Quality Plan

Version 2

Urgent Care

Quality Plan

Contents

Revision History

Date	Version	Author(s)	Notes
4/08/2022	1.00	Jen Gruger, PMI-PBA - Physician Practices Quality Manager	Original Version
7/27/2022	1.01		Addressed grammar and spelling items. No substantive changes.
10/5/2024	2	Jen Gruger, PMI-PBA – Physician Practices Quality Manager	Substantive changes: New version number; organization name change; and Measures/Areas of Focus

Urgent Care

Quality Plan

Overview

The purpose of the Quality Plan is to confirm that there is a detailed written document that specifies the quality standards, practices, resources, specifications, and the sequence of activities relevant to General Hospital Urgent Care, a department of General Hospital of NM (GHNM), located in Alamogordo, New Mexico. Following the guidance provided by the 2022 Urgent Care Association (UCA) Accreditation Standards & Preparation Manual ("UCA Standards Manual") the plan defines the Quality Goals of the facility and includes acceptable performance metrics and the frequency of measurements. It outlines appropriate detection and prevention methods. Once the plan is operational, a Quality Improvement (QI) team leverages the plan to assess, measure, monitor, and continually improve the plan.

The plan is aimed at improving General Hospital Urgent Care patient outcomes and is aligned with the overall Quality goals of the entire organization (referring to GHNM.)

The QI team will provide verification and validation of all project deliverables to be completed by the team. The QI Lead will be responsible for:

- Tracking, assessing, and ensuring all Quality measures are in alignment with UCA expectations for quality.
- Inspecting and commenting on all draft and final project document deliverables for traceability, correctness, and fidelity to the UCA requirements.
- Assigning sections or sub-sections of the Quality Plan to staff members who will be responsible for ensuring the appropriate review and formulation of improvement/action plans where needed.

This Quality Plan outlines the areas of focus required by UCA as outlined in the UCA Standards Manual - QI.1 and provides guidance for:

A. Management identifying risk and areas of focus
B. Frequency of measurement of Quality areas
C. Responsible individuals identified
D. Acceptable performance indicators identified
E. Corrective action plan
F. Measurement tools available
G. Data utilized to improve patient care
H. Methodology for Providers and staff to be involved in the process

I. A plan for initial implementation and review/revision annually

Measures/Areas of Focus

There will be a minimum of six areas of focus including the following four required areas as detailed in the UCA Standards Manual. All items are monitored monthly at a minimum and several are supported by alerts triggered at the point of care in the EMR:

1. Patient Feedback/Satisfaction (QI.4)
    a. Via third party vendor post encounter survey
    b. Follow up call protocol
    c. Additional methods as determined by GHNM

2. Antibiotic Stewardship (QI.5)
    a. Via monitoring of MIPS criteria specific to antibiotic monitoring
    b. Alerts and POC recommendations in the EMR

3. Medication Monitoring (QI.6)
    a. Best practices including but not limited to two patient identifiers, cross checking and appropriate time-out verification processes.
    b. Fall-outs are reported appropriately, recorded by staff and documented via incident report in VigiLanz.

4. Unexpected/unfavorable Occurrences Monitoring (QI.7)
    a. Staff are trained and aware of written policies on reporting unexpected/unfavorable occurrences via VigiLanz.

Two additional measures, which may change annually, are included as APPENDIX B and are monitored monthly at a minimum and supported by EMR reporting and direct observation and Quality Improvement suggestions from the Quality department.

Quality Improvement Plan

Quality Improvement (QI) includes, at a minimum, an identified individual champion dedicated to overseeing quality initiatives and a plan for ongoing clinical, service, administrative or other improvement opportunities. Examples of quality improvement tools in place include monthly performance reports, feedback processes and care gap plans using the PDSA cycle.

In addition to meeting annually at a minimum with staff including providers to review the Quality Plan, QI activities the project team will implement to ensure quality are as follows:

1. Identify Urgent Care Supervisor (or a delegate) as the individual QI champion or QI Lead
2. Identify measured items, including:
    a) Reason measure was selected
    b) Frequency of measurement
    c) What is measured
    d) How it is measured
3. Provide staff with educational materials for each measured item including benchmarks

4. Implement a training plan
5. Establish a data collection process
6. Identify who is responsible for data collection

Training Plan

Training will be delivered to General Hospital Urgent Care workforce via the following methods:

- New hires – through New Employee Orientation and department-level onboarding process.
- By the Physician Practices Quality Management Department as needed.
- Additionally, as needed, should measures change or when gaps are identified through the QI process.

Training will include processes for reporting and remediation.

Data Collection and Frequency of Measurement

Data will be collected via the standard available reports from the various EMR systems and/or via direct observation with additional reporting tools provided occasionally by the GHNM Physician Practices Quality Department upon request of the QI Lead.

A number of alerts triggered at the point of care are built into the EMR.

Reports will be reviewed, at a minimum, on a monthly basis. Gaps in performance will be identified and addressed via PDSA cycle (Plan, Do, Study, Act).

Reports and any plans of action to address gaps in performance and improve patient care will be available for at least three (3) years per the UCA Standards Manual.

A Quality Plan Audit Log will be maintained as shown in APPENDIX A.

Anonymous Reporting Process

QI Officer maintains log of reported occurrences should any workforce member elect to report lapses in quality or unfavorable occurrences. The method of reporting will be the same as for all GHNM employees via VigiLanz.

APPENDIX A - Quality Plan Audit Log

Planned Quality Review Date	Activity Reviewed	Issue(s)	Corrective Action Plan
7/1/2024	Measures/Areas of Focus	Updated to align with hospital Comprehensive Quality Committee requirements	None needed
9/26/2024	Entire Quality Plan	New version number; organization name change; and Measures/Areas of Focus	None needed

APPENDIX B – Additional Measure Details

Hand Hygiene

Total number of times hand hygiene was completed/Total number of hand hygiene opportunities identified.

The hand hygiene measure was implemented in FY24 to encourage better infection control. Due to the volume of patients seen and the reasons for visit we started monitoring hand washing done by the staff to ensure that they were following policy and protocol for infection control. This is counted manually by QI Team Leader on randomly selected days of the week and recorded manually via direct observation of the staff to make sure they are performing hand hygiene steps upon entering and exiting the exam rooms.

LWOBS – Left without being seen

Total number of patients who LWOBS/Total number of patients seen.

Left without being seen is tallied up at the end of every month. This provides pertinent data to help monitor our wait times and patient satisfaction. QI Team Leader and QI Leads round on patients both in the waiting room as well as the exam room to try to improve performance in this measure.