QUALITY IMPROVEMENT, RISK MANAGEMENT, AND PATIENT SAFETY PLAN

SAHARA SURGERY CENTER
2023

The mission of Sahara Surgery Center is focused on delivering the highest quality, cost effective healthcare that effectively responds to the needs and safety of our patients by minimizing the possibility for injury or harm to our patients. We are committed to the care, dignity and improvement of human life to the patient populations we serve.

In keeping with the mission of the Sahara Surgery Center, the community, HCA initiatives, and regulatory standards for ambulatory surgical care, this plan allows for a planned, systematic, organization-wide approach to the quality improvement process, risks, patient safety and assessing opportunities to reduce risk. This is accomplished through an effective risk and quality program, as well as, a medication and radiation safety plan that are all targeted toward improving patient safety. The activities will be carried out in a collaborative and interdisciplinary manner. When identified, individual competency issues and process changes will be coordinated with the management team and human resources. The overall strategies of the program include

- Improving patient safety and reducing risk to patients which includes, but not limited to medication and radiation safety, safe quality care and reducing risk of injury to patients and staff. This will be accomplished through true learning from errors.
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety;
- Assuring that quality improvement initiatives continue to focus on high priority areas of clinical care, monitoring of process and outcome indicators; redesigning processes and systems and providing education to foster improvement;
- Positioning Sahara Surgery Center to achieve earning expectations and maintain effective cost-containment strategies while providing high quality of patient care, and
- Meeting the expectations of the HCA internal initiatives, as well as, the external regulatory agencies, accrediting bodies (state, CMS, (AAAHC, TJC) and collaboration with nationally recognized quality organizations (ASCQC, AHRQ) through the identification of opportunities to improve patient care, demonstration of appropriate action taken, and follow up on the effectiveness of action taken.

Strategies will be incorporated in each of the following areas to identify opportunities and set goals to achieve and sustain the desired results in striving to become a high reliability organization (HRO):

- Performance Improvement Processes
- Quality studies
- Risk Management Strategies
- Patient Safety Initiatives
- Infection Control Strategies
- Medication Safety Strategies
- Radiation Safety Initiatives

Goals

- Achieve a culture of patient safety that is a common, consistent practice as evidenced by maintenance of complications at or below the benchmark.
- Instill a sense of ownership at all levels of the organization through quarterly comparison of center performance with other HCA ambulatory surgery centers
- Commit to zero patient harm with emphasis on zero wrong site procedures, zero retained surgical items and zero patient burns
- Identification of Quality Improvement opportunities with completion of a formal quality study that results in sustained process improvement
- Improve identification of opportunities for improvement by increasing the reporting of medication errors and close calls. Analyze these reports for trends and take action which may include the performance of a quality study.

HCA Patient Safety Organization (PSO), LLC

HCA established a Patient Safety Organization, LLC in spring of 2014 in accordance with provisions of the Patient Safety and Quality Improvement Act (Public Law 109-41). The PSO is a component of its parent entity, HCA. The mission of the PSO is to conduct activities to improve patient safety and the quality of healthcare delivery. The vision is to assist participating providers in the elimination of preventable patient harm. The activities of the organization include:

- Improve patient safety and the quality of health care delivery
- Collect and analyze Patient Safety Work Product (PSWP)
- Develop and disseminate information regarding patient safety
- Utilize PSWP to encourage a culture of safety and provide assistance to effectively minimize patient risk.
- Maintain procedures to preserve confidentiality and provide appropriate security of PSWP
- Utilize qualified medical personnel
- Operate a patient safety evaluation system (PSES) and provide feedback to participants of the PSO
- Utilize the Serious Event Analysis (SEA) process to identify the root causes of serious safety events, per policy.

Sahara Surgery Center is a member of the HCA Patient Safety Organization (PSO), LLC. The Administrator serves as the designated PSO Contact and oversees all activities of the PSO for the center, while the Risk/Quality Manager should serve as the Contact Designee The Center will provide patient safety work product (PSWP) documents as requested by the PSO. The center will receive information from the PSES to evaluate opportunities for improving patient safety and quality care. All information submitted will remain confidential within the PSO.

Quality Improvement Plan

The Center maintains an ongoing quality improvement program that has a broad scope to address administrative, clinical, and cost-effective performance. The program also addresses patient outcomes, patient care processes, as well as, medication, radiation and patient safety. Elements of the program include, but are not limited to a

- Written plan that addresses the scope of health care services provided by the Center and how the quality improvement plan for these services are assessed.
- Interdisciplinary QI committee for the development, implementation, review and oversight of the program. The committee has administrative, clinical and physician participation.
- Set goals and objectives that are reviewed and updated at least annually.

- Quality improvement activities such as audits/rounding and studies to identify opportunities for improvement with processes or patient care. These Quality improvement activities can be addressed/managed in one of the following ways:
    - Performance of Quality Improvement studies utilizing the ten (10)-step process that is encouraged by the Accreditation Association for Ambulatory Healthcare (AAAHC).
    - Establishing a process for addressing identified performance improvement priorities. This process should address the following:
        - The defined process needing improvement including goals and opportunities for improvement
        - Analysis of the process and associated data to identify underlying causes
        - Implemented actions that address opportunities for improvement
        - Identification of methods and/or tools to monitor and sustain improvement
- Measurement of data against benchmarking sources.
- Annual reviews of the effectiveness of the program.
- Submit periodic reports to Governing Body that encompass a summary of the quality improvement, medication and safety activities, findings and process changes if indicated.

Risk Management and Patient Safety

Definitions of Potential Risk Issues
Event: A discrete, auditable and clearly defined occurrence (**N**ational **Q**uality **F**orum).

Occurrence: The action, fact, or instance of something that happens synonymous with an event. An event, situation, or process that contributes to, or has the potential to contribute to, a patient or visitor injury, or degrade our ability to provide optimal patient care. Reportable occurrences can generally be divided into the following types based on severity: Sentinel events, patient and visitor injuries, [adverse events], near misses (close calls, good catches etc.), and safety concerns. (**N**ational **P**atient Safety **F**oundation)

Incident: Synonymous with occurrence or event. An occurrence or event that interrupts normal procedure and can precipitate an untoward or unplanned outcome. An unusual event that occurs at the facility, such as an injury to a patient. Involved damage that is limited to parts of a unit, whether the failure disrupts the system or not. (NPSF). A patient safety event that reached the patient, whether or not the patient was harmed (NQF).

Adverse Event: A patient safety event that resulted in harm to a patient. (The Joint Commission, 2018). Any injury caused by medical care. Examples:

- pneumothorax from central venous catheter placement;
- anaphylaxis to penicillin;
- postoperative healthcare acquired wound infection;

Identifying an event as adverse does not imply "error," "negligence," or poor-quality care. It simply indicates that an undesirable clinical outcome resulted from some aspect of diagnosis, treatment or therapy, as opposed to an underlying disease process. Thus, pneumothorax from central venous catheter placement counts as an Adverse Event regardless of insertion technique. Similarly, postoperative healthcare acquired wound infections count as adverse events even if the operation proceeded with optimal adherence to sterile procedures and the

patient received appropriate antibiotic prophylaxis in the perioperative setting. (**A**gency for **H**ealthcare **R**esearch and **Q**uality, **P**atient **S**afety **Net**work- AHRQ, PSNet)

Sentinel Event: A Patient Safety Event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel Events are a subcategory of Adverse Events. (The Joint Commission, 2018).

An adverse event in which death or serious harm to a patient has occurred, usually used to refer to events that are not at all expected or acceptable—e.g., an operation on the wrong patient or body part. The choice of the word sentinel reflects the egregiousness of the injury (e.g., amputation of the wrong leg) and the likelihood that investigation of such events will reveal serious problems in current policies or procedures. (Agency for Healthcare Research and Quality PSNet)

Serious Safety Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and may result in any of the following:

- Death
- Permanent harm
- Severe temporary harm (Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition or additional major surgery, procedure, or treatment to resolve the condition).

Such an event may result in patient injury as well as cause damage to the Facility and/or HCA's reputation as well as the Facility's accreditation, certification or licensure.

Close Call (Near Misses/Good Catches): Events or situations that could have resulted in an adverse event (accident, injury, or illness), but did not, whether by chance or through timely intervention. Such events have also been referred to as "near miss" incidents. An example of a close call would be a surgery or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure (Source: VA Patient Safety Program).

Serious Event Analysis (SEA): A method of problem solving that attempts to identify the root causes of a process or processes. The SEA process attempts to evaluate the underlying "whys" for the variances and solve problems by attempting to identify and correct the root causes of events, as opposed to simply addressing their symptoms. By focusing on the correction of root causes, problem recurrence can be prevented. An analysis is done *after* an event has occurred. All staff members involved, as well as, the Risk Manager and physicians involved shall participate in the SEA analysis The SEA process is typically used as a reactive method of identifying event(s) causes, revealing problems and identifying opportunities to reduce the risk of future occurrences. The SEA action plan is reported at the quality meetings, MEC and GB meetings.

Risk Management:

The Center maintains an ongoing risk management program designed to protect the life, safety and welfare of the patients and employees. Risk management addresses strategies from the organizational, operational, human resource and liability areas of the organization. Goals of the program may include, but are not limited to:

- Improving patient safety and reducing risk to patients;
- Reducing medical/healthcare system errors and hazardous conditions by creating an environment in which patients, their families, surgery center staff, and medical staff are able to identify and manage actual or potential risks to patient safety
- Reviewing and tracking of variance reports and litigations for trends.
- Reviewing and tracking of adverse outcomes, near misses (close calls) or sentinel events to identify gaps or opportunities for improvement.
- Maintaining a strong credentialing and privileging process and current bylaws that meet community standards
- Keeping abreast of current standards for risk management and adapting practice and policies that are compliant with standards.

It is evident through the goals, activities and processes that the quality improvement and risk management programs intertwine and cross all spectrums of the organization. Quality care, as well as patient and employee safety are at the center of focus of both programs. The operational linkage between Risk management, Safety, Quality and Infection Control is accomplished through the following mechanisms:

- Issues or trends identified through chart reviews, peer reviews, safety, radiation and infection control rounds are discussed and referred to the appropriate department for evaluation and/or corrective action
- Data from variances that identified trends, adverse events or any events that impact the quality or safety of patient care will be reviewed and referred to appropriate risk and leadership personnel for investigation, analysis and corrective action
- The Risk Manager will review current issues and risk reduction strategies with appropriate personnel and coordinate a plan of action. This will be reported to MEC/GB.
- The Quality Committee will serve as the oversight committee and/or Patient Safety Committee for Patient Safety, Risk Management, and Infection Control. Medication Safety and Radiation Safety fall within a subsection of the Quality Committee and will be addressed as indicated.

These plans engage active involvement of all members of the healthcare team, as well as patients, families and physicians, addressing an environment which:

- Encourages recognition and acknowledgment of opportunities to improve quality performance and to reduce risks to patient safety,
- Initiates actions to improve processes or reduce these risks,
- Encourages internal reporting of what has been found and the actions taken;
- Focuses on processes and system,
- Minimizes individual blame or retribution for involvement in a medical/health care error; and
- Challenges leaders of the organization to be responsible for fostering a “non-punitive” culture of continuous improvement, reducing risk and creating a safe environment for patients, employees and physicians.

Medication Safety

A designated regional pharmacist oversees the medication practices and processes at the Center. Their duties include, but are not limited to

- Conducting medication rounds and audits providing feedback on areas of opportunities. This includes validation of medication safety practices.
- Adhering to strict processes for ordering, administration and tracking of controlled substances.
- Collaborating with the Center on choice of pharmaceutical vendors and formularies
- Collaborating with the Center on policy review and development
- Participating in review of any medication error or diversion

- Assuring controlled substance ordering and monitoring is in accordance with state and federal regulations

All relevant activities are reported through QI/MEC/GB.

Radiation Safety

This facility utilizes radiation emitting equipment and therefore, by direction of the Governing Body/Board, Radiation Safety will be a subgroup of representatives to be included under the QI/Safety/Risk committee to report radiation safety activities. Key activities are established by the HCA Corporate Radiation Right policies, Governance policies and Fluoroscopy policies:

- Designate an individual that is approved by MEC/GB to oversee the program
- Oversee ongoing measurement, periodic review, and improvement of key radiation safety practices and provide a quarterly report to the QI/Risk/Safety committee (Quarterly rounds)
- Periodic maintenance of equipment
- Maintaining and reviewing exposure time logs
- Communicate relevant radiation safety activities, as necessary, to the staff.
- Serve as a resource for radiation safety as it relates to staff and patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Educate staff on radiation safety practices

Infection Control

The Center conducts an annual infection control risk assessment in order to identify areas of opportunities to reduce the risk of infections (Refer to Infection Control Plan, IFC). All activities are reported through QI/MEC/GB.

Peer Review Peer Review is overseen by the medical staff and occurs in accordance with requirements outlined by AAAHC, CMS, and other regulatory agencies. The Ambulatory Surgery Center assists in the identification of and tracking of quality improvement and peer review on medical staff members and allied health professionals. Peer review activities including the review of medical staff related variances, trends and other data are reported up through the MEC and Governing Board as outlined in the Medical Staff Bylaws, or equivalent. A summary of a provider's peer review activity is reviewed at the time of re-credentialing or more frequently if needed.

Confidentiality

All quality improvement, peer review activities and data are considered confidential. Requests by outside sources for QI, Risk management, Peer Review or credentialing informational reports will be forwarded to the appropriate HCA administrative/corporate staff when indicated.

ORGANIZATION STRUCTURE AND PROCEDURE

Role of Leadership

Leaders play a key role in facilitating improvement and ensuring a safe environment. The Sahara Surgery Center leadership includes the Governing Body, Medical Executive Committee; the facility based Medical Directors, Administrators, Risk/Quality/Safety/Radiation Safety/Infection Control designees and Clinical Managers. Leaders foster quality improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate.

Governing Board/Medical Executive Committee

The Board has the ultimate authority and accountability for the quality and risk programs to ensure that the quality of patient care is provided in an efficient, safe, timely and cost-effective manner. The Governing Body provides support for the improvement strategies and delegates to the Medical Executive Committee and leadership at each facility, the authority to perform assessment and improvement activities through committees

and teams. Quarterly, the Governing Body shall receive a report on the activities of the quality, patient safety and risk management programs. These functions include, but are not limited to:

- Assure QI/Risk/Radiation/Medication/Patient Safety is an integral part of the Center's objectives, plans and management structure
- Provide resources to support the QI/Risk/Patient Safety programs.
- Assure that improvements are sustained and evaluated for effectiveness
- Review and approve policies, reports, QI/Risk/Safety/IFC data collection and analysis, the QI/Risk/Patient Safety plans and annual evaluation.

Administration

The Governing Board is ultimately responsible for all quality, risk and patient safety activities. The Governing Board has delegated the Administrator, in collaboration with the V.P. of Operations to oversee all activities and provide reports to the Governing Board. Delegated qualified personnel are assigned to support the proper functioning of quality improvement and risk management activities. Administration will participate in performance improvement activities, rounding, and in the assignment of priorities to the functions identified by performance improvement activities.

Key Priorities:

- Assure patient care is delivered safely
- Ensure the ongoing competencies of the staff
- Support an environment that promotes process improvement, quality outcomes, reduction in risk, patient and employee safety and customer satisfaction
- Oversee review and current compliance with regulatory standards (CMS, CDC, TJC state and AAAHC)

Key Activities:

- Develop specific goals, objectives, and targets for quality improvement, patient safety, risk management, infection control, as well as, radiation and medication/ patient safety.
- Designate responsibility to qualified individuals or an interdisciplinary committee to ensure quality and risk goals/objectives, as well as patient safety are achieved.
- Provide adequate time and training, as well as resources, for personnel to participate in quality improvement activities and to improve patient safety.
- Assure clear systems and policies/procedures for internal and external reporting of information relating to performance indicators/measures and medical/health care errors.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors. Actively encourage all staff to identify and report hazardous conditions and errors in a blame-free environment.
- Establish or support changes in processes, functions and services to sustain improved performance and to prevent recurrence and reduce risk to patients.
- Assure the effectiveness of the quality and risk management goals/objectives and contributions to improving patient safety are measured and assessed annually.

Quality Improvement/ Risk/Infection Control/Radiation Safety/Medication Safety/Patient Safety Committee

Each facility has a quality improvement committee, which derives goals from the Governing Body, Medical Executive Committee, Administration, staff and other sources. Primary responsibility of this committee is to maintain a culture of patient safety throughout all patient care processes and organizational functions. This committee is interdisciplinary and includes, but not limited to the QI/Risk/IFC Manager, Facility Administrator, Medical Director and Clinical Managers. Other members such as supervising radiologist, pharmacy nurse etc will be added to the committee as indicated by the agenda. The committee is designed to provide upper management support and direction for improvement efforts.

Key activities:

- Establish and oversee ongoing measurement, periodic review, and improvement of key processes, including the review of identified Quality Indicators. Oversee actions for improvement of Quality Indicators as needed
- Assist in identifying opportunities for improvement and participate in QI studies.
- Participate in Ambulatory Surgery Division quality, risk and patient safety initiatives including Best Practices
- Communicate relevant activities, as necessary, to the staff.
- Support a system that builds and reinforces a non-punitive culture for reporting and reducing errors
- Serve as a resource for patient safety/regulatory issues and for the regulatory component of accrediting agencies.
- Provide periodic reports on quality improvement activities to Medical Executive Committee and Governing Board.
- Educate staff on quality, risk and patient safety activities

Quality Studies or Performance Improvement Activities

Quality studies or Performance Improvement Activities will reflect the scope of services, priorities and findings from performance monitoring or other sources. Studies will address clinical, administrative, and/or cost of care issues and will be documented in the (10) step format, for those centers with AAAHC accreditation. The 10-step format includes:

- State the purpose of the process improvement opportunity/purpose of the study
- Identify the goal of the study
- Description of data to be collected and established criteria
- Evidence of Data Collected
- Data analysis
- Comparison of actual data to goal
- Development of corrective action and execution timeline
- Re-measurement and monitoring to determine if actions have been achieved and improvements are sustained
- Development of additional corrective actions if needed
- Communication of results to appropriate personnel, MEC and Governing Board

For those centers that utilize the Joint Commission for accreditation, their Quality Improvement and/or performance improvement activities may be documented in the 10-step format outlined above or may follow the Plan-Do-Check-Act (PDCA) model. The model includes the following:

- Plan- utilize existing quality data or monitoring sources to determine processes requiring change and goals for achieving change
- Do- implement actions to accomplish change
- Check- perform additional monitoring or data collection in order to evaluate the effectiveness of the implemented actions. Evaluate the results
- Act- Stabilize the change actions if results are favorable or develop additional corrective actions. Begin the cycle again if necessary.

Staff Education

The staff receives an orientation on quality improvement, risk management, infection control and patient/employee safety initiatives within 30 days of employment as part of new employee orientation. At least annually, a review of the process and accomplishments will be conducted through an appropriate mechanism.

Clinical leaders will receive periodic training on any updates to initiatives, new statistical reporting or other information as indicated.

Ongoing Measurement

The Quality/Risk Manager in collaboration with the Facility Administrator and Medical Director oversees ongoing measurement. These are outlined on the addendum to this plan.

Design of New Processes

When the Center is considering a new process (for example, providing a new patient service, constructing a new facility, or redesigning an existing service), a multidisciplinary team should be convened to ensure that the process considers:

- The organization's mission, vision and strategic plans;
- Patient and community needs;
- Information about performance and outcomes of the process (including information from reference data bases).
- Current evidence-based practice and research
- Current regulatory standards

Periodic Assessment and Improvement

Based on ongoing review of measurement data, this plan provides for assessment of data against historical trends and available benchmarks whenever possible. The Quality Committee, Medical Executive Committee and Governing Board review quality measures and quality improvement activities quarterly.

Assessment may be triggered for any of the following:

- By any sentinel event;
- By important undesirable single events, which may include:
  - "Near miss" events
  - Significant injury or death
  - Any significant untoward event during moderate sedation or anesthesia;
  - Any serious adverse drug or medication error event; and
  - Any significant hazardous condition.
  - Any significant infection control breech or trend

- By important undesirable patterns or trends, which may include:
  - Staffing effectiveness or clinical issues;
  - Any quality measure that varies substantially from an expected range; and
  - When the organization's performance significantly varies below that of other ambulatory surgery settings or recognized standards.

Select quality data is submitted to HCA and trended with internal benchmarks across the company. This information is shared at the facility, division and enterprise level. This information is used to develop division and enterprise wide quality and risk initiatives and for external benchmarking in the ambulatory surgery arena.

In addition to ongoing measurement, the Center may at any time proactively assess its culture of patient safety as well as specific processes of care that have been identified within the healthcare industry as having the potential to harm patients. The Center may periodically assess processes using tools provided from a variety of outside sources to identify potential risks to patients and opportunities for improvement.

REFERENCED ORGANIZATIONS

AAAHC- Accreditation Association for Ambulatory Health Care, Inc., http://www.aaahc.org/
TJC- The Joint Commission, https://www.jointcommission.org/
AHRQ – Agency for Healthcare Research and Quality, https://www.ahrq.gov/
ASC QC- Ambulatory Surgery Center Quality Collaboration, https://www.ascquality.org/home
CDC- Centers for Disease Control and Prevention, https://www.cdc.gov/
CMS-Centers for Medicare and Medicaid Services, https://www.cms.gov/
FDA- Food & Drug Administration, https://www.fda.gov/
NQF- National Quality Forum, http://www.qualityforum.org/Home.aspx
NPSF-National Patient Safety Foundation, http://www.npsf.org/
SMDA-Safe Medical Device Act, https://www.fda.gov/MedicalDevices/Safety/ReportaProblem/default.htm
VA Patient Safety PROGRAM, VA National Center for Patient Safety, https://www.patientsafety.va.gov/
WHO- World Health Organization, WHO.Int

ONGOING QUALITY AND RISK MANAGEMENT
PERFORMANCE MEASUREMENTS (as applicable)

Performance Measure	Data Source	How Calculated	Frequency
**Patient Satisfaction	Press Ganey/Postop Call	Percent	Quarterly
OMP Completion	OMP	Percent	Quarterly
**Patient Grievances	Grievance Process	Raw Number	Quarterly
Complications			
**Retained Foreign Body	Variance Reports	Raw number	Quarterly
**Wrong site, patient, procedure	Variance Reports	Raw number	Quarterly
**Direct Admits	Variance Reports	Rate	Quarterly
**Indirect Hospital Admits	Variance Reports	Rate	Quarterly
**Indirect ER Visits	Variance Reports	Rate	Quarterly
**Post Op DVT/PE	Variance Reports	Raw number	Quarterly
**Mortality within 7 days r/t procedure	Variance Reports	Rate	Quarterly
**Falls	Variance Reports	Rate	Quarterly
**Burns	Variance Reports	Raw number	Quarterly
**Medication Errors	Variance Reports	Rate	Quarterly
**Normothermia	Variance Reports	Percentage	Quarterly
**Close Call Events	Variance Reports	Raw number	Quarterly
Variations in expected performance	Variance Reports	Raw number	Quarterly

Performance Measure	Data Source	How Calculated	Frequency
Infection Control			
**Surgical Site Infection	Variance Reports, Post op letters	Rate	Quarterly
Physician Response	Survey	Percentage	Quarterly
**Hand Hygiene Compliance	Visual Observations	Percentage	Quarterly
**Antibiotic Administration	Chart Review/SQI	Percentage	Quarterly
**IUSS use	CSP Data Tracking	Percentage	Quarterly
**Additional Indicators as identified via the ICRA	ICRA	Variable	quarterly
Medical Record Review			
Medical Record Delinquency	Chart Review	Percentage	Quarterly
**Medical Chart Audit Results – components TBD based on variances	Chart review	Percentage	Quarterly
Radiation Safety			
**Dosimetry Badge w/in Range	Radiation tracking system	Raw number	Quarterly
Radiation Time – average	Radiation tracking system	Raw number	Quarterly
Training completion per policy	Radiation tracking system	Percentage	quarterly
High Volume / High Risk Indicators			
Storage, Administration, Inventory, Diversion	Pharmacy Audit, Administration Record Review	Raw Data	Quarterly
Quality Indicators related to new services lines (i.e. Total joints, Robotics, PPMs etc)	Variance Reports, Audits	Raw Data	Quarterly
Patient Flow			
On time start and flow of surgical cases	Manual data collection	Average time	Quarterly
Turn-over time	Manual data collection	Average time	Quarterly
Case Cancellations – same day	Manual data collection	Raw number	Quarterly
Pre-op Care			
Pre-op instructions	Manual data collection	percentage	Quarterly
DVT assessment – including use of SCE when indicated	OMP and Manual Chart Review	Percentage	Quarterly
Fall Assessment – completion and implementation of prevention activities	OMP and Manual Chart Review	Percentage	Quarterly
Intra-Op Care and Processes			
Time Out/Correct Site Verification process	Visual observations and chart review	Percentage	Quarterly
Blood Utilization	Chart Review, Lab data	Raw number	Quarterly
Resuscitation			
Code Blue – occurrence and results	Code Forms and Variance reports	Raw number	Quarterly
Malignant Hyperthermia – occurrence and results	Code Forms and Variance reports	Raw number	Quarterly

Diagnostic Results			
Pre and Post Op diagnosis agreement	Chart review	Percentage	Quarterly
Specimen results received	Lab reports, manual logs	Percentage	Quarterly
Medication Usage			
Medication Reconciliation – completion per policy	Chart review	Percentage	Quarterly
Performance of independent double checks – per policy	Visual observations	Percentage	Quarterly
Controlled substance audit results	Manual data collection	Percentage	Quarterly
Life Safety			
**Surveillance Rounds – results	Monthly Surveillance Rounds	Percentage / raw number	Quarterly
Recalls – compliance with process	Monthly data collection	Raw number	Quarterly
**Drill – completion / results (fire, infant, provider, MH etc.)	Drill completion forms	Raw number	Quarterly

**** indicates that the Quality Indicator is required data collection. Quality Indicators without an asterisk are optional based on center need**

QI/RISK GOALS for 2023

Clinical Services Group (CSG)/HCA Initiatives

Compliance with CSG initiatives

- Conscious Sedation Guidance
- Medication Safety-Diversion Guidebook
- USP 800 Guidebook

Clinical Safety Improvement Program 2023 Goals

1. AHRQ Culture of Safety- Action Items and Implementation
    a. Implementation of Weekly Safety Rounding
        i. Marked site visible and complete
        ii. OR quiet for time out
        iii. Time out completed accurately
    b. Implementation of daily huddle
        i. Development of huddle board
    c. Completion of Monthly Quality Report (MQR)
2. Medical Director Engagement
    a. Participation in required meetings
3. Learning Organization
    a. 100% completion of assigned Health Stream courses by employees
    b. Completion of assigned Physician Education as evidenced by return email correspondence

2023 Center-specific Goals

1. To continue to identify area of opportunity to reduce the IUSS rate, and to sustain the IUSS rate ≤ 5% (as per HCA benchmark).
2. To comply with and meet the requirements of the 2023 Clinical Safety Improvement (CSIP) Program
3. Improve staff dosimetry compliance to 100%
4. Continue to identify and implement immediate access to MIFU's" for Sterile Processing
5. Maintain Direct Admits in line with HCA Upper Benchmark. - By continuing the current process of conducting pre-op phone call assessments and use of One Medical Passport.
6. Under the guidance of the Regional Pharmacist continue to refine the accountability process of controlled substances in the OR, PACU and Pain Departments.
7. Update the Medical Diversion program by developing a monitoring and reporting program that discourages diversion and strengthens accountability by continually seeking to improve controls.
8. Increase Risk Management in-service participation to 100%.
9. Perform two Quality Improvement Studies per year with analysis
10. Increase reporting of Close calls with analysis for trending
11. Increase reporting of Peer Review Trending issues, continue peer review efforts with analysis for trending
12. Increase capture of patient email addresses during admission process to increase compliance with customer satisfaction surveys