YOUR HOSPITAL

PERFORMANCE IMPROVEMENT PLAN

1998

Approval:

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Utilization Review/Quality Assurance/Risk Management Committee Chairman — **Date**

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Chief Executive Officer/ Performance Improvement Task Force — **Date**

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Director of Nursing — **Date**

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Board of Directors Representative — **Date**

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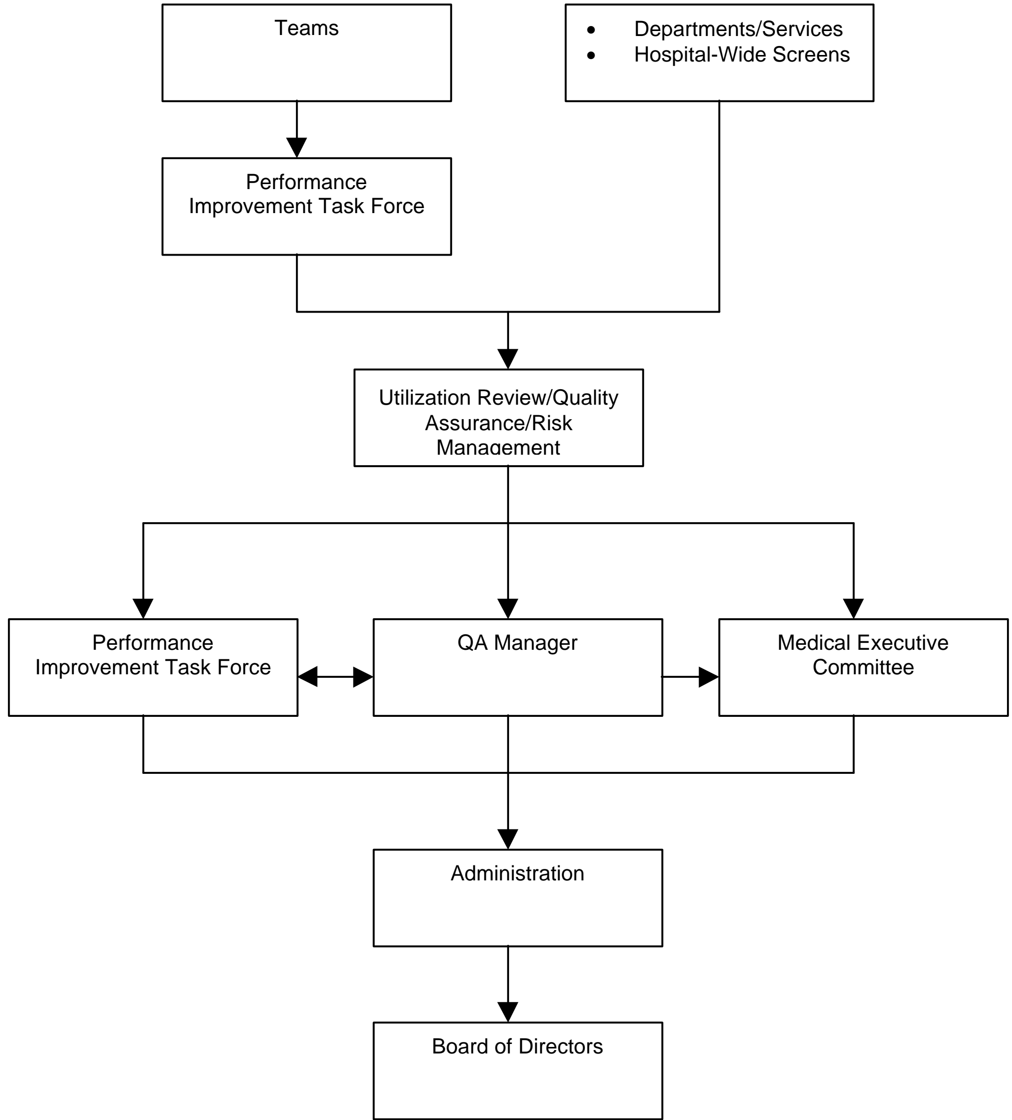
Performance Improvement Activities
Communication Flow



Performance Improvement Plan
1998

I. Introduction

The Performance Improvement Plan established here is utilized by all services and departments through the facility. Your Hospital uses the Plan–Do–Check–Act model for improving performance.

II. Purpose

The purpose of the performance improvement efforts at Your Hospital is to ensure delivery of the best possible care for our patients. It is the goal of this plan to provide a mechanism and process designed to identify opportunities to improve care and services by measuring, assessing, and improving care in a systematic and ongoing manner.

III. Mission

The mission of the Performance Improvement is to guide all components of the organization towards obtaining patient outcomes of the highest quality and providing services that meet or exceed the exceptions of our customers.

IV. Objectives

A. To utilize a hospital-wide approach to improve important functions carried out by this organization, using team efforts whenever possible

B. To increase the probability of desired patient outcomes, including patient and physician satisfaction, by assessing and improving those governance, managerial, clinical and support processes that most effect those outcomes

C. To identify opportunities to improve patient care and services provided

D. To establish priorities for improving care and services that have the greatest impact on patient care outcomes and patient satisfaction

E. To provide guidance and knowledge to individuals and groups of individuals for improving processes in which they are involved

F. To coordinate performance improvement activities and integrate the efforts of all disciplines throughout the organization whenever appropriate

V. Goals

A. To utilize an interdisciplinary hospital-wide team approach to performance improvement activities

B. To maintain a performance improvement team to be responsible for each key function; evaluate the need for performance improvement activities for the function on an ongoing basis; to review policies and procedures relating to each function and make necessary revisions; to establish priorities for measuring performance; to initiate performance improvement measurements in priority areas

C. To develop a patient care pathway relating to operative and other procedures, in a collaborative performance improvement team effort

D. To utilize a standard format for documenting and reporting all performance measures hospital-wide

E. To modify the mortality review process and incorporate review of the autopsy results

F. To collect data on staff views regarding performance improvement activities

G. To collect data on the appropriateness of behavior-management procedures

H. To establish priorities for performance improvement activities

I. To implement and Performance Improvement Newsletter as a mechanism to increase awareness, and coordination and improvement efforts

J. To develop a formal tool for prioritizing performance improvement activities

VI. Priorities for Improvement

The priorities for improvement are as follows:

A. Education

B. Restraint Usage

VII. Authority and Accountability

A. Board of Directors

1. The Board of Directors bears the ultimate responsibility for the quality of patient care and services provided by the organization's medical staff members, and other professional and support staff.

2. The Board of Directors is responsible for performance improvement activities within the organization.

3. The Board of Directors will review periodic reports of findings, actions and results from performance improvement activities in order to assess the program's efficiency and effectiveness.

4. The Board of Directors delegates and directs the Hospital Administration and the Medical Staff to

a) Recommend the strategic direction

b) Implement performance improvement efforts

c) Assess and prioritize the performance improvement activities

d) Provide resources and support systems for performance improvement function related to patient care services and safety

e) Require mechanisms to assure that all patients with the same health problem are receiving a comparable level of care

f) Review information needed to educate the members of the Board of Directors to their responsibility for the quality of patient care

g) Evaluate the Performance Improvement Plan annually and improve the mechanism as needed

B. Chief Executive Officer

1. The Chief Executive Officer is responsible for providing support for the proper functioning of hospital-wide performance improvement activities.

2. The Chief Executive Officer provides the Board of Directors with pertinent information regarding performance improvement activities.

3. The Chief Executive Officer provides support, direction, and/or assists with the resolution of problems or opportunities to improve care or services was needed.

C. Organizations Leaders

1. The Organization's Leaders are responsible for the following:

2. Developing and implementing mechanisms designed to ensure the uniform performance of patient care processes throughout the organization.

3. Developing and implementing an effective and continuous program to measure, assess, and improve performance.

4. Continuously assessing and improving the performance of care and services provided.

5. Adopting an approach to performance improvement that includes planning the process for improvement, setting priorities for improvement, assessing performance systematically, implementing improvement activities based on assessment, and maintaining achieved improvements.

6. Participating in cross-organizational activities to improve organizational performance as appropriate.

7. Communicating information relevant to cross-organizational performance improvement activities to appropriate individuals.

8. Allocating adequate resources for assessing and improving the organization's governance, managerial, clinical, and support processes, by assigning personnel, as needed, to participate in performance activities, providing adequate time for personnel to participate in performance improvement activities, creating and maintaining information systems and appropriate data management processes to support collecting, managing, and analyzing data need to facilitate ongoing improvement in performance, and providing for staff training in performance improvement methods.

9. Analyze and assess the effectiveness of their contributions to improving performance.

D. Performance Improvement Task Force

1. The Performance Improvement Task Force is responsible for overseeing performance improvement activities.

2. The Performance Improvement Task Force provides guidance and support for hospital-wide performance improvement efforts and is responsible to the Utilization Review/Quality Assessment/Risk Management Committee and to the Chief Executive Officer for its actions.

3. Membership of the Performance Improvement Task Force will include the Chief Executive Officer, Quality Assurance Manager, Utilization Review Director, Director of Nursing, and Team Leaders of all hospital-wide key functions.

4. The Performance Improvement Task Force will meet as often as necessary to carry out its required functions.

5. The Performance Improvement Task Force is responsible for the following:

a) Fostering a culture that promotes a commitment to continually improving the quality of patient care and services

b) Providing education to key personnel, as needed, on the approaches and methods of performance improve teams and activities

c) Assessing and prioritizing process improvement projects

d) Monitoring and evaluating the progress of Performance Improvement Teams

e) Managing the flow of information to ensure follow-up

f) Reporting performance improvement activities to the Utilization Review/Quality Assessment/Risk Management Committee and Board of Directors

g) Assigning process improvement activities to the appropriate cross-functional team

h) Assisting and providing guidance to teams as needed

i) Assisting and coordinating departments and teams in the transition to hospital-wide team efforts in performance improvement activities

E. Performance Improvement Teams

1. A cross-functional team will be assigned for hospital-wide functions, as necessary

2. A team leader will be assigned to each Performance Improvement Team by the Performance Improvement Task Force

3. The team will be responsible for the following:

a) Maintaining a current awareness of all external requirements regarding the function

b) Establishing a complete membership representative of all necessary departments or services, with approval of the appropriate Department Manager

c) Developing and revising the necessary policies and procedures for the function assigned

d) Establishing priority areas for the function assigned

e) Initiating performance improvement activities, as needed, for the function assigned

f) Determining educational needs of staff regarding all aspects of the function, and developing a plan for inservicing, and implementing the educational activities

g) Documenting all activities of the team, including a record of meeting minutes, performance improvement activities, performance improvement team composition, and Performance Improvement Team Goals

h) Developing performance improvement measures for areas established as priorities by the team members

i) Implementing actions necessary for improving performance

4. The team leader's responsibilities will include the following:

a) Coordinating all team efforts

b) Providing guidance to the team members as needed

c) Assigning team functions as appropriate - record taking, time keeping

d) Determining frequency and scheduling of team meetings as necessary

e) Collecting and maintaining all policies and procedures relating to the function

f) Reviewing and approving all policies and procedures, assist team members in other appropriate individuals or teams or committees that may need to review and approve the policy and procedure

g) Presenting all necessary policies and procedures to the Performance Improvement Task Force for review and approval

h) Maintaining a record of all team activities, including minutes, performance improvement activities and performance improvement team composition, and submitting Performance Improvement reports to the QA Manager quarterly

i) Submitting revised Team Goals to the Performance Improvement Task Force and QA Manager annually

j) Reporting team performance improvement measures and activities to the Performance Improvement Task Force and to the Utilization Review/Quality Assurance/Risk Management Committee as scheduled

5. The team members responsibilities will include:

a) Working as part of the team to analyze, understand, document, and simplify the designated process

b) Attending meetings and remain until adjournment

c) Participating in discussions and providing input from their knowledge base

d) Completing assignments in a timely manner

F. Utilization Review/Quality Assessment/Risk Management Committee

The Utilization Review/Quality Assessment/Risk Management Committee is responsible for the following:

1. Overseeing the hospital-wide performance improvement activities

2. Assessing the delivery of care through performance improvement reporting

3. Reviewing results and actions taken for performance improvement opportunities

4. Making recommendations to the appropriate individual, committee, department or service for further action to resolve problems or to further improve care

VIII. Scope

A. Departments/Services

The following departments/services are included in the performance improvement activities:

1. Anesthesia

2. Cardiology

3. Detox Unit

4. Discovery Unit

5. Emergency Department

6. Emergency Medical Services (Pre-hospital)

7. Food/Nutrition Services

8. Geriatric Behavioral Health Service

9. Intensive Care

10. Infection Control

11. Key Care Home Health

12. Laboratory

13. Medical Records

14. Medical-Surgical Nursing Units

15. Neuro Diagnostic

16. Nuclear Medicine

17. Operating Room/Endoscopy

18. Post Anesthesia Care Unit

19. Pharmaceutical Care

20. Radiology

21. Respiratory

22. Social Work Services

23. Short Stay Surgery Unit

24. Vascular Lab

B. Performance Improvement Teams

1. The Performance Improvement Task Force will assign teams for hospital wide functions as necessary. As the problem areas or other needs arise, the Performance Improvement Task Force may refer the issue or opportunity for improvement to the appropriate team for investigation.

2. In addition, cross-functional teams can be organized upon the approval of the Performance Improvement Task Force.

3. The following Teams are ongoing:

a) Ambulatory Clinics

b) Assessment of Patients

c) Care of Patients

(1) Anesthesia Care/Operative and Other Procedures

(2) Medication Usage

(3) Nutrition Care

(4) Special Procedures

d) Continuum of Care

e) Education

f) Information Management

(1) Information Management – IM.3

IX. Approach To Designing, Measuring, Assessing And Improving Performance

G. Plan

Planning for the improvement of patient care and health outcomes includes a hospital-wide approach.

1. The organization maintains a plan that describes the organization's approach, processes, and mechanisms that comprise the organization's performance improvement activities.

2. The Team approach serves as a means of collaboration between departments and disciplines in planning and providing systematic organization-wide improvements.

3. The organization utilizes the Plan – Do – Check – Act Performance Improvement Model as the framework for improving performance, as further described in **Attachment I.**

B. Design

In order to design effective processes, functions or services, the following key elements are considered when relevant and available:

1. The process design is based on the organization's mission, vision, and strategic plan.

2. Consideration is given to the needs and expectations of patients, staff, and others.

3. Research into current literature and practice guidelines

4. Design is consistent with sound business practices

5. Baseline performance expectations are utilized to guide measurement and assessment activities

C. Measure

Data collection as the basis of all Performance Improvement activities provides a means of measuring performance through which informed decisions can be made.

1. Data is collected for a comprehensive set of performance measures based on the priorities established for the organization in order to

a) Establish a baseline when a process is implemented or redesigned

b) Describe process performance or stability

c) Describe the dimensions of performance or stability

d) Describe the dimensions of performance relevant to functions, processes, and outcomes

e) Identify areas for improvement

f) Determine whether changes in a process have met objectives

2. Data is collected as a part of continuing measurement, in addition to data collected for priority issues.

3. Data collection considers measures of processes and outcomes.

4. Data collection includes at least the following processes or outcomes:

   a) Operative and other invasive and noninvasive procedures that place patients at risk

   b) Processes related to medication use

   c) Processes related to the use of blood and blood components'

   d) Appropriateness of admissions and hospital stays

   e) Needs, expectations, and satisfaction of patients

   f) Staff views regarding performance and improvement opportunities

   g) Appropriateness of behavior-management procedures

   h) Autopsy results

   i) Risk management activities

   j) Quality control activities

      Quality Control activities are ongoing and records are maintained in, at least, the following areas:

      (1) Laboratory

      (2) Diagnostic Radiology

      (3) Dietetic

      (4) Nuclear Medicine

      (5) Equipment used in administering medication

      (6) Pharmaceutical equipment used to prepare medications

D. Assess

The assessment process involves the necessary disciplines or departments to draw conclusions about the need for more intensive measurement. A systematic process is used to assess collected data in order to determine whether specifications for newly designed processes were met, the level of performance and stability of important existing processes, priorities for possible improvement of existing processes, actions taken to improve the performance improvement processes, and whether changes in the processes resulted in improvement.

1. Collected data is assessed at least quarterly and findings are documented and are forwarded through the proper channels as outlined in this plan.

2. The methodology for documenting the activities is described in **Attachment I**.

3. A pre-determined level of performance, or threshold, which would trigger a more in-depth review, is established for each performance measure to assist in the assessment of the data collected. The reference used may include the following:

a) Internal comparisons in performance of processes and outcomes are made over time

b) Performance comparison of data is made about processes with up-to-date information

c) Performance comparison of data is made about processes and outcomes with other hospitals utilizing reference databases when possible

4. The assessment process includes the use of statistical process control techniques/tools as appropriate. Training for use of statistical process control is provided to the hospital leaders; team members/staff are educated regarding statistical process control techniques on an 'as needed' basis.

5. When assessment of data indicates, a variation in performance, more intensive measurement and analysis will be conducted and in addition, the department/service or team will reassess its performance measurement activities and re-prioritize them as deemed necessary. Intensive assessment is initiated when statistical analysis shows the following:

a) Important single events, levels of performance, and patterns or trends that vary significantly and undesirably from those expected

b) Performance that varies significantly from other organizations

c) Performance that varies significantly and undesirably from recognized standards

6. Assessment is performed on the following:

a) Major discrepancies between preoperative and postoperative diagnoses in pathology reports

b) Confirmed transfusion reactions

c) Significant adverse drug reactions

d) Adverse events or patterns of adverse events during anesthesia use

e) Processes and outcomes related to behavior-management procedures

7. When findings of the assessment process are relevant to an individual's performance, the pertinent information will be provided to

a) The medical staff leaders responsible for determining their use in peer review and/or periodic evaluations of a licensed independent practitioner's competence at reappointment

b) The department/service director responsible for determining the competence of individuals who are not licensed independent practitioners

8. When a performance measurement does not reach the predetermined acceptable level of performance, or if it is reached, but evaluation indicates the performance is not acceptable, the performance improvement process should continue. If the level of performance shows no improvement for the time frame established by the established department/service or team plan, an intensive evaluation should be conducted with input from the Performance Improvement Task Force, Utilization Review/Quality Assurance/ Risk Management Committee, or QA Manager regarding the need for continued measurement.

9. When no opportunities to improve are found after two quarters of data collection, the performance measure should be re-evaluated to determine the need to continue measurement, and re-prioritization of performance measurements should occur.

E. Improve

When opportunities for improving performance are identified, a systematic approach is used to redesign the involved process, or to design a new process. The leadership, through the Performance Improvement Task Force and Utilization Review/Quality Assurance/Risk Management Committee will establish hospital-wide priorities.

1. When an opportunity for improvement is identified by a department or service, the department/service will determine if other disciplines or departments that have an impact on the process in the design/redesign of the process. If other disciplines or departments are involved, the opportunity for improvement will be referred to the appropriate established team

2. The appropriate team/department will establish priorities for improvement based on the guidelines established in this plan. When necessary, the Performance Improvement Task Force and/or the Utilization Review/Quality Assurance/Risk Management Committee will assist the team or department/service in establishing priorities.

3. The appropriate team will use the Plan-Do-Check-Act approach to

a) Establish an action plan

b) Identify performance expectations

c) Establish performance measures

d) Implement actions on a trial basis when possible

e) Compare the results of the action taken to the performance expectations by

f) Develop a new action plan when the desired result is not achieved

g) Incorporate effective actions into the hospital's standard operating procedures

h) Verify that improvements are maintained through performance measurement and assessment activities

4. When opportunities are identified through Performance Improvement findings, educational needs are determined and efforts taken to provide the necessary education.

F. Guidelines for Prioritizing Opportunities for Improvement

1. Priorities are established based on the element of risk to patients, the number of patients involved, problem prone areas, newness of the service or process involved, patient satisfaction, and the organization's mission, vision and strategic plan.

2. Considering these elements, the team members, having knowledge and expertise in the given area, will evaluate the priorities for the team.

3. When necessary, the Performance Improvement Task Force will assist in prioritizing performance measurement efforts for the team, or will make recommendations regarding prioritizing.

4. The Performance Improvement Task Force will establish priorities for performance improvement efforts for the organization as a whole, based on the above guidelines.

G. Performance Improvement Activities

Performance improvement activities will include, but not be limited to the following:

1. Departments/Services

Performance Improvement activities are carried out and are documented by each department/service outlined in the above scope, as described by the guidelines in **Attachment I.**

2. Teams

Teams will adopt the same methodology as utilized by departments/services, as described by the guidelines in **Attachment I**.

3. Medical Staff

a) It is the Responsibility of the Medical Executive Committee to oversee mechanisms used to conduct performance improvement activities and to make recommendations to the Board of Directors regarding the organization of the performance improvement activities, and the results of efforts to improve care

b) The medical staff supports and provides participation on interdisciplinary teams as needed, based on the activities of the team.

c) Relevant findings, conclusions, recommendations, and actions taken to improve care, are communicated to the appropriate medical staff members periodically at the department meetings, and to appropriate individuals through the department chairman.

d) Medical Staff Peer Review

Cases with medical care concerns will undergo medical staff peer review. The cases will be forwarded to the appropriate medical staff department chairman or his/her designee, or appropriate medical staff committee for review, and any further action will be taken based upon recommendation of the chairman of the department or committee.

4. Screening Measures

a) Performance measures will be used hospital-wide to screen for adverse or unusual occurrences or potential problem areas, and as a means of identifying opportunities to improve care or services as deemed necessary by the Quality Assurance Manager.

Refer to Attachment II – Performance Screening Measures and Guidelines

b) When standard of care concerns are raised peer review of the individual case will be obtained by forwarding the case to the responsible department/service for investigation utilizing the Performance Improvement Case Review Referral form. Any department or service can initiate the review form.

c) Results of screening will be aggregated quarterly for trending purposes, and will be forwarded to the appropriate department/service for review

5. Mortality Review and Autopsy Screening

d) Screening is conducted by a non-physician reviewer on all mortalities as indicated in the Mortality Review Guidelines.

e) Cases with variations are forwarded for peer review.

Refer to Attachment II – Mortality Review Guidelines

6. Patient Surveys

a) Patient surveys are utilized to evaluate the needs and expectations of patients.

b) A summary of the findings is reviewed periodically by the Performance Improvement Task Force.

c) When opportunities for improvement are noted, pertinent information is forwarded to the appropriate department or individual for review and evaluation and action as necessary.

7. Operative and Other Procedures

a) Review of appropriateness of operative and other procedures is performed by the Infection Control/Transfusion Review/Surgical Case Review Committee at least quarterly.

b) Necessary actions are taken by the Infection Control/Transfusion Review/Surgical Case Review Committee or recommendations are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individuals.

c) Pertinent information regarding findings is communicated to the appropriate department and individuals, to the Medical Executive Committee, and to the QA Manager.

d) Operative and Other Procedures Continuing measurement will include review of the following:

   (1) Selection of the appropriate procedure

   (2) Patient preparation for the procedure

   (3) Performance of the procedure

   (4) Post-procedure care

   (5) Post-procedure patient education

e) The Operative and Invasive Procedure/Anesthesia Care Team will determine priority areas to be included in the review of Operative and Other Procedures Review.

f) The Operative and Other Procedures/Anesthesia Care Team will initiate a team effort for data collection, aggregation, and analysis of the selected performance measures.

g) The Operative and Other Procedures/Anesthesia Care Team will forward a summary of their findings to the Department of Surgery, along with any actions taken to improve care.

h) The Department of Surgery will review the findings and make any further recommendations to the Operative and Other Procedures/Anesthesia Care Team, or take any additional action/s necessary to improve care.

8. Medication Usage

a) The Pharmacy and Therapeutics and Nutrition Care Committee, coordinated by the Department of Pharmaceutical Care, carries out the Medication Usage functions at least quarterly.

b) Necessary actions are taken by the Pharmacy and Therapeutics and Nutrition Committee or recommendations are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individuals.

c) Pertinent information regarding findings is communicated to the appropriate department and individual/s, to the Medical Executive Committee and to the QA Manager.

d) Medication Usage processes include measurement of at least the following:

(1) Prescribing or ordering medication

(2) Preparing and dispensing

(3) Administering

(4) Monitoring the medications' effects on patients

e) Adverse drug reactions (All significant drug reactions undergo an intensive assessment)

f) The Pharmacy and Therapeutics and Nutrition Care Committee is also responsible for the development and maintenance of the drug formulary as well as approval of policies and procedures relating to the selection, distribution, and handling, use, and administration of drugs.

g) The Committee reviews all significant untoward drug reactions.

9. Blood Usage

a) The Blood Usage Review functions are carried out by the Infection Control/Transfusion Review/Surgical Case Review Committee at least quarterly.

b) The following blood use processes are measured on an ongoing basis:

(1) Ordering practices

(2) Distributing, handling and dispensing

(3) Monitoring blood and blood component effects on patients

(4) Review of availability of blood and blood components

(5) Review of transfusion reactions (All confirmed transfusion reactions undergo an intensive assessment)

c) Necessary actions are taken by the Infection Control/Transfusion Review/Surgical Case Review Committee or recommendations for action are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individual/s.

d) Pertinent information regarding findings is communicated to the appropriate department and individuals, to the Medical Executive Committee, and to the QA Manager.

10. Management of Information Function

a) The Medical Records Committee carries out the Medical Record Review functions at least quarterly. The Medical Record Review function includes the review of clinical pertinence and timeliness.

b) The Medical Record Review Committee takes necessary actions or recommendations are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individuals.

c) Pertinent information regarding findings is communicated to the appropriate department and individuals, the Utilization Review/Quality Assurance/Risk Management Committee, and to the QA Manager.

d) Pertinent information is communicated to the Medical Executive Committee.

11. Infection Control

a) The Infection Control functions are carried out by the Infection Control/Transfusion Review/Surgical Case Review Committee at least quarterly.

b) The Review includes approval of policies and procedures relating to Infection Control, review and evaluation of infection statistics, focused review on infection concerns and/or issues as appropriate, review and input into the hospital's Employee Health Program.

c) Necessary actions are taken by the Infection Control/Transfusion Review/Surgical Case Review Committee or recommendations for action are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individual/s.

d) Pertinent information regarding findings is communicated to the appropriate department and individuals, to the Medical Executive Committee, and to the Utilization Review/Quality Assurance/Risk Management Committee and the QA Manager.

12. Utilization Review

a) The Utilization Review/Quality Assurance/Risk Management Committee carries out the Utilization Review functions at least quarterly.

b) The review includes those elements related to determining the appropriateness of admissions and continued hospitalization.

c) The Utilization Review/Quality Assurance/Risk Management Committee takes necessary actions, or recommendations for action are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individual/s.

d) Pertinent information regarding findings is communicated to the appropriate department and individuals, to the Medical Executive Committee, and to the QA Manager.

13. Risk Management

a) The Utilization Review/Quality Assurance/Risk Management Committee carries out the Risk Management functions at least quarterly.

b) The functions include an evaluation of all reported events related to patient, visitor, and staff safety including sentinel events.

c) The Utilization Review/Quality Assurance/Risk Management Committee takes necessary actions, or recommendations for action are forwarded to the appropriate department, Medical Staff Department Chairman, or responsible individual/s.

d) Pertinent information regarding findings is communicated to the appropriate department and individuals, to the Medical Executive Committee, and to the QA Manager.

14. Environment of Care Function

a) The Safety Committee carries out the Environment of Care Function at least quarterly. The Safety Review function includes the following:

(1) Safety Management

A safety management program is designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injury.

(2) Security Management

A security management program addresses security concerns regarding patients, visitors, personnel, and property.

(3) Hazardous Materials Management

A hazardous materials and wastes program provides a safe process for selecting, handling, storing, using, and disposing of hazardous materials from receipt through use and hazardous wastes from generation to final disposal.

(4) Emergency Preparedness

An emergency preparedness program provides a process for implementing specific procedures in response to a variety of disasters (natural or manmade events which cause major disruption in the environment of care).

(5) Life Safety Management

A life safety program provides a process for protecting patients, personnel, visitors, and property form fire and the products of combustion.

(6) Equipment Management

An equipment management program controls the clinical and physical risk of equipment used for diagnosis, treatment, monitoring and care of patients.

(7) Utilities Management

A utilities management program is designed to ensure reliability, minimize risks, and reduce failures of utility systems.

b) The Safety Committee takes necessary actions, or forwards recommendations for action to the appropriate department, Medical Staff Department Chairman, or responsible individual/s.

c) Pertinent information regarding findings is communicated to the appropriate department and individuals, to the Medical Executive Committee, and the Utilization Review/Quality Assurance/Risk Management Committee, and to the QA Manager.

X. Communication Plan

The method of communication of the Performance Improvement efforts is as follows:

A. Performance Improvement Task Force

1. The Performance Improvement Task Force will coordinate Performance Improvement efforts.

2. The Performance Improvement Task Force will forward problem areas, or areas of concern to the appropriate team for consideration via the Team Leader. When it is recognized that team efforts overlap those of another team, the Performance Improvement Task Force will advise the appropriate Team Leaders to coordinate the Performance Improvement efforts.

B. Teams

1. Teams will report Performance Improvement efforts to the Team Leader of the specific function

2. Team Leaders will make a report of findings to the Performance Improvement Task Force

3. Team Leaders will present a written report to the Utilization Review/Quality Assurance/Risk Management Committee as scheduled

4. Written reports will be presented to the Medical Executive Committee via Utilization Review/Quality Assurance/Risk Management Committee meeting minutes

5. Written summary is periodically provided to the Board of Directors

C. Departments

1. Department Managers will provide a written report to the Quality Assurance Manager

2. Department Managers will present a verbal and written report to the Utilization Review/Quality Assurance/Risk Management Committee periodically, as outlined by the reporting schedule approved by the Utilization Review/Quality Assurance/Risk Management Committee

3. Written report is provided to the Medical Executive Committee via Utilization Review/Quality Assurance/Risk Management Committee meeting minutes

4. Written summary is periodically provided to the Board of Directors

D. Education

1. Education of Performance Improvement efforts and methodologies will be provided to the staff on orientation, and will include information regarding data collection, aggregation, and statistical process control as the need arises with participation in the process.

2. Education regarding Performance Improvement methods and activities will be provided to the organizational leaders on an ongoing basis.

XI. Annual Appraisal

A. Departments/Services and Teams

Performance Improvement efforts will be evaluated annually by each department or service and active interdisciplinary team. The annual evaluation will be forwarded to the Quality Assurance Manager.

Refer to Attachment III

B. Performance Improvement Plan

The Performance Improvement Plan will be reviewed and evaluated annually by the Utilization Review/Quality Assurance/Risk Management Committee. The annual appraisal will consider the achievement of the goals and objectives of the plan, the efficiency of the plan, and the effectiveness of the plan. The Performance Improvement Task Force can make recommendations to the Utilization Review/Quality Assurance/Risk Management Committee for revisions and improvements in the Performance Improvement efforts.

Refer to Attachment IV

XII. Signatures of Approval

The Performance Improvement Plan will be approved annually by the Performance Improvement Task Force, the Chairman of the Utilization Review/Quality Assurance/Risk Management Committee, the Medical Executive Committee, and the Board of Directors.

Attachments

Attachment I Guidelines for Documenting Performance Improvement Activities

Attachment II

Performance Screening Measures and Guidelines

Performance Improvement Concurrent Screening Form

Performance Improvement Case Review Referral Form

Mortality Review Guidelines

Mortality Review Worksheet

Attachment III Performance Appraisal Annual Evaluation Form (Department/Services and Teams)

Attachment IV Annual Appraisal Performance Improvement Plan (1998)