Encompass Health Rehabilitation Hospital of Henderson

Policy#: 170	Title: Performance Improvement & Safety Plan	Category: Plans
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PURPOSE

To improve safety and quality for patients and caregivers and to provide a safe environment for employees, providers, visitors and the community we serve. We believe integrated care delivery across the healthcare continuum and coordinated approach is critical to achieving the best outcomes for patients and reducing error/risk. The program supports the creation of an environment in which, our staff and leaders can identify and manage actual and potential risks to safety and elevate expectations and outcomes through our Core Values. We exist to provide a better way to care that elevates expectations and outcomes.

RESPONSIBILITY

1. The ultimate responsibility for the implementation and operation of this Plan is the hospital CEO.

2. The Safety Committee, Quality Council, MEC, and Governing Body will provide interdisciplinary input and oversight related to patient, visitor and staff safety.

POLICY

I. Performance Improvement Dashboard

The objective of the Quality Dashboard is to provide an effective and efficient way to document and communicate the Quality Program with consideration for Regulatory, Quality of Documentation, Processes and Outcomes. The Quality Dashboard will be completed on a monthly basis and outliers will be reported to Quality Council, MEC and governing body at least quarterly. The Quality Dashboard measures are categorized into the following categories.

Acute Care Transfer	Medical Staff
Consulting	Medication Management
Contracted/Ancillary Services	Operations
Dietary	Patient Care
Discharge	Patient Safety
Education	Patient Satisfaction
Facility Management	Quality of Care
Human Resources	Regulatory/Accreditation
Infection Prevention	

II. Purpose of Performance Improvement

The performance improvement activities of the hospital are a coordinated comprehensive and ongoing effort to assess the effectiveness of all care and services provided based on the mission and values of the organization. These activities require a proactive approach with collaboration and coordination on all levels of the organization. The organization has a planned, systematic, organization-wide, and department specific approach to planning, designing, assessing, and improving its performance. The goal and purpose shall to be to strive, with the resources available, for optimal outcomes with continuous, incremental improvements that are consistently representative of a high standard of practice with the medical community and community at large.

The plan is to minimize risks to patients, visitors, employees, and staff while improving the quality and safety for patients. The attainment of the goals developed shall be in consideration of the internal and external customer needs with improvement processes focusing on improved patient outcomes, patient safety, and cost effectiveness. The goals are not limited to those departments and services that directly provide care to persons served, but all departments and individuals that are involved with the products provided by the organization.

III. Process Improvement Method

The organization shall utilize a systematic method to improve the organizational performance. Various methodologies have been assessed throughout the history of the organization. The most effective and simplest method is the use of the PDCA model.

P - Plan

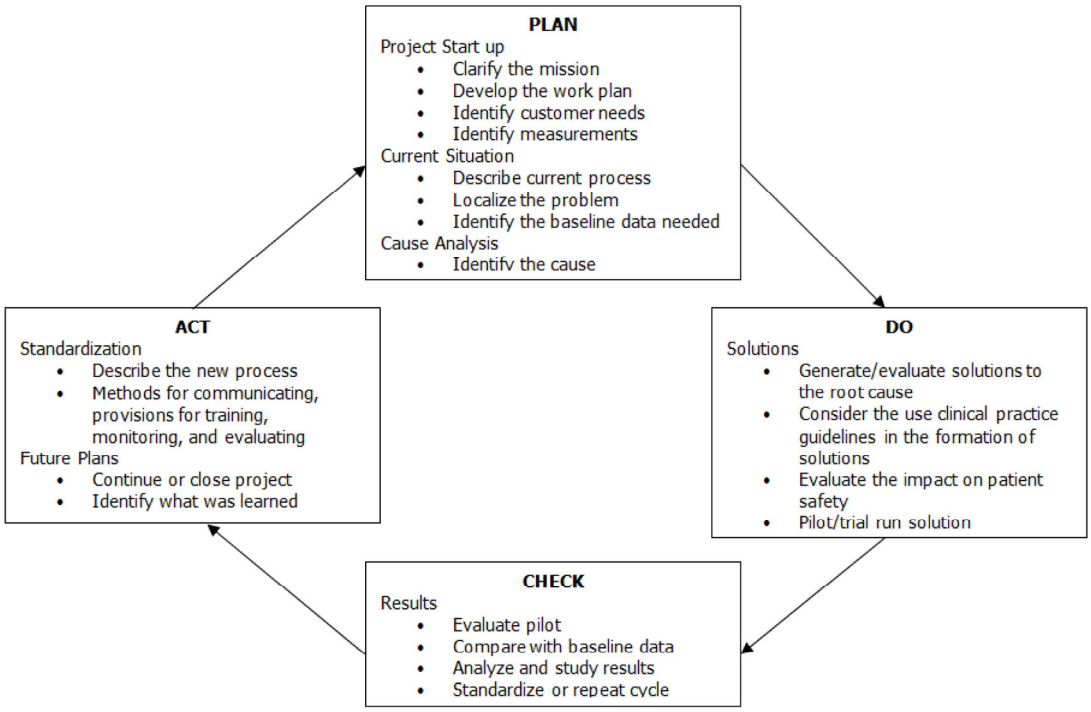
D - Do

C - Check

A - Act

The above method is at the core of performance improvement activities throughout the organization and is incorporated in the logic of improving services at every level. Performance improvement techniques such as brainstorming, multi-voting, flow-charting, etc. will be utilized in improvement activities as appropriate to the team. Graphic representation of data and methods utilized during improvement processes is encouraged during presentations of activities and outcomes.

The Plan/Do/Check/Act Cycle



Additional proactive assessment of at least one high-risk process will occur every 18 months in order to reduce medical/health care errors. The selection of the process will occur based on information published from a variety of sources including, but not limited to, The Joint Commission (TJC). The study of the process will utilize the proactive risk assessment process outlined by TJC. Proactive risk assessment is similar to the PDCA process, but without specific data to support the process or an event to direct attention to a process that is undesirable. The proactive assessment is indeed a PI project and should not be separate from the performance improvement activities of the hospital.

Proactive Risk Assessment

1. Assess the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (potential "failure modes).

2. For each identified failure mode, identify the possible effects on the patient ("effect"), and how serious the possible effect on the patient ("criticality" of the effect)

3. For the most critical effects, conduct a root cause analysis to determine why the variation (failure mode) leading to that effect occurs.

4. Change the process or system to minimize the risk of that failure mode or to protect patients from the effects of the failure mode identified. Utilization of clinical practice guidelines, when available and appropriate, for the process development in order to reduce variation.

5. Test and implement the redesigned process.

6. Identify and implements measures of the effectiveness of the redesigned process.

7. Implement a strategy for maintaining the effectiveness of the redesigned process.

IV. Roles and Responsibilities

The responsibility for the success of performance improvement is in the hands of every employee in the organization with specific roles and responsibilities determined to expedite organization wide efforts. The authority for implementing the performance improvement plan is afforded to the CEO by the Governing Body.

Governing Body

The Governing Body is the ultimate authority and is committed to the provision of quality and safe patient care and services. The Governing Body promotes and sustains an equitable culture of safety through their processes. Reporting of organizational performance and improvement is reported at least quarterly with a summary of significant improvements and significant issues. The responsibility to optimize the organizational performance through appropriate utilization of resources is directed by the Governing Body. The Governing Body, through its voting membership, shall facilitate Performance Improvement as follows:

1. Provide direction in setting priorities;
2. Oversee the planning, design, implementation, and ongoing monitoring;
3. Establish an organizational culture, which supports commitment;
4. Implement strategies to measurably and equitably improve safety for health care professionals and all staff within the organization;
5. Provide adequate resources; and,
6. Receive, review and accept reports regarding the effectiveness to help guide direction.

Medical Executive Committee (MEC)

The MEC shall be responsible for the ongoing quality of medical care and professional services. The MEC will regularly assess their organizational structure and allocation of resources to ensure patient and workforce safety. In conjunction with the Quality Council, this body shall have responsibility for medical staff improvement and focused review activities. These responsibilities will be accomplished by:

1. Representation and participation on Quality Council;
2. Assessing and analyzing data related to the quality and safety of patient care; and,
3. Involvement by medical staff members in performance improvement activities.
4. Involvement in program evaluation and review.

Quality Council

The Quality Council is responsible for overseeing the Plan by:

1. Monitoring and assessing data;
2. Acting on recommendations from staff, departments and patients and their families to equitably engage these groups in the co-production of safety improvement efforts;
3. Identifying and prioritizing performance improvement projects that address recognizable gaps;
4. Providing education and training needs related to performance improvement; and,
5. Evaluating the overall effectiveness and adjust as appropriate.

Senior Management, Leadership and Departmental Leadership

Senior leadership, which includes members of both the administrative and Medical Staff, participate in the Plan as demonstrated through:

1. Development and communication of the organization's strategic goals in conjunction with the Governing Body;
2. Collection and assessment of pertinent data; and,
3. Supporting the use of internal resources (both human resources and other financial resources) to allow participation and implementation of the Plan in departmental projects and interdisciplinary teams (organizational performance improvement teams).
4. Ensure the implementation of an integrated patient safety program throughout the organization.

5. Responsible for interacting with staff in a manner that promotes a just culture and encourages transparency through open reporting of safety risks.
6. Ensure safety of the workplace to address the determinants of health at all times, especially in times of crisis.
7. Analyze gaps and opportunities for leadership and governance development to improve safety standards.
8. The leadership team members may request the assistance of internal behavioral management staff or external resources if a staff member(s) needs support in coping with an adverse event.
9. Hospital leadership will identify barriers to effective communication among caregivers relative to patient care, redesign of processes to eliminate barriers to communication and monitor communication for effectiveness. Specific attention will be directed to the processes for ensuring accurate, timely, and complete verbal and written communication among care givers and all others involved in utilization of data.

Performance Improvement Teams (PI or PIT)

Teams carry out interdisciplinary and complex performance improvement projects as directed by the quality council. These project teams will:

1. Follow the approved formats for team projects;
2. Use the adopted performance improvement processes; and
3. Report regularly to the quality council.

Patient Safety Officer

The Governing Board appoints a Patient Safety Officer. The Patient Safety Officer/Director's role includes:

- Participating in hazard surveillance, event reporting, reviewing, and the development of patient safety policies and procedures to meet the shared goals for safety across the continuum of care.
- Analyzing and seeking resolution of patient safety issues and works with the appropriate staff to implement recommendations and to monitor patient safety improvement activities.
- Report on findings, recommendations, actions taken, and results of measurements through the hospital quality structure.

All Staff

All staff are responsible for gaining knowledge in organizational performance improvement and participate by:

1. Being the eyes of the hospital and looking for opportunities to improve;
2. Participating in their departmental projects;
3. Committing to continuous learning within the organization;
4. Participating in PI projects; and
5. Communicating to leadership areas identified and recommending possible solutions utilizing the communication mechanisms put in place by the Senior Leadership and Quality Council.

The meeting frequency of the above Committees/teams and their subsequent responsibilities will occur according to the needs of the organization, but no less frequently than required by accrediting bodies and/or the bylaws which govern the Committee, if they exist. Communication of the activities and performance shall occur in both a formal and informal process, but all formal methods will utilize the following structure. The arrows within the representation indicate the two-way communication within the organization.

ORGANIZATIONAL COMMUNICATION STRUCTURE

Quality Council reports to Medical Executive Committee that reports to Governing Body.

VI. Prioritizing Organizational Performance Improvement Activities

Organizational performance activities and projects are judged and prioritized based on their impact on our customers and the core values of our organization. Activities for consideration are obtained from various customers (internal and external to the organization) including, but not limited to members of the committees listed, hospital employees, Medical Staff members, organizational leaders, referral sources and payers, and the community at large. The activities and projects should address the patients' priorities and recognize them as a part of the health care team. Information is obtained from the use of the patient grievance/comment system and various types of formal and informal surveys taken during the interview process with customers.

In many instances, a significant improvement in processes can be made without the need for a formalized team. These improvements occur during brainstorming sessions between staff and leaders. These do not require the time that larger projects may entail, but make measurable differences in the operations of the organization. This type of activity is communicated through the hospital quality reporting structure.

Meeting/Records:

Quality Council, Medical Executive Committee and Governing Body meetings are held, at a minimum, quarterly. Quality Dashboard outlier data is reviewed at least quarterly. Performance Improvement Teams report progress at a minimum quarterly. Safety data is reviewed at least quarterly, including occurrences of patient safety events and other risk-related events, and actions to improve safety. Records of all Quality Council, Medical Executive Committee and Governing Body Meetings activities are maintained. Minutes will reflect recommendations from these groups and any action taken.

Quality Council Membership:

Medical Director or Medical Staff physician representative

Administrator (CEO)

Director of Quality Management/ Patient Safety (DQR)

Chief Nursing Officer and or nursing management representative (CNO)

Director of Therapy Operations and or therapy leadership representative (DTO)

Director of Pharmacy Services (DOP)

Director of Plant Operations (DPO)

Business Development Director (BDD)

Director of Human Resources (HRD)

Case Management Director (DCM)

Controller (CFO)

Infection Control Preventionist/ Employee Health Nurse

Dietician

Other Department Representatives, Frontline Staff, and Contract Services

VII. Education and Training

All employees are educated regarding performance improvement and safety plan upon hire, including risks specific to their role, annually at re-orientation processes, and through ongoing in-service and other education and training programs, as needed. Education encompasses the performance improvement methods, input into performance improvement activities, and responsibility for the continued improvements within the organization.

Staff will be oriented to their roles in preventing and reporting adverse occurrences as related to their specific job responsibilities and as a part of the hospital-wide efforts to improve patient outcomes and safety. *Policy 600, Electronic Event Reporting* describes the process for reporting of every occurrence that meets the following definition: any happening not consistent with the routine care or operation of the facility, or the desired routine care of the patient and/or operation of the facility, which places our patients and visitors at increased risk for harm.

VIII. Monitoring, Collecting, and Analyzing Data

Data is the foundation of performance improvement activities. Data alone is insufficient to improve the performance of the organization. Analysis of data and implementation of actions following data analysis can enable widespread learning that is necessary for improving best practice guidelines and promoting safety. A process for data use is required. This process includes:

- planning
- collection
- assessment/analysis
- actions

1. Data planning involves the determination of appropriate data that will effectively measure the process/outcome that has been prioritized. The planning of data collection should be timely at intervals that allow for effective assessment, conclusions, and recommendations.

2. Data collection objectively measures the processes and indicators. Measurements are made to accurately assess the outcomes and must be defined. Method for collection, resource for data, and the formula for data calculation must be documented in order to compare the impact of the process change.

3. Data assessment and analysis must be performed in order to utilize the data as information that allows the organization to make informed decisions regarding changes in culture, processes, patient care, and performance of business functions.

4. Actions based on the data and information obtained is planned in order to improve the performance of the organization. These actions are planned by the department, team, or organizational structure identified as responsible for the improvement. National Clinical Practice Guidelines and evidence based practices are considered when developing improvement strategies.

Data utilized by the organization is obtained from internal and external sources. Comparison data is desirable in all measurement functions in order to determine the appropriate level of operation. Data measurement and analysis over time determines the ability of the process to succeed in all circumstances.

Actively request staff to periodically discuss their opinions, needs, perceptions of risks to patients and suggestions for improving safety. The actions taken as a result of this staff input will be reported to the MEC/GB annually.

Opportunities for performance improvement may be identified by the systematic review of the internal and external data obtained by the organization. Measurements that fall below the acceptable expectations and thresholds typically indicate an opportunity for improvement. Additionally, data may indicate acceptable levels, but may not necessarily suggest optimal efficiency and effectiveness.

VIII. Department Involvement

In order for the organization performance plan to be effective, it must be supported by the department-specific activities. The performance improvement process is both organization wide and department specific. The plan not only represents a hospital wide approach to performance improvement; moreover, it dictates the need for each department to assess its role in the organization's strategic plan. Each department must assess its customer, their needs and expectations, and gauge its ability to meet these needs through objective measurements. Reports of significant findings, activities, and actions will be reported through the hospital quality structure.

IX. Plan Effectiveness

On an annual basis, the plan will be assessed for its impact on the organization's improvement within the strategic goals developed using pre-established, objective process criteria to assess their effectiveness in improving patient outcomes and safety. Hospital leadership will measure and assess the effectiveness of their contributions to improving patient safety. To accomplish these goals, leaders will: Set measureable objectives for improving safety. Draw conclusions based on their findings and develop and implement improvement in their activities. Evaluate their performance in supporting sustained improvement.

Attachments

Quality and Safety Learning System.docx

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