 2) Severity of infection report 3) Review and evaluate the measure of improvement of patient safety 4) Review and evaluate the measurement to prevent and control infections	1) Quality and Patient Safety Plan update 2) Checklists and Policies reviewing and revising

Product Safety Recalls:

1. Address a product safety recall upon notification.

A. Inventory and remove recalled product from possible use.

B. Notify affected medical staff and evaluate a substitute product.

C. Inventory patients who may have received a recalled medical device from implant logs or records.

D. Consult with the Medical Director and/or Quality Assurance Committee to evaluate the situation and determine an appropriate method for patient notification if an implanted medical device has been recalled. The medical director, as an agent of the QA/PI committee reports the incident to the Medical Executive Committee.

Safety Education:

1. Provide Safety Education and Training at orientation and at least annually thereafter. Address general safety processes, area specific safety and job related hazards.

2. Provide Safety Guidelines in the General Orientation including:

   A. Review of Safety Policies and Guidelines.

   B. Body Mechanics.

   C. Hazardous Materials Communication.

   D. SDS/ Hazardous Waste.

   E. Safety Risk / Responsibilities.

   F. Equipment Safety/Operations Manuals.

   G. Emergency Preparedness.

   H. Utility Systems and Electrical Safety.

   I. Infection Control/Exposure OSHA.

   J. Reporting of Sentinel Events.

   K. Variance, accidents/injuries, Security and Safety concerns.

   L. Fire and Life Safety.

   M. Safety Concerns.

   N. Security

o. OSHA.

3. Include specific safety standards related to safe practices and the safe use, inspection, cleaning and maintenance of specialized equipment in the Department / Job Specific orientation.

4. Provide updates when new equipment is introduced.

5. Review General Safety Guidelines annually.

Reference:

Center for Medicare and Medicaid Services (April, 2015). Standard Operations Manual Appendix L – Guidance for Surveyors: Ambulatory Surgery.

The Joint Commission. (2020) Accreditation Standards and Requirements for Ambulatory Surgery Centers

Facility Name: Durango Outpatient Surgery Center	Policy And Procedure Guideline Name: Risk Management Plan	Policy Number: RM 100
	Subject Category: Risk Management	Effective Date: 2008
		Revised Date: 12/2016, 12/2018, 12/2020
		Page 1 Of 3

The Risk Management program is an essential part of monitoring performance. The program is set in place to continuously monitor data within the facility and provides guidance for the selection and implementation of loss controls measures. Such a program will also assist us to prevent/reduce risk exposures to our patients, employees, physicians and visitors in our facility, select and maintain equipment and technology appropriately, and conserve facility property.

PURPOSE

The purpose of Facility's program is to

1. Identify the sources from which losses may arise;
2. Evaluate the financial risk involved in each exposure in terms of expected frequency, severity, and impact;
3. Management of risks by elimination, reduction, or control through the operation of a coordinated and effective program
4. Monitoring of risks continuously and systematically;
5. Initiate proactive programs to reduce liability.

SCOPE

Risk Management at Facility is inclusive of all departments, services, and health care professionals. Performance Improvement activities provide on-going monitoring, evaluation, and resolution of actual or potential threats to the quality of health care delivered at Facility.

AUTHORITY

The Governing Board of Facility has the ultimate responsibility to monitor the quality of care provided in the facility. In addition, the Governing Board strives to provide a safe environment for patients, employees, physicians and visitors by requiring and supporting the establishment and maintenance of effective Risk Management strategies. The Governing Board delegates Risk Management to the Administrator who may appoint a designated individual responsible for Risk Management. The Risk Management Program operates with the support and under the authority of the Governing Board through the Board's approval for the plan.