Quality & Patient Safety Program

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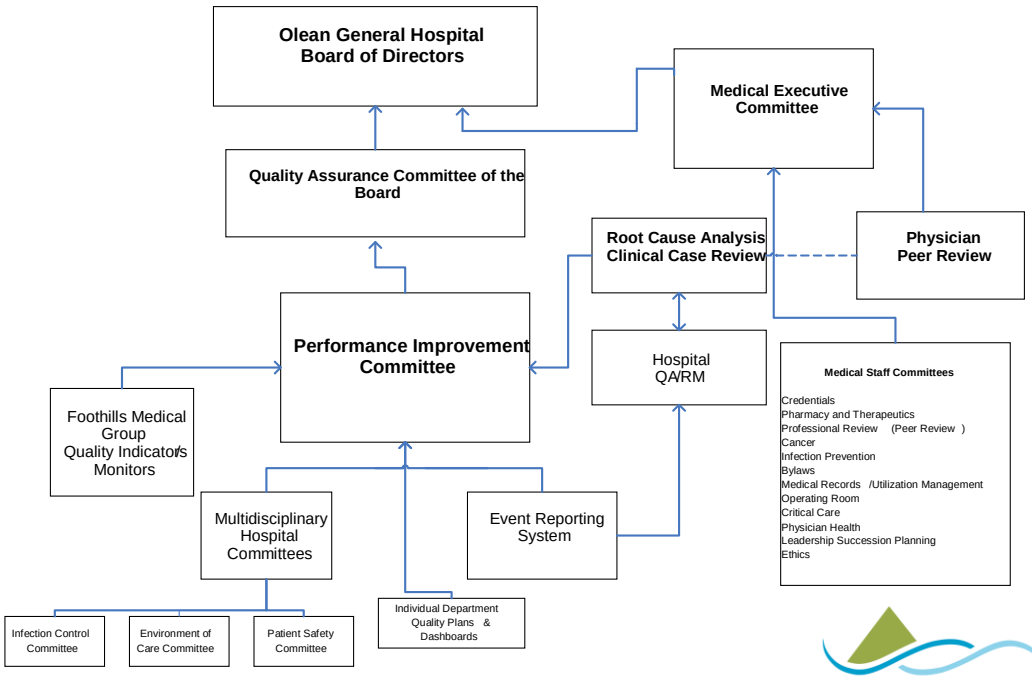
Olean General Hospital

Introduction

Olean General Hospital (OGH) is committed to providing quality and safe care to each and every patient it serves. The hospital's quality mission is to provide the right care at the right time in the right place and by the right people. The context for the hospital's quality mission and focus will follow Kaleida Health's Quality and Patient Safety Plan which provides a framework upon which an integrated and comprehensive program monitors, assesses and improves the quality of safety of patient care delivered.
To ensure quality and safety, the organization seeks to develop a culture of improvement that includes an organization wide commitment to continuous learning, rigorously seeking out and applying best practices and providing open communication and transparency.

Governance, Reporting Plan Structure – Roles and Responsibilities

Kaleida Health – Quality Improvement & Patient Safety Committee (QAIPSC)



Board of Directors

The OGH Board of Directors has ultimate responsibility for the safety and quality of care provided in the hospital. Board members receive regular education regarding patient quality and safety topics.

Quality Assurance (QA) Committee of the Board

The QA Committee of the Board assists the Board of Directors in overseeing and ensuring the quality of clinical care, patient safety, and patient satisfaction throughout the organization. The responsibilities of the QA Committee include:

- Reviewing and recommending a Quality Plan with annual improvement targets
- Reviewing and recommending quality/safety related policies and procedures
- Approving and monitoring a dashboard of key performance indicators compared to hospital goals and industry benchmarks
- Reviewing sentinel events and root cause analyses and, as appropriate, recommend corrective action
- Monitoring summary reports of hospital and medical staff quality and patient safety activities
- Reviewing management's corrective plans with regard to negative variances and serious errors
- Overseeing compliance with quality and safety regulatory and accreditation standards
- Staying abreast of new developments relative to quality and performance improvement initiatives
- Making recommendations to the Board of Directors on all matters related to the quality of care, patient safety, and patient satisfaction

The committee includes members of the Board of Directors, senior management, the Medical Staff and the community.

Management

The support and active involvement of hospital management is basic to the success of the hospital's quality improvement efforts and includes:

- The personal engagement of senior managers relative to quality and safety as characterized by their advocacy for quality improvement efforts within the hospital, their active participation in quality improvement teams, and the dissemination and review of quality performance data.
- The promotion of the hospital's culture of safety and quality improvement. Relevant work includes the establishment of norms regarding collaboration across departments and disciplines with respect to quality improvement activities and the establishment of quality goals and the regular communication to all staff with respect to performance results and the identification of opportunities for improvement.

Performance Improvement Committee (PIC)

The Performance Improvement Committee coordinates the hospitals quality and safety program and serves as a primary "funnel" of hospital specific quality and safety information to the Board of Directors. PIC participation includes the hospital CEO, COO, CMO, CNO, various department managers and numerous safety champions. PIC responsibilities include:

- Coordinating the hospital's Quality and Safety program and developing the annual quality and safety work plan for the organization.
- Providing a framework for a planned, continuous, systematic and organization wide approach to designing, measuring, assessing and improving hospital quality and safety performance.
- Initiating and monitoring staff education and training related to quality and safety improvement.
- Ensuring adequate resources exist to achieve quality, safety, and performance improvement priorities.
- Identifying organizational trends and opportunities for quality and safety improvement.
- Reporting to the Quality Assurance Committee of the Board at least quarterly on various quality and safety improvement initiatives and performance results.
- Reviewing sentinel events, root cause analyses, and clinical case reviews.
- Reviewing dashboards of key quality and safety indicators from all hospital ancillary and support departments.
- Receiving minutes and reports from Environment of Care, Infection Prevention and Control and Patient Safety Committees.

Departmental Responsibilities

Each department is responsible for assessing and improving quality within their respective area of responsibility. Towards this end, each department develops and utilizes a departmental dashboard report that monitors relevant quality and safety indicators. Additionally, each department develops and annual quality improvement plan and reports to PIC annually relative to plan progress.

Medical Staff Responsibilities

The basic responsibilities of all members of the OGH Medical Staff are:

- The provision of appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals, and
- Their participation, as assigned or requested, in quality /performance improvement/peer review activities.

The Medical Staff performs ongoing professional practice evaluations (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the medical staff. Practice evaluations are inclusive of the following:

- Drug use review
- Infection control studies
- Blood use review
- Mortality review
- Medical record timeliness
- Outcome studies such as repeat surgeries/procedures/tests.
- Internal and outside peer review activities is

Medical Staff Committees

Physicians serve on the following medical staff committees that impact quality and safety:

- Medical Executive Committee
- Credentials
- Pharmacy and Therapeutics
- Professional Review (Peer Review)
- Cancer
- Infection Prevention
- Bylaws
- Medical Records/Utilization Management
- Operating Room
- Critical Care
- Physician Health
- Leadership and Succession Planning
- Ethics

Multidisciplinary Committee Responsibilities

There are multiple multidisciplinary committees at OGH that focus on specific aspects of quality and safety. They include:

Patient Safety Committee

The Patient Safety Committee is a standing interdisciplinary group lead by the Patient Safety Officer. Members include clinical managers and front line staff to oversee the management of the organization's Patient Safety program using the Joint Commission Patient Safety standards as a guide. The committee is responsible for the:

- Review of aggregated occurrence data from Risk Management. This data will be trended and patient safety issues prioritized. The prioritized issues will be sent to the appropriate committee, department manager or team for investigation.
- Review of reports from committees and teams identified as the components of the Patient Safety Plan to look for safety issues that need to be addressed.
- Provision of education for all staff to develop knowledge and skills for reporting recording real or potential safety concerns.

- Reporting at least semi-annually to the governing body on the occurrence of medical/health care errors and actions taken to improve patient safety, both in response to actual occurrences and proactively.
- Review and monitoring of improvement strategies from sentinel event root cause analysis and clinical case reviews.
- Evaluation of the National Patient Safety Goals as defined by the Joint Commission and oversight of the implementation of processes as to achieve these goals.
- Review all sentinel alerts issued by the Joint Commission and assign an ad hoc team to evaluate current practices.

Environment of Care Committee

The Environment of Care Committee and the Committee Chairman is responsible for developing, implementing, and monitoring the hospital's Safety Management Plan.

The committee:

- Establishes a mechanism to review and approve safety policies and procedures.
- Maintains individualized safety policies and procedures.
- Maintains a hazard surveillance program for all hospital properties. The frequency of such surveillance rounds shall be annually for non-patient care areas and twice a year for patient care areas. Surveillance will also include all clinics, off-site buildings, and properties.
- Establishes policies and procedures for the reporting and investigation of incidents.
- Reviews incidents reports involving injury to patients, employees, physicians, and visitors. Recommendations are then made based upon findings or the identification of trends.
- Participates in the orientation and continuing education program of hospital staff. Provides information to the Clinical Education Department regarding identified training needs and also provides information for inclusion in the Annual Mandatory Training program. This information is reviewed for accuracy by the Safety Committee Chairman annually.
- Reviews the results of the Product Recall Program, Equipment Management Program, Utility Management Program, Life Safety Management Program, Security Program, and Hazardous Materials Program on a quarterly standing-agenda item basis. Reports from the Infection Control Committee, Laser Safety Committee, and Radiation Safety Committee are reviewed quarterly on a standing-agenda item basis.
- Reviews the critiques of disaster drills and summary reports of fire drills. Recommendations will be made and policy changes will be made as deficiencies are identified.

- Participates in the hospital's Performance Improvement Program. Goals and performance measures will be established annually to assist in evaluating the Safety Management Plan. These measures will assess staff safety management knowledge and skill, the level of staff participation in safety management activities, hazard surveillance activities, and deficiencies.
- Provides information to both Administration and the Board of Directors via quarterly reports to the PIC.
- Performs an annual assessment of the Safety Management Program that includes an evaluation of the performance improvement activities related to Safety, Security, Hazardous Materials & Wastes, Emergency Preparedness, Life Safety, Medical Equipment, and Utility Systems. This annual evaluation will be presented to the Safety Committee, Administration, and the Board of Directors.

Infection Control (IC) Committee

The Infection Control Committee is responsible for facilitating and coordinating hospital infection prevention & control efforts through a variety of activities. These activities include:

- Formulation of objectives and policies consistent with the hospital's infection control focus as identified in an annual risk assessment.
- Setting priorities to assure appropriate interventions and services as determined by patient needs.
- Determination of resources necessary for infection prevention and control and allocation of resources when necessary.
- Promoting and overseeing the educational activities necessary to promote collaborative practice and empower the staff to effectively assist in the infection prevention activities.
- Overseeing the development and implementation of the Infection Prevention Program.
- Receiving and reviewing regular reports that reflect the status and success of infection prevention and control efforts.
- Approving changes in systems and activities identified as necessary for the improvement of patient care and reduction in incidence of infection.
- Taking necessary actions to ensure that opportunities to improve patient care and reduce infections are implemented.

A3 Lean

A primary tool utilized for performance improvement is the A3 Lean methodology which has been adopted by OGH as the designated approach to administration problem solving. A3 Lean utilizes the following basic methodology:

- Formulation of a statement of the problem being studied as viewed from the perspective of the patient
- Compilation of background information
- Definition of the current state and identification of associated problems
- Problem analysis
- Future state definition
- Countermeasures needed to achieve the future state
- Detailed implementation plan
- Cost / Benefit depiction
- Trial
- Follow Up Plan

A3 Lean improvement processes emphasize the inclusion of hospital employees as they have significant knowledge of problems and insight into potential solutions.

2018 Quality Focus Areas

The key strategic goal of the 2018 Quality Plan for OGH is to improve the respective hospitals' CMS overall star rating to 4 stars which would place the hospitals' performance in the top 20% nationally. This will be achieved by utilizing target benchmarks for each CMS measure that are consistent with 4 star performances. OGH priority focus areas are identified below. The issues, background, current conditions are in the work plan. This is the 2nd year the focus areas continue to be the priority performance indicators in an attempt to hardwire processes and systems.

A. Safety of Care

Goals:

1. Maintain the number of C-*difficile* Hospital-acquired cases to less than or equal to 1.0 S.I.R (Standardized Infection Ratio) = Observed / Expected
2. Maintain the number of catheter-associated urinary tract infections (CAUTI) ICCU & Med Surg to less than or equal to 1.0 S.I.R.

Accountability:

C.diff – Antibiotic Stewardship Committee / Infection Control Committee

CAUTI – Infection Prevention & Control Nurse Manager and Nursing Med Surg and ICCU Nurse Managers, & providers.

B. Readmissions:

Goal:

1. Reduce 30 day readmissions rates (unplanned) to the following:

a. Chronic Obstructive Pulmonary Disease (COPD) < 20%
b. Acute Myocardial Infarction – Heart Attack (AMI) < 16.8%
c. Heart Failure (HF) < 21.9%
d. Pneumonia < 17.1%
e. Stroke < 12.5%
f. Hip/Knee surgery < 4.6%
g. Readmission rate of unplanned admissions hospital-wide <10%

Accountability: Care Managers; Nurse Managers and Providers

C. Patient Experience

Goals:

1. Improve the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ratings to a 4 Star with overall focus on the following measures:
    a. The survey respondents will score an increase in the communication with nurses to 80% or higher
    b. The survey respondents will score an increase in the communication with doctors to 82% or higher

c. The survey respondents will score an increase in the responsiveness of hospital staff to 68% or higher
d. The survey respondents will score an increase in pain management to 71% or higher
e. The survey respondents will show an increase in better communication about medicines to 65% or higher
f. The survey respondents will score the cleanliness of the patient room and bathroom to at least 74% or higher.
g. The survey respondents will show an improvement in the quietness @ night around the patient room to 52% or higher
h. The survey respondents will show an improvement in the communication regarding discharge education and home support to 85% or higher
i. The survey respondents will show an improvement in the patient's understanding of care at discharge to 52% or higher

Accountability: Initiatives will be led by Nursing and Quality staff.

D. Effectiveness of Care

Goals:

1. Increase the Emergency department care for the Stroke patient – Cat Scan results within 45 minutes of arrival – 68% or higher.
2. Following a colonoscopy with a history of polyps appropriate timeframe for follow up is documented 80% of the time or higher.
3. Patients are assessed and given influenza vaccination during their hospital stay 94% or higher.

Accountability:

Stroke patient CT scan - ED Medical Director, Nurse Manager & Radiology Director
Colonoscopy documentation – Surgical Services Manager & Gastroenterologists
Influenza vaccination – Nurse Managers

E. Timeliness of Care

Goals:

1. Decrease ED arrival to pain med given for broken bones to 53 minutes or lower.
2. Decrease ED arrival to ED departure for admitted patients to 260 minutes or lower.
3. Decrease ED Admit ordered to ED departure order for admitted patients to 90 minutes or lower.

4. Decrease arrival to ED departure for discharged patients to 142 minutes or lower.
5. Decrease ED arrival to seen by Provider to 24 minutes or lower.

Accountability:
ED metrics (1-5) - ED Nurse Manager, ED Medical Director & ED Throughput Committee

F. <u>Efficient Use of Medical Imaging</u>

Goal:

1. Decrease the use of double CT scans of the chest "combination" (with and without contrast) when a single scan is all patient need to 2.1% or lower.

Accountability: Radiology Manager, Radiology Medical Director

Please note that each hospital department has its own annual quality plan and reports on progress to the Hospital's Performance Improvement Committee