PURPOSE
Sunrise Hospital & Medical Center | Sunrise Children's Hospital (SHMC|SCH) develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality, and patient safety assessment, and performance improvement program.

SCOPE
House Wide

POLICY/STRUCTURE
A. SHMC|SCH has a leadership structure to support operations and the provision of care.
B. Structure is formed by three (3) leadership groups:
   1. Board of Trustees (BOT), the organized medical staff which is represented by the Medical Executive Committee (MEC), and Senior Leadership.

BOT
A. BOT serves as the governing body legally responsible for the conduct of SHMC|SCH as an institution.
B. BOT has ultimate responsibility for safety and quality which is derived from their legal responsibility and operational authority for SHMC|SCH performance.
C. In this context, the BOT provides for internal structures and resources, including staff that supports safety and quality.
D. Working with the MEC and Senior Leaders, the BOT establishes a mission, vision, and goals of the organization to support safety, quality of care, treatment, and services.
E. Roles and responsibilities of the BOT in ensuring performance improvement (PI) and patient safety activities include:
   1. Reflects the complexity of SHMC|SCH organization and services; involves all SHMC|SCH departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.
   2. Identifies those responsible for planning, management, and operational activities.
   3. Identifies those responsible for the provision of care, treatment, and services.
   4. Defines in writing its responsibilities.
   5. Approves SHMC|SCH written scope of services.
   6. Selects and approves the Chief Executive Officer (CEO) responsible for managing SHMC|SCH.
   7. Works with the Senior Leaders and the MEC to annually evaluate SHMC|SCH performance in relation to its mission, vision, and goals.
   8. Ensures the ongoing program for quality improvement and patient safety is defined, implemented, and maintained.

9. Establishes clear expectations for safety.
10. Provides the organized medical staff, represented by the MEC with the opportunity to participate in governance and the opportunity to be represented at BOT meetings.
11. Assumes full legal authority and responsibility for operations of SHMC|SCH and medical staff.
13. Establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.
14. Provides for the resources needed to maintain safe, quality care, treatment, and services.
15. Provides a system for resolving conflict among individuals working within the organization.
16. Receives and reviews reports summarizing the data, analysis, findings, and recommendations related to facility-wide organizational Performance Improvement (PI) Projects and Clinical Safety Improvement Program (CSIP).
17. Reviews the annual PI and CSIP Appraisal.
18. Approves the annual PI and Patient Safety Plan (PSP).

Medical Staff and MEC

A. SHMC|SCH has an organized medical staff that is accountable to the BOT.
B. Medical staff is represented by the MEC.
C. Role and responsibilities of the MEC in ensuring PI and patient safety activities include:
   1. Organized and accountable to the BOT for the quality and safety of the medical care provided to the patients.
   2. Operates under Medical Staff Bylaws and Rules and Regulations approved by the BOT.
   3. Oversees the quality of care, treatment and services provided by those individuals with clinical privileges.
   4. Approves the PI and (PSP) including the design of the PI and patient safety activities.
   5. Requires the Medical Staff departments to continuously assess and improve the quality of care and services provided, continue to evaluate the competence of individuals with or without clinical privileges (i.e., allied health providers) and provide information for the re-credentialing process.
   6. Requires the Medical Staff to maintain quality control programs, as appropriate.
   7. Systematically evaluates SHMC|SCH performance activities of departments, committees and functional teams by the review of minutes, reports, and inquiries directed to/from the departments or committees by the MEC.

Senior Leaders

A. SHMC|SCH identifies the responsibilities of its Senior Leaders.
B. Role and responsibilities of Senior Leaders in ensuring PI and patient safety activities include:
   1. CEO manages SHMC|SCH and leads the Senior Leadership group.
   2. Senior Leaders work with the organized medical staff and the governing body to define their shared and unique responsibilities and accountabilities.
   3. CEO, MEC, the Chief Nurse Officer (CNO), and the Vice-President (VP) of Quality Management (QM) work together to make certain that the facility-wide PI and PSP along with training programs address identified problems.
   4. Discuss issues that affect SHMC|SCH and the population(s) it serves, including the following:

a. PI and Clinical Safety Improvement activities.
b. Reported safety and quality issues.
c. Proposed solutions and their impact on SHMC|SCH resources.
d. Reports on key quality measures and safety indicators.
e. Safety and quality issues specific to the population served.
f. Input from the population(s) served.

5. Ensures the scope of the safety program includes the full range of safety issues, from potential to no-harm errors (e.g., lessons learned, close calls, near misses).
6. Provides and encourages the use of systems for blame-free internal reporting of a system or process failure.
7. Defines sentinel events and ensures the performance of credible serious event analysis in response to sentinel events.
   See: HCA.PSO.006 Serious Safety Event Notification, Identification, and Management
8. Selects one (1) high-risk process and conducts a proactive risk assessment at least every 18 months.

C. Creates and maintains a culture of safety and quality throughout the organization.
D. Organization regularly evaluates the internal culture of safety and quality
E. The evaluation allows Leaders to:
   1. Prioritize and implement changes identified by the survey.
   2. Provide opportunities for all individuals who work in SHMC|SCH to participate in safety and quality initiatives.
   3. Develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
   4. Create and implement a process for managing behaviors that undermine a culture of safety.
   5. Provide education that focuses on safety and quality for all individuals.

Patient Safety Officer (Nevada Revised Statutes [NRS] 439.870)

A. Organization has designated the Risk Manager as the Patient Safety Officer for the organization.
B. Patient Safety Officer:
   1. Serves on the Quality Care and Patient Safety Committees (PSC).
   2. Promotes a culture of safety and the elimination of avoidable harm.
   3. Supervises the reporting of all sentinel events.
      See: HCA.PSO.006 Serious Safety Event Notification, Identification, and Management
   4. Reports all sentinel events and the actions taken to ensure the event does not reoccur.
   5. Acts as deemed to be necessary to ensure the safety of patients as a result of an investigation of the event.

Department Directors

A. Department Directors of each ancillary/nursing service area is responsible for all PI and Patient Safety activities as they relate to their specific areas.
B. Directors are responsible for the continuous assessment and improvement of their department's performance, promotion of patient safety, and the maintenance of appropriate quality control programs.
C. Directors are responsible for evaluating the effectiveness of care delivered in their departments and the clinical performance of their staff.
D. Although it is recognized that process issues or deficiencies account for most variances in

performance, when PI activities lead to a determination that an individual is unable or unwilling to improve, modification of the individual's job assignment will occur or other appropriate action will be taken.

E. Significant findings of PI or Patient Safety activities will be reported through the appropriate channels.

PSC and Quality Care Committee (QCC)

A. PSC and the QCC are responsible to the BOT, MEC, and Senior Leaders for the overall operation of the PI and PSP.

B. These interdisciplinary committees include but are not limited to, representatives from the BOT, Senior Leaders, Medical Staff, QM, Pharmacy, Nursing Leadership, Infection Control, Ancillary Services Directors, Patient Safety Officer, and Facility Safety Officer.

C. On an annual basis the PSC and QCC performs an annual appraisal of the PI and Patient Safety activities.

D. At this meeting, current PI priorities, patient safety priorities, and associated activities are reviewed and evaluated.

E. General functions of the PSC and QCC include:
   1. Collects data to monitor its performance.
   2. BOT, MEC, and Senior Leaders set priorities for and determine the frequency of data collection.
   3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.

F. Collects data and reports to the MEC, and BOT.

G. Types of data collected includes but is not limited to:
   1. PI priorities identified by leaders.
   2. Operative or other procedures that place patients at risk of disability or death.
   3. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
   4. Adverse events related to using moderate or deep sedation or anesthesia.
   5. Use of blood and blood components.
   6. All reported and confirmed transfusion reactions.
   7. Number and location of cardiac arrests
   8. Resuscitation performance to include outcomes of resuscitation and any transfers to higher level of care post resuscitation
   9. Behavior management and treatment.
   10. Significant medication errors.
   11. Significant adverse drug reactions.
   12. Patient thermal injuries that occur during magnetic resonance imaging exams.
   13. Pain assessment and reassessment including interventions and effectiveness.
   14. Data requirements as outlined in The Joint Commission (TJC) PI Standards.

H. SHMC|SCH considers collecting data on the following:
   1. Staff opinions and needs
   2. Staff perceptions of risk to individuals
   3. Staff suggestions for improving patient safety
   4. Staff willingness to report adverse events

I. Patient perception of the safety and quality of care, treatment, and services.

J. Evaluates the effectiveness of all fall reduction activities including assessment, interventions, and education.

K. Effectiveness of its response to change or deterioration in a patient's condition.

1. Note: Measures may include length of stay, response time for responding to changes in vital signs, cardiopulmonary arrest, respiratory arrest, and mortality rates before and after implementation of an early intervention plan.

L. PSC shall have oversight of the SHMC|SCH Patient Safety Program, which includes but is not limited to:
1. Review the annual PSP and Strategies.
2. Collect data to monitor PSP performance.
   a. Measure, analyze, and track safety indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH services, and operations.
3. Types of data collected includes but is not limited to:
   a. Patient safety related to the use of at least two (2) patient identifiers when giving medication, blood products, or before a procedure.
   b. Infection Prevention as it relates to the use of proven guidelines such as hand cleaning to prevent infections of Catheter Associated Urinary Tract Infections (CAUTI), Central Line Associated Bloodstream Infections (CLABSI), Surgical Site Infections (SSI), and other SHMC|SCH acquired infections.
   c. Safe surgical practices by prevention of mistakes made in surgery such as wrong patient, wrong site, and wrong procedure with use of standardized *Time Out* practices before any treatments or procedures.
   d. Use of medication safety as it relates to the prevention of significant medication errors.
   e. Evaluate the effectiveness of all fall reduction activities including assessment, interventions, and education.
   f. Evaluate the effectiveness of the reduction of all SHMC|SCH acquired conditions (HAC) to improve health outcomes and reduce length of stay.
4. Receive reports from the patient safety officer pursuant to NRS. 439.870
5. Review and evaluate the quality of measures carried out by the medical facility to reduce the number of severities of sentinel events and infections that occur at the medical facility.
6. Ensures all Patient Safety policies/checklists follow protocols to improve the health outcomes of patients at the medical facility and will include, without limitation:
   a. Checklists related to specific types of treatment must include, without limitation, a requirement to document that the treatment provided was properly ordered by the provider of health care.
   b. Checklists for ensuring that employees of the medical facility and contractors with the medical facility who are not providers of health care follow protocols to ensure that the room and environment of the patient is sanitary.
7. Checklists to be used when discharging a patient from the facility which includes, without limitation, verifying that the patient received:
   a. Proper instructions concerning prescription medications;
   b. Instructions concerning aftercare; and
   c. Any other instructions concerning his or her care upon discharge.

M. Ensure that a policy for appropriately identifying a patient before providing treatment the policy will require the patient to be identified with at least two (2) personal identifiers

before each interaction with a provider of healthcare.

1. Personal identifiers may include without limitation, the name, and date of birth of the patient.

N. Ensure that a policy regarding the nationally recognized standard precautionary protocols to be observed by providers of health care at the facility including, without limitation, protocols relating to hand hygiene.

O. Monitor and document the effectiveness of the patient identification (ID) policy.

P. At least annually, review and revise the patient safety checklists and patient safety policies adopted and consider any additional patient safety checklists and patient safety policies that may be appropriate for adoption for use at the medical facility as necessary to ensure that the checklist or policy, as applicable, reflects the most current standards in patient safety protocols.

Q. Evaluate actions of the patient safety officer in connection with all reports of sentinel events alleged to have occurred at the medical facility.

R. Ensure that on or before July 1 of each year, the Patient Safety officer will submit a report to the Director of Legislation Counsel Bureau for transmittal to the Legislative Committee on Health Care.

1. Report must include information regarding the development, revision, and usage of the patient safety checklists and patient safety policies and a summary of the annual review conducted pursuant to paragraph (II).

S. Evaluate the recommendations provided to the executive or governing body of the medical facility regarding:

1. Number of sentinel events that occurred at the medical facility during the preceding calendar quarter;
2. Number and severity of infections that occurred at the medical facility during the preceding calendar quarter; and
3. Any recommendations to reduce the number and severity of sentinel events and infections that occur at the medical facility.

T. Evaluate the role of the Patient Safety Officer in the adoption of patient safety checklists and patient safety policies as required by NRS 439.877, including the review of the checklist and policies annually and revision of the checklists and policies as the patient safety committee determines necessary.

QCC Compiles and Analyzes Data

A. Program includes, but is not limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes and patient safety, including:

1. Sets expectations for using data and information to improve the safety and quality of care, treatment, and services.
2. Responsible for the implementation of successful corrective action plans in affected problem areas.
3. Measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, SHMC|SCH service and operations.
4. Develops, implements, and maintains an effective, ongoing, facility-wide, data-driven quality assessment and performance improvement program.
5. Compiles data in usable formats.
6. Uses statistical tools and techniques to analyze and display data.
7. Analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

8. Compares data with external sources, when available.
9. Analyzes its Organ Procurement conversion rate data as provided by the Organ Procurement Organization (OPO).
10. Uses the results of data analysis to identify improvement opportunities.

B. In regard to staffing:
1. When SHMC|SCH identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes.
2. When analysis reveals a problem with the adequacy of staffing, the Senior Leaders responsible for the facility-wide patient safety program are informed, of the results of this analysis and actions are taken to resolve the identified problem(s).
3. At least once a year, the leaders responsible for the facility-wide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.

C. QCC considers participation in Quality Improvement Organization (QIO) cooperative projects.

D. Trauma Program manages an intensive Performance Improvement and Patient Safety (PIPS) program regarding its practice.
1. Minutes of the program's reviews are submitted to the MEC and the BOT through the Department of Surgery.
2. In addition, members of the SHMC|SCH Quality Assurance Program attend the Trauma Peer Review Committee meetings.

PSC and QCC ensures the organization improve performance on an ongoing basis, including

A. Prioritizes the identified improvement.
B. Acts on improvement priorities.
C. Evaluates actions to confirm that they resulted in improvements.
D. Acts when it does not achieve or sustain planned improvements.
E. PSC and QCC drafts priorities for the organization's PI activities, which are recommended for adoption through the MEC and the BOT.
F. QCC considers factors such as:
1. Focus on high-risk, high-volume, or problem-prone areas,
2. Consider the incidence, prevalence, and severity of problems in those areas.
3. Affect health outcomes, patient safety, and quality of care.

Patient Safety Organization (PSO)

A. SHMC|SCH is committed to an organizational environment aimed at improving patient safety and the quality of healthcare provided.

B. To further this objective, SHMC|SCH contracted with Hospital Corporation of America (HCA) PSO, LLC (HCA|PSO|LLC), a federally certified PSO, to receive assistance in conducting a wide variety of patient safety activities intended to reduce medical errors in a legally protected environment.

C. Generally speaking, patient safety work product (PSWP) is not subject to subpoena or discovery in State or Federal court, in administrative proceedings, or pursuant to the Freedom of Information Act (FOIA), and cannot be disclosed except as permitted under the Patient Safety and Quality Improvement Act (PSQIA) and its associated regulations. *(See 42 Code of Federal Regulations [CFR] § 3.204, Privilege of patient safety work product; and 42 CFR § 3.206, Confidentiality of patient safety work product.)*

D. SHMC|SCH will be receiving and exchanging patient safety information with the PSO,

including event or incident reports and investigations, analytic tools such as serious event analysis (SEA), root cause analyses (RCA), patient safety communications, quality reviews, and other documents aimed at improving patient safety.

E. Documents will be submitted in a standardized format to allow for comparison with like Providers.

F. As part of this effort, SHMC|SCH will operate a Patient Safety Evaluation System (PSES) designed to encourage internal reporting of adverse events, near misses, and unsafe conditions for purposes of reporting to HCA PSO, LLC.

G. PSES will be the vehicle for collecting, managing, and analyzing information for patient safety purposes.

H. Designated SHMC|SCH personnel will collect patient safety information and report it to HCA PSO, LLC on an ongoing basis for analysis and feedback.

Methodology

A. FOCUS-Plan-Do-Study -Act (PDSA) is the methodology used for PI projects.

B. Using this methodology data is systematically aggregated and analyzed on an ongoing basis.

C. Statistical tools used are displayed in diagram II below.

FOCUS

Find an Improvement Opportunity

A. Review results of measurement activities and input from staff, patients, medical staff, and other customers.

B. How are we doing compared to ourselves/external benchmarks over time?

C. What situation yields an opportunity for improvement?

D. What processes should be addressed first?

Organize a Team that Knows the Process

A. Is there representation from those who work in the process

B. Educate the team on the PI process.

C. Establish the team purpose, process and measures of team progress.

Clarify Current Knowledge of the Process

A. Is the process well defined, including the customers, their needs and expectations?

B. Do our perceptions of the process relate to the actual process?

C. "Flow chart" the process to determine the actual flow or sequence of events that the process follows.

D. What is the baseline data on the current process?

E. Review recent scientific literature for up to date information regarding the process.

Uncover Root Cause of the Process Variation

A. "Fishbone" a cause and effect diagram to allow the team to identify, explore and graphically display, in increasing detail, all of the possible causes related to a problem.

B. Are the causes the root cause or just symptoms of the problem?

C. What are the causes that have the greatest impact in priority order?

Start the Improvement Cycle

A. What new knowledge have you acquired about the process?

B. What changes need to be made to improve the process?

PDSA

Plan Improvement

A. Who, what, when and how are we going to change the process

B. Data collection-who, what, where, when and how are we going to track the process change?

C. Identify those forces that assist or prevent change-force field analysis.

Do Improvement

A. Implement change

Study Results

A. Compare the data analysis
B. What was learned?
C. What does the team want to continue to do?
D. What would the team do differently?

Act (To sustain improvement and continue to improve or abandon change and start cycle again)

A. What part of the process needs to be standardized?
B. What policies/procedures need to be revised?
C. Who needs to be trained?
D. Determine method for ongoing measurement.

SEA

A. Is the primary PI methodology used for analysis of significant unanticipated outcomes and/or Sentinel Events.
   See: HCA.PSO.006 Serious Safety Event Notification, Identification, and Management

EXTERNAL DATA SOURCES

A. Data is also collected as indicated for participation in the following external databases or for participation with the following organizations:

Livanta

A. Centers for Medicare & Medicaid (CMS) contracted Quality Improvement Organization (QIO) has developed Healthcare QI Initiatives that examine patterns of practice.
B. Areas for study are suggested by practitioners in the community, university, hospital settings, nationally recognized patient safety and quality improvement organizations and CMS.
C. Studies enable hospitals and medical staff to compare their performance with what may be optimal levels of practice.

Comprehensive Health Outcomes Information System (CHOIS) Reports

A. CHOIS is designed to identify opportunities for improvement, identify best practices, and manage resources appropriately, effectively, and efficiently.
B. Clinical Outcome Summary Reports are distributed on a quarterly basis.
C. Data captured in this report reflects numerous clinical indicators.
D. These indicators were developed through medical staff focus groups.
E. Data is risk and severity adjusted using CMS's Refined diagnosis-related group (DRG)s and economic cycle research institute (ECRI), a risk index used to adjust complication rates, Risk Adjusted Mortality Index (RAMI) and the Risk Adjustment Specialty Algorithm (RASPEC) as appropriate.
F. Each hospital is provided with actual and risk adjusted mortality and complication rates.
G. Rates are compared to the company overall and national statistics.
H. Patient and Provider level details are provided to facilitate a detailed analysis of the cases reflected in the data.

TJC Measurement System (ORYX)

A. This is TJC initiative to integrate performance measures into the accreditation process.
B. It involves a collection of service, process and outcome indicators related to specific patient populations.

C. Data for this initiative is collected through the Comprehensive Outcomes Measurement Evaluation and Transmission (COMET) database.
D. Information is collected at the facility level and transmitted directly to TJC from HCA, as the chosen vendor for this project.
E. Data abstracted through the COMET system are also submitted to CMS for public reporting through the Hospital Compare website.
F. Hospital Compare website was created through the efforts of the CMS, an agency of the United States Department of Health and Human Services (DHHS), along with the Hospital Quality Alliance (HQA).
G. HQA is a public-private collaboration established to promote reporting on hospital quality of care.
H. HQA consists of organizations that represent consumers, hospitals, Providers and nurses, employers, accrediting organizations, and Federal agencies.
I. Information on this website can be used by any adult needing hospital care.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

A. HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care.

Vermont Oxford Neonatal Database

A. Oxford Neonatal Database is a comprehensive database of 600 plus neonatal intensive care (NICU) centers which compares morbidity, mortality, and length of stay data on the very low birth weight infants (501 to 1500 grams).
B. As part of this network, the neonatal intensive care quality benchmarking project applies a team approach to health care benchmarking with the goal of improving the effectiveness and efficiency of neonatal intensive care.

Cancer Registry

A. Cancer Registry submits cancer data on select neoplasms to the State of Nevada Administrative Code (NAC) 457.010 to 457.040.
B. Data is generally requested annually.
C. Cancer Registry department manages the cancer program and the American College of Surgeon's Commission on Cancer accreditation.
D. Accreditation program maintains a robust set of metrics pertaining to 37 standards for the diagnosis, treatment and follow-up of cancers.
E. As part of the accreditation, the Cancer Registry collects data adhering to the Commission of Cancer (COC)s strict criteria and submits data to the National Cancer Data Base (NCDB).
F. Data is submitted to the NCDB at schedule intervals.
G. NCDB data is used nationally to identify areas for quality improvement as well as direct other important activities.
H. NCDB database is available at a facility level providing tools such as hospital comparison benchmarks, survival reports, Cancer Program Practice Profile Reports, Rapid Quality Reporting System, and the Cancer QI Program data reports.
I. COC used NCDB data to direct participating organizations to perform special studies throughout the year.

Trauma Registry

A. Trauma Registry at Sunrise is a State of Nevada database.
B. Nevada Trauma Registry (NTR) data is collected from all licensed acute care hospitals and trauma centers in Nevada.
C. NTR can provide information on the incidence, and prevalence, morbidity, and mortality of injuries in Nevada.

D. Data can be broken down to a specific county, specific hospital, specific race, or specific age group, for example.
E. Data are available for state, private or federal entities, grant applicants to measure the impact of trauma on Nevada and initiate health education programs that address traumatic injuries.

Society of Thoracic Surgeons (STS)

A. Offers outcome programs in the areas of Adult Cardiac, General Thoracic, and Congenital surgery.
B. By committing to collecting outcomes data to the STS National Database, surgeons are committing to improving the quality of care that their cardiothoracic surgery patients receive.
C. SHMC|SCH participates in the STS database, using the national comparisons and benchmarking as an integral part of the PI program for Cardiovascular Services.

American College of Cardiology (ACC)/National Cardiovascular Data Registry (NCDR)

A. NCDR is the recognized resource for measuring and quantifying outcomes and identifying gaps in the delivery of quality cardiovascular patient care in the United States.
B. Its mission is to improve the quality of cardiovascular patient care by providing information, knowledge and tools, implementing quality initiatives, and supporting research that improves patient care and outcomes.

Perinatal Services Quality Initiative

A. Perinatal Services Program is an HCA Corporate Initiative to improve perinatal services and reduce the risk associated with the delivery of maternal and infant care.

Emergency Management Risk Initiative

A. Emergency Management Risk Initiative audit is one of the fundamental elements in the creation of the risk managed Emergency Department (ED).
B. This is the most powerful audit tool available in emergency medicine.
C. It is clinically oriented and provides an unprecedented look at the individual practitioner, the emergency practitioners as a group, and ED systems.
D. Audit is accomplished through the Sullivan Group via an agreement with HCA hospitals.
E. SHMC|SCH participates on a semi-annual basis.

Get with the Guidelines GWTG™

A. Stroke Management Tool (Outcome Sciences) is a comprehensive quality management measurement tool that captures critical information regarding the care and treatment of patients with an acute stroke, with an emphasis of secondary prevention.
B. Database is used to assess and measure internal compliance of treatment standards, and the ability to provide concurrent comparison to external entities and provides national benchmarks.

Leapfrog

A. Leapfrog Hospital Survey is the public reporting initiative launched in 2001 by the Leapfrog Group.
B. Leapfrog Group is an independent, not-for-profit organization aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded.
C. Leapfrog strives to make giant "leaps" forward in safety, quality, and affordability of healthcare by promoting transparency.
D. Leapfrog Group Survey assesses hospital performance based on 28 different metrics.
E. Leapfrog algorithm computes a letter grade reflecting the hospital's performance based on these metrics.

F. Currently nine (9) different Safe Practices are assessed.
G. These safe practices, created by the National Quality Forum (NQF), have been found to reduce preventable medical mistakes.
H. Leapfrog works to continually assess safe practices and new practices are added or removed accordingly.
I. Leapfrog algorithm also analyzes 18 data points from the publically reported data as required by the CMS.

National Healthcare Safety Network (NHSN) Database

A. NHSN is a secure, internet-based surveillance system that integrates former Center for Disease Control (CDC) surveillance systems, including the National Nosocomial Infections Surveillance System (NNIS), National Surveillance System for Healthcare Workers (NaSH), and the Dialysis Surveillance Network (DSN).
B. NHSN enables healthcare facilities to collect and use data about HAC infections, adherence to clinical practices known to prevent HAC infections, the incidence or prevalence of multidrug-resistant organisms within their organizations, trends and coverage of healthcare personnel safety and vaccination, and adverse events related to the transfusion of blood and blood products.

American Burn Association (ABA) registry

A. ABA is designed to improve the quality and cost of burn care by collecting and exchanging information on burn injuries and outcomes.

American College of Surgeons (ACS) National Surgical Quality Improvement Program Pediatrics (NSQIP)

A. ACS NSQIP Pediatric is a surgical quality improvement program specific to pediatric surgery. It is the first multispecialty national database to measure surgical outcomes for pediatrics.
B. ACS NSQIP Pediatric is the nation's first and only risk-adjusted, clinical, outcomes-based program to measure and improve pediatric surgical care.
C. ACS NSQIP Pediatric data powers a preoperative risk calculator tool that allows clinicians to input an individual patient's risk factors—such as age, sex, and American Society of Anesthesiologists (ASA) class—into a statistical model that calculates the likelihood of various outcomes.

Extracorporeal Life Support Organization (ESLO) Registry

A. ELSO registry provides member institutions with data to improve the quality of care to patients who received Extracorporeal Membrane Oxygenation (ECMO) care.
B. Data submitted by Centers to the Registry includes personally identifiable information: gender, race, nature, and severity of illness, technical details of extracorporeal support used, dates of service, complications, and outcomes.

ACS and American Society for Metabolic and Bariatric Surgery (ASMBS) Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)

A. Sets national standards for bariatric surgery centers with a goal of advancing safety and quality.
B. MBSAQIP recognizes facilities that implement defined standards of care, document their outcomes, and participate in regular reviews to evaluate their bariatric surgical programs.

REFERENCES

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program
NAC 449.3152 Quality Improvement Program
NRS 439.865 Patient Safety Plan
NRS 439.870 Patient Safety Officer

NRS 439.875 Patient Safety Committee
Joint Commission Requirements for Performance - Performance Improvement Chapter

PERFORMANCE IMPROVEMENT REPORTING STRUCTURE

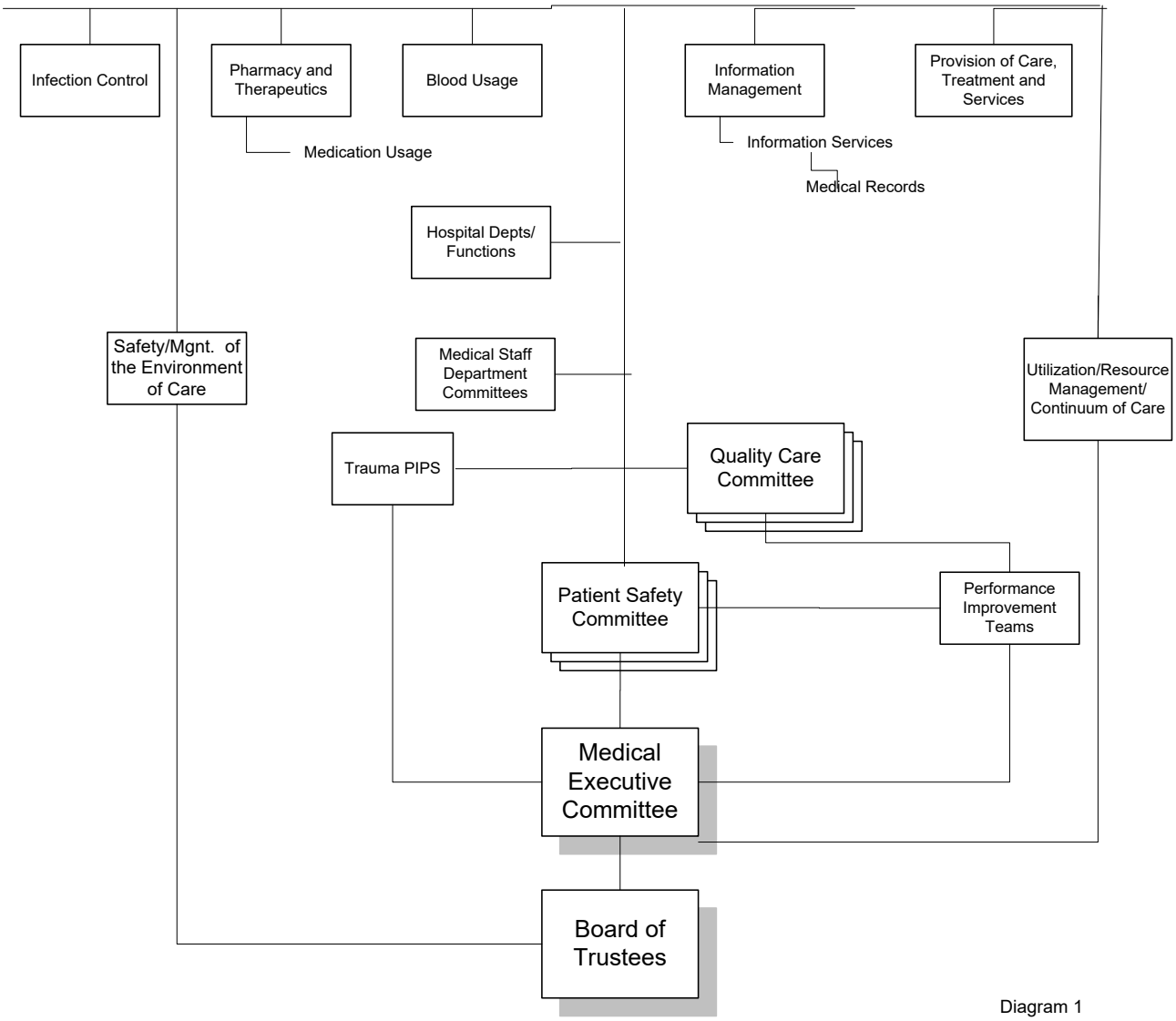


Diagram 1

FOCUS - PDSA

Find Process Improvement Opportunity → Brainstorming, Control Charts, Comparison charts

Organize A Team that Knows the Process → Brainstorming

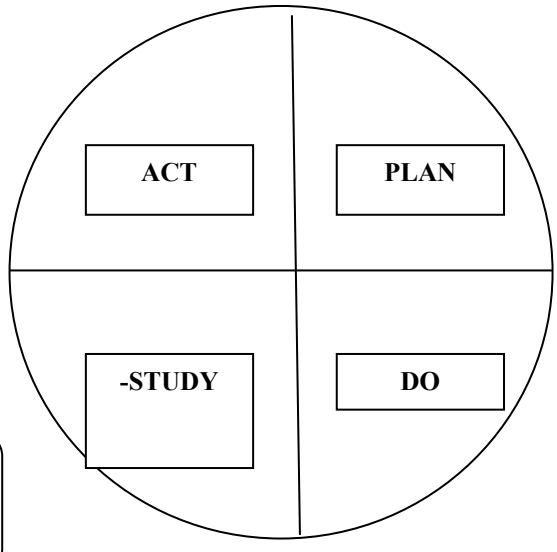
Clarify Current Knowledge of the Process → Flow Chart, Brainstorming, Cause and Effect Diagram, Literature Search

Uncover Root Causes of Process Variations → Cause and Effect Diagram, Pareto Chart, Brainstorming, Failure Mode & Barrier Analysis

1. Start

PDSA Improvement

Brainstorming
Cause & Effect Diagram



Brainstorming
Checklist
Cause and Effect Diagram
Force Field Analysis

Pareto Charts
Run Charts
Control Charts

Checklist
Implementation
Guidelines