

Moore County Hospital District
Performance Improvement Plan

Performance Improvement Plan

I. PURPOSE

The Moore County Hospital District (MCHD) Performance Improvement Plan defines a systematic, organization-wide approach to improving the delivery of patient care services that positively affect patient outcomes. This plan is consistent with the mission and vision of MCHD to provide continuously improving, quality health care to our customers, based on their needs and available district resources.

II. SCOPE

All District departments are included in the Performance Improvement Plan. Hospital District departments, appropriate to the prioritized performance improvement (PI) activities, will have at least one measurement indicator identified for each department. Included in the Performance Improvement Plan is the Perinatal Program Plan, the Governing body, their roles and credentials.

III. STRUCTURE

A. Leadership

The Board of Directors of MCHD is ultimately responsible for performance improvement. The Board of Directors delegates to the CEO and other senior leaders of the hospital and medical staff, the responsibility of oversight of an effective, organization-wide Performance Improvement Plan. The leaders set expectations, develop plans, and manage processes to improve the quality of the hospital's governance, management, clinical, and support activities. The leaders are responsible for adopting an approach to PI that is utilized in reporting and in team activities. Leaders are also responsible for setting priorities and reprioritizing in response to sentinel events or unexpected or unusual occurrences.

Leaders establish a positive culture of safety and quality within the organization through planning, education, providing support, such as time and resources, and empowering staff to participate in PI activities. Leaders actively participate in interdisciplinary performance improvement activities, as appropriate.

The Governing body of the Perinatal Program consists of the Neonatal Medical Director (NMD), Maternal Medical Director (MMD), the Maternal Program Manager (MPM), and the Neonatal Program Manager (NPM). The responsibilities and authority of the NMD, MPM and NPM shall include but are not limited to: ensuring that the QAPI Program is specific to neonatal/infant care, is ongoing, data driven and outcome based; regular participation in the neonatal QAPI meeting. The MPM/NPM is responsible for developing and/or revising policies, procedures and guidelines; and regularly participates in the neonatal QAPI meeting.

B. Performance Improvement Council

The Performance Improvement Council (PIC) is an inter-disciplinary body consisting of the CEO, CNO, COO, CFO, CPO, CMO, Physician Representative (s) appointed by the Chief of

Performance Improvement Plan

Staff and Long Term Care Administrator. The PIC is responsible for the direction, prioritization, monitoring and evaluation of performance improvement and the distribution of updated regulatory requirements to departments or committees in need of the information for implementation.

C. Interdisciplinary Teams

Interdisciplinary Teams are designed to address hospital-wide topics, analyze data, and guide improvements. Quality Assurance Process Improvement Nurse and department directors will meet yearly to identify performance improvement projects. Recommendations for performance improvement initiatives outside of that process are submitted to the PIC for consideration, prioritization, and approval or denial.

D. Quality Assessment Process Improvement Nurse

The QAPI Nurse is responsible for directing and managing clinical improvement initiatives. Assists and facilitates the development and implementation of the Process Improvement Plan and annual activities work plan. Works closely with department directors regarding: data collection, analysis, improvement strategies and effectiveness of strategies.

IV. PLAN

The MCHD Performance Improvement Plan is based on the core concepts of continuous quality improvement techniques and methods. The Performance Improvement Plan may be revised as changes occur in the organizational structure or scope of services.

V. PRIORITIZATION

Annually, PI activities will be prioritized with an emphasis on patient safety and quality of patient care services. Opportunities for improvement and the formation of PI teams will be prioritized using the following criteria:

- A. Patient safety
- B. Patient satisfaction
- C. Mission and core values
- D. High volume, high risk and problem prone processes
- E. Regulatory requirements

Priorities will be formulated into a work plan that describes the selected data indicators, frequency of data collection and reporting and the persons responsible to perform the activities. Data collection and analysis requirements by regulatory and accreditation entities will be included in the work plan (PI Dashboard). The work plan is a dynamic document. As changes in the internal or external environment occur, the work plan may be reprioritized.

Performance Improvement Plan

VI. IMPROVEMENT METHODOLOGY

A systematic process will be utilized to:

- A. Collect valid and reliable data
- B. Analyze data to identify areas for improvement
- C. Implement actions
- D. Determine whether actions were effective

At a minimum the organization collects data on:

- A. PI priorities identified in the work plan
- B. Significant medication errors
- C. Adverse drug reactions
- D. Operative and other invasive procedures
- E. Significant discrepancies between preoperative and postoperative diagnoses including pathology
- F. Adverse events related to sedation and anesthesia
- G. Blood and blood components
- H. Confirmed transfusion reactions
- I. Patient's perception of safety and quality of care (patient satisfaction)
- J. Results of Resuscitation and effectiveness of Rapid Response Team
- K. Evaluate the effectiveness of the fall reduction program

Data analysis will utilize statistical tools and comparisons:

- A. Trended over time within the organization
- B. With external databases
- C. With best practices as benchmarks

Opportunities for improvement may be identified and actions implemented at the departmental level. The Plan-Do-Study-Act (PDSA) model used to test and implement change will be required if a department's quality indicator falls below the goal for two consecutive months in a quarter. The PDSA will be shared with the overseeing Senior Leader of that department and with PIC. Departments can also be referred to the PIC for possible PI Team formation. Memorial Nursing and Rehabilitation Center (MNRC) will follow their Process Improvement regulatory process.

VII. REPORTING

An annual schedule of departmental reporting to PIC is formulated. Reports of findings, conclusions, recommendations, and actions are communicated to the Performance Improvement Committee.

Performance Improvement Plan

The CEO and/or his designee, is responsible for communicating information from PIC to the Board of Directors. Formal reporting will proceed at least twice annually. The Board of Directors recommendations and or actions will be communicated to the Performance Improvement Committee.

VIII. SENTINEL EVENTS

Definition: A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof.

Leaders of the organization are responsible for defining the policy and procedure for responding to a sentinel event. If a sentinel event occurs in the district, the district will form a taskforce, composed of persons close to the involved process, to review the incident and conduct a root-cause analysis.

Once the root cause analysis has been conducted, the team will develop an appropriate action plan to address any variations identified and establish measures for any changes made. The action plan will be presented to the Performance Improvement Committee for approval. Periodic progress reports will be reported to the Performance Improvement Committee until the issue is determined to be resolved. Lessons learned from root cause analyses and the results of proactive risk assessments are disseminated to staff that provide services for the specific care process that was evaluated.

At least once a year, the Board of Directors receives a written report of the following:

- A. All system or process failures
- B. The number and type of sentinel events
- C. Whether the patients and the families were informed of the event
- D. All Actions taken to improve safety, both proactively and in response to an actual occurrence.

IX. Confidentiality

Confidentiality shall be maintained, based on full respect of the patient's right to privacy and keeping with district policy and state and federal regulations. All employees of the district or outside agencies that are involved in performance improvement will be made aware of their responsibility of confidentiality. All data shall be considered the property of the district and the district shall ensure the maximum protection of all confidential data, including any findings, recommendations or actions.

X. ANNUAL APPRAISAL

Performance Improvement Plan

Annually, the Performance Improvement Committee shall be responsible for review of the PI Plan and annual work plan of prioritized PI activities. The review shall determine if the goals of the work plan were met, provide an explanation of those not met and propose changes for the following year. The Medical Executive Committee shall have input into the evaluation.

The Board of Directors will review the annual evaluation and provide final approval of the PI Plan if revised and annual work plan. (See meeting minutes of Performance Improvement Committee, Medical Executive Committee and the Board of Directors for approval of the PI Plan and work plan.)

Performance Improvement Plan

Approval of Plan

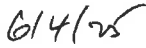
The Performance Improvement Plan has been reviewed, evaluated, and approved by the hospital's Medical Staff, PIC and Governing Board and constitutes the official plan, policy, and procedure for conduction of performance improvement at MCHD.

Quality Assurance Process Improvement Nurse

Date




Chief of Medical Staff



Date



Chief Executive Officer



Date

Chairman of the Board of Directors

Date