HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: Continuous Quality Improvement Plan **Effective Date: 10/1/2005**
Policy Number: 112 **Med Staff:**
Regulation: **Admin:**

I. POLICY

Section One: Introduction

A) PURPOSE

To ensure that the governing body, medical staff and professional service staff demonstrate a consistent endeavor to deliver optimal care in an environment of minimal risk.

In keeping with the facility's mission, the plan allows for systematic, coordinated and continuous approach to improving performance, focusing upon the processes and mechanisms that address these values.

As patient care is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise performance improvement activities. The hospital-wide program, established by the medical staff with support and approval from the governing board, has the responsibility for monitoring every aspect of patient care, from the time the patient enters the facility, through diagnosis, treatment, recovery, and discharge, in order to identify and resolve any breakdowns that may result in sub-optimal patient care and safety, while striving to continuously improve and facilitate positive patient outcomes.

B) CONTINUOUS QUALITY IMPROVEMENT (CQI) OBJECTIVES

1) Maintain a comprehensive, effective system for monitoring and evaluating the quality of patient care and services provided throughout the facility in a cost-effective manner.

2) Assure that patient care is provided and maintained at an optimal level consistent with the professional standards held in the medical community.

3) Improvement of existing processes and functions through a systematic approach that includes identifying a potential improvement, testing the strategy for change, assessing data from the test to determine if the change produced improved performance, and implementing the improvement strategy system wide.

4) Provide for a collaborative approach to review the health care practices at the facility for their quality, cost effectiveness, and positive outcome on the patients treated.

5) Focus of quality improvement data at a central point for examination analysis and documentation of ongoing activities. Data is to include use of statistically valid performance measures and quality control techniques.

6) Provide for a performance improvement assessment process that includes comparative data about the facility's processes and outcomes over time, use of current sources about the design and performance of processes (such as practice parameters) and the facility's performance of processes and outcomes in relationship to that of other organizations, including reference databases.

7) Provide for established criteria that allow for setting of priorities for improvement activities. This criteria gives priority consideration to:
   a. Processes that affect a large percentage of our patients.
   b. Processes that place our patients at risk, if not performed well when indicated, and/or performed when not indicated.
   c. Processes that have been, or are likely to be, problem prone.

8) Reduction of malpractice and general liability through objective patient care evaluation: specific review of occurrences resulting in malpractice actions and/or adverse outcomes in order to assure system, process and procedure correction, including procedures for credentialing.

9) To identify, assess and implement correction plans for urgent situations requiring immediate action and incurred losses to isolate factors that have caused professional liability claims to be filed with a focus on development of preventive measures against recurrence.

10) Assure an effective communication system for reporting performance improvement activities throughout the facility, including to the governing board, medical staff and administration.

11) Assure compliance with the requirements of all federal, state and accrediting agencies in regard to quality assessment and performance improvement activities.

Section Two: Systematic Approach to CQI

A) DIMENSIONS OF QUALITY

In order to focus on what is performed throughout the facility and how well it is performed in the provision of healthcare, emphasis is placed upon "dimensions of quality" between the hospital staff and its customers. These dimensions of quality include:

1) Performance – primary, basic operating characteristics of the services provided

2) Features – characteristics of the services provided that add to its basic functioning

3) Timeliness – available or complete when the customer wants it

4) Reliability – Dependability – consistency of performance over time

5) Conformance – Accuracy – degree to which the services provided matches established standards and any promises that were made to the customer

6) Serviceability – Flexibility – speed and ease in resolution of problems and complaints

7) Durability – the ability to stay up to date or the useful life of the service provided

8) Responsiveness – the willing ness to help customers

9) Aesthetics – sound, look, taste, or feel

10) Reputation – past performance, image of Hardin County General Hospital and the services provided

11) Tangibles – physical facilities, equipment, and credentials of staff

12) Assurance – ability to make the customers feel that they can put their trust in you

13) Empathy – the caring, individual attention provided to customers

B) CQI METHODOLOGY

Hardin County General Hospital uses the FOCUS-PDCA as its CQI methodology. The FOCUS-PDCA is an acronym for the following procedural steps:

FIND
To identify a priority opportunity for improvement. To list and prioritize problems.

ORGANIZE
To organize a team with appropriate knowledge of the process.

CLARIFY
To understand the current process and ensure use of "Best Current Process."

UNDERSTAND
To understand the key quality characteristics and process variables (root causes) and the relationships between them.

SELECT
To select and improvement.

PLAN
To plan implementation. To continue data collection.

DO
To test and/or implement the change.

CHECK
To study the effects of the change in the process.

ACT
To implement the change systematically. To "institutionalize" the gain.

C) NEW PROCESS DESIGN/PROCESS REDESIGN IDENTIFICATION

Opportunities for improvement are identified from ongoing studies/quality assurance activities, surveys, reported improvement suggestions, or topics of interest discussed at meetings.

Suggestions for CQI activities are reviewed for appropriate response by the Quality Council. Responses may be in the form of quick fix responses to problems identified. CQI teams may be established to further study the opportunity for improvement using the FOCUS-PDCA methodology. Quality improvement studies involving a single departmental issue may use an abbreviated PDCA method.

All CQI activities are facilitated by the Director of Quality Improvement and reported upon at quarterly CQI Committee meetings.

Section Three: Implementing the CQI Plan

A) TEAMS

The Quality Council, a committee of administration and department heads, establishes teams. Teams are sanctioned to conduct FOCUS-PDCA analyses of specific identified opportunities for improvement. The Quality Council chooses team members and appoints a Team Leader and Facilitator. Members are informed of the opportunity identified and boundaries of the process through the use of an Opportunity Statement.

Teams are comprised of individuals familiar with, and in ownership of, the process involved. Teams meet until the methodology is complete and improvements have been chosen and acted upon.

Teams complete a storyboard upon the conclusion of the team highlighting the accomplishments of the team. Team results are reported at Quarterly CQI meetings and at meetings of the board of directors through the storyboard.

B) TRAINING

CQI training is conducted with all new employees and at training sessions throughout the year. Employees are trained in the Hospital's CQI Plan, the FOCUS-PDCA methodology, data collection, analysis and presentation.

All employees have the opportunity to receive training in the FOCUS-PDCA methodology. This training is encouraged for all involved in Teams and is required for those serving as Team Leaders and Facilitators.

Specific training opportunities for staff are arranged through the Department of Medical Education on an as needed basis as needs are identified.

C) RESOURCES

The Director of Quality Improvement maintains a library of resource material on conducting and analyzing CQI activities. The Director of Quality Improvement is available as a resource in conducting departmental CQI studies, preparing data collection tools and conducting data analysis.

D) QUALITY RESPONSIBILITY OF LEADERSHIP AND STAFF

To achieve fulfillment of the objectives, goals and scope of the Quality Improvement Plan, the organizational structure is designed to facilitate an effective system of monitoring, assessment and evaluation of the care and services provided throughout the facility.

The Governing Board is responsible for the quality of patient care provided by:

1) The Governing Board requires the medical staff to implement and report on the activities and the mechanisms for monitoring, assessing and evaluating the quality of patient care, for identifying opportunities to improve patient care and services for performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect affect on patient care, including management and administrative functions.
2) The Governing Board provides for resources and support systems for the performance improvement functions and risk management functions related to patient care and safety.
3) The Governing Board has the responsibility to evaluate the effectiveness of the performance improvement activities performed throughout the facility and the Quality Improvement Plan as a whole.

The Medical Staff, in collaboration with the leaders of the facility, has the responsibility to provide measurement on a continuing basis to understand and maintain the stability of systems and processes; measurement of outcomes to help determine priorities for improving systems and processes; and assessment of individual competence and performance when appropriate.

This process is composed of the following steps:

1) Assign responsibility for monitoring, assessing and evaluating performance improvement activities.

2) Delineate the scope of care and services provided.

3) Identify the key aspects of care, focusing on those aspects that relate to the health and safety of the patients served.

4) Identify the objective and statistically valid performance measurers (indicators) for monitoring and assessing the key aspects of care.

5) Establish benchmarks or thresholds that trigger intensive assessment and evaluation of the function, process and/or care provided.

6) Monitor, assess and evaluate the key aspects of care by assessment of data collected in order to determine:
    - Whether design specifications were met.
    - The level of performance and stability of important existing processes.
    - Priorities for possible improvement of existing processes.
    - Actions to improve the performance of processes and functions.
    - Whether changes in the processes and/or functions resulted in improvement.

7) Assess the care related to the key aspects and key processes under monitoring when thresholds are reached in order to identify opportunities to improve performance or resolve problem areas.

8) Take actions to correct identified problem areas or improve performance.

9) Evaluate the effectiveness of the actions taken and document the improvement in care.

10) Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments, or services and to the Quarterly CQI meetings and the Board of Directors.

The medical staff delegates the oversight responsibility for quality improvement activity monitoring, assessment and evaluation of patient care services provided throughout the facility to the Quality Improvement Committee.

The Administration and Department Heads function to provide the framework for planning, directing, coordinating, providing, and improving healthcare services that are responsive to community and patients' needs and that improve patient health outcomes. To achieve this goal, the following processes are performed:

1) Planning for services. The mission statement is reflected in long-range strategic and operational plans, resource allocation, and facility policies. Information obtained from patient satisfaction surveys and other patient feedback mechanisms is incorporated into the planning process.

2) Directing services. Patient care and support services are organized, directed and staffed in a manner that is appropriate with the scope of services offered.

3) Implementing and coordinating services. Patient care and support services are integrated throughout the facility.

4) Improving services. Plans and expectations are established with processes managed to measure, assess and improve the performance of the facility's governance, management, clinical, and support processes.

5) As appropriate, written reports of conclusions, recommendations, actions taken to improve performance and the results of actions taken are maintained and reported.

Hardin County General Hospital staff is responsible for quality patient care by identifying their customers and the customers' needs. Staff should continuously evaluate the following:

1) Who receives your work? Who depends on you? Who are your customers?

2) How well are you meeting your customers' needs and expectations?

3) Does your customers' definition of quality differ from yours?

4) Do any of our processes in the "dimensions of quality" need adjusted?

It is the responsibility of all Directors of the Board, Administrators and Department Supervisors and staff to meet or exceed the expectations of the customers of Hardin County General Hospital. As part of the CQI Plan, direct or indirect patient care departments of the facility are responsible for quality improvement activities which include monitoring, assessment and evaluation of the quality and appropriateness of patient care provided.

E) ESTABLISHMENT OF CQI PRIORITIES

To assure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the CQI Plan is evaluated for effectiveness at least annually and revised as necessary.

The administration, medical staff, management staff and ancillary and nursing departments will evaluate the effectiveness of quality improvement activities performed annually and report their findings to the Quality Improvement Committee.

The Director of Quality Improvement will aggregate review findings and provide an overall evaluation of the effectiveness of the CQI Plan for the medical staff and the governing board.

The CQI Plan will be reviewed and revised as necessary to assure the effectiveness of the quality improvement activities related to patient care and services provided throughout the facility, and approved on an annual basis by the medical staff and the governing board.

Section Four: Evaluation

A) MEASURING RESULTS

Data is collected using data sheets, check sheets, surveys and through interviews. Data is gathered and measured according to the following rules:

1) What questions do we need to answer?
2) What data analysis tools do we expect to use?
3) What type of data do we need to construct this tool and answer the question?
4) Where in the process can we get this data?
5) Who in the process can give us this data?
6) How can we collect this data from these people with minimum effort and chance of errors?
7) What else do we need to capture for future reference, analysis, and traceability?

B) FINDING VARIANCE/ROOT CAUSE ANALYSIS

By clarifying the processes involved in individual CQI studies the most important quality characteristic, Key Quality Characteristic, is identified. The Key Quality Characteristic must be operationally defined by combining knowledge of the customer with knowledge of the process. Key Quality Characteristics can be measured to understand the actual performance of the process.

Key Process Variables have a cause-effect influence on the Key Quality Characteristic and can be studied as causes of variation in any CQI study. The Key Process Variables are typically stratified in the following areas:

People – staff, patients, contractors, suppliers
Machines – test equipment, data bases
Materials – supplies, input information
Methods – procedures, protocols, techniques
Measurements – bias, inaccuracy in data collected

Key Process variables are a component of the process that has a cause and effect relationship of sufficient magnitude with the Key Quality Characteristic that manipulation and control of the Key Process Variables will reduce variation of the Key Quality Characteristic and/or change its level. Key Process Variables are the root causes of variation in the CQI process studied.

C) ASSESSING THE RESULTS

Data is analyzed for the following reasons:

To determine which improvement opportunities to select for CQI teams
To identify the primary cause of a problem
To monitor the effectiveness of a process improvement
To determine when further stratification of data is indicated
To find the vital few causes accounting for the majority of the variation in a process

Comparisons, trends, distributions and correlations are shown using a variety of charts and diagrams such as bar charts, pie charts, run charts, histograms and scatter diagrams. Often data is put in chart or graph form to make the data understandable by reducing it to a few summary values and/or showing a graphical “picture” of the data.

Benchmarking is sought to compare Hardin County General Hospital data with that of peers of similar size and scope. Benchmarking is achieved through contacts within the healthcare industry and group affiliations.

Data is analyzed for changes in the processes that occurs as a result of a specific cause or because of special circumstances; to develop a reasonable and relevant explanation for the pattern of variation; and to identify a pattern of correlation or possible cause-effect relationships.

D) COMMUNICATION OF QUALITY RESULTS

All quality improvement activities conducted at Hardin County General Hospital are reviewed and reported upon at quarterly CQI committee meetings. CQI Committee members include members of administration, department heads, department supervisors and key staff.
Results of CQI activities are communicated to individual departments by the departmental supervisors.

Key CQI activities are reported to the medical staff at Monthly Medical Staff meetings as necessary.

The results of all CQI Team results are reported to the Board of Directors, Medical Staff and Hospital Staff through the use of Storyboards.

The Board of Directors choose a "dashboard of indicators" to stay informed of quality improvement activities at Hardin County General Hospital. These indicators are collected, benchmarked and presented to the CQI Committee and Hospital Board of Directors on a quarterly basis.

E) ANNUAL EVALUATION AND IMPROVEMENT OF THE CQI PLAN

The CQI plan will be evaluated annually to determine if objectives and goals are met. Goals will be re-evaluated with input from the Board of Directors, Medical Staff and Administration.

Section Five: Annual Goals

(see attachment)

II. DEFINITIONS

Quality – Meeting the needs and expectations of patients and/or other customers with a minimum of effort, rework, and waste

CQI – Continuous Quality Improvement – The culture, strategies and methods necessary for continual improvement in meeting and exceeding customers' expectations.

FOCUS-PDCA – CQI methodology of Find, Organize, Clarify, Understand, Select, Plan, Check and Act

III. RESPONSIBILITY

All Staff

IV. EQUIPMENT

N/A

V. PROCEDURES

INFECTION CONTROL: N/A

N/A

VI. DOCUMENTATION

QI Process Idea Form