**Penrose-St. Francis Health Services**

**ORGANIZATIONAL PERFORMANCE IMPROVEMENT**

**AND PATIENT SAFETY/RISK MANAGEMENT PLAN**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Revised:** | **June 1994** | **July 1996** | **January 1998** | **April 1999** |
| **May 2000** | **July *2001*** | **June 2002** | **May 2003** | **June 2005** |
| **June 2008** **Feb, 2010**  |

APPROVED BY:

|  |  |  |
| --- | --- | --- |
| Administration |  |  |
| Date  |  | Margaret Sabin, CEO |
|  |  |  |
| Clinical Effectiveness Committee |  |  |
| Date  |  | Jeffrey Oram-Smith, MD, Chairman |
|  |  |  |
| Medical Executive Committee  |  |  |
| Date  |  | Steven Myers, MD, Chief of Staff |
|  |  |  |
| Community Board of Directors |  |  |
| Date  |  | Cathy Robbins-Beard, Chair |

**Table of Contents**

[SECTION 1: OVERVIEW 3](#_Toc201727900)

[Executive Summary 3](#_Toc201727901)

[Mission, Organization Values and Operating Philosophy 3](#_Toc201727902)

[Definitions 3](#_Toc201727903)

[Components of the Process 4](#_Toc201727904)

[SECTION 2: SCOPE 4](#_Toc201727905)

[Scope of Quality/Performance Improvement Activities 4](#_Toc201727906)

[Goals and Objectives 4](#_Toc201727907)

[Responsibility / Accountability 4](#_Toc201727908)

[SECTION 3: APPROACH 5](#_Toc201727909)

[Priorities for Quality/Performance Improvement Activities 5](#_Toc201727910)

[Approach to Quality/Performance Improvement 6](#_Toc201727911)

[SECTION 4: PLANNING and DESIGNING 6](#_Toc201727912)

[SECTION 5: STRUCTURE 7](#_Toc201727913)

[Structure for Quality/Performance Improvement 9](#_Toc201727914)

[SECTION 6: PATIENT SAFETY/RISK MANAGEMENT 9](#_Toc201727915)

[Summary 9](#_Toc201727916)

[Scope 9](#_Toc201727918)

[Plan 10](#_Toc201727919)

[Reporting 11](#_Toc201727948)

[Statutory Protection 13](#_Toc201727949)

[SECTION 7: MEASUREMENT 13](#_Toc201727950)

[Data Gathering and Measurement: 13](#_Toc201727951)

[SECTION 8: EVALUATION 13](#_Toc201727952)

[Annual Evaluation of the Performance Improvement Process 13](#_Toc201727953)

APPENDIX…………………………………………………………………………………………………12

SECTION 1: OVERVIEW

Executive Summary

Penrose-St. Francis Health Services is dedicated to improving systems and outcomes, a process known as continuous quality/performance improvement. Organizational quality/performance is linked to our mission and core values. Our energy and convictions focus on “excellence and quality service” as the heart of what we do and how we do it. We believe the objective, measurable quality of organizational performance and customer service, will be the differential advantage in care delivery.

An integrated outcomes system-wide process to improve organizational quality/performance results in improved patient safety and cost savings. Innovation and creativity are central themes of this effort. Although regulatory requirements must be met, the motivation behind our process development is our desire to continuously improve the services we deliver to our customers. A collaborative, cross-department effort to maximize patient safety, produce positive outcomes, increase customer satisfaction, and cost effectiveness drives our improvement efforts. We evaluate results in order to constantly improve our services and streamline our systems via the Clinical Effectiveness Committee.

Mission, Organization Values and Operating Philosophy

**MISSION**

[**Penrose-St. Francis Patient Safety and Care Plan, Part 1**](..%5CPSF%20PS%20and%20CP%20scope.doc)

**ORGANIZATION VALUES**

[**Penrose-St. Francis Patient Safety and Care Plan, Part 1**](PSF%20PS%20and%20CP%20scope.doc#corevalues)

**Operating Philosophy**

[**Penrose-St. Francis Patient Safety and Care Plan, Part 1**](PSF%20PS%20and%20CP%20scope.doc#philosophy)

Definitions

1. **Performance Improvement**: The continuous study and adaptation of functions and processes of a health care organization to increase the probability of achieving desired outcomes and to better meet the needs of patients and other users of services. Performance is what is done and how well it is done.

2. **Dimensions of Performance**: (Key Quality Characteristics - KQC)

The dimensions of performance represent characteristics of what is done and how well it is done*.* These dimensions are:

|  |  |
| --- | --- |
| 1. Efficacy
 | 1. Continuity
 |
| 1. Appropriateness
 | 1. Safety
 |
| 1. Availability
 | 1. Efficiency
 |
| 1. Timeliness
 | 1. Respect and Caring
 |
| 1. Effectiveness
 | 1. Customer Satisfaction
 |

3. **Scope of Care / Service**: Inventory of processes that make up a specified function, including activities performed by governance, management, clinical and/or support personnel.

Components of the Process

**Customer-Focused:** Our customers play an important role in helping us to improve our care and service. Information is regularly solicited, formally and informally, to assist us in making improvements.

**Goal-driven**: Performance Improvement is driven by goals and objectiveswhichflow directly from the Mission, Core Values, Vision, and Strategic Plan.

**Flexible:** The quality/performance process evolves to meet the needs of our customers and the changing healthcare environment.

**Comprehensive**: The quality/performance improvement process includes the ability to look at both individual departments / services and interdisciplinary cross-department processes and outcomes.

SECTION 2: SCOPE

Scope of Quality/Performance Improvement Activities

Penrose-St. Francis Health Services is comprised of a comprehensive network of diagnostic and therapeutic services. All participate in Quality/Performance Improvement activities. Services are offered in the following settings:

* Inpatient
* Ambulatory Care
* Outpatient

**Key strategic areas have been identified as follows:**

* Cancer
* Medical/Surgical
* Cardiology/Pulmonology
* Wellness/Prevention
* Rehabilitation
* Maternal/Child
* Behavioral Health
* Critical Care (Urgent, Emergent)

 Individual department / service develops written goals / objectives and scope of services pertaining to their area(s).

Goals and Objectives

* Base improvement activities on customer feedback.
* Assess systems and processes of care and service to identify opportunities for improvement.
* Demonstrate cost savings as a result of organizational quality/performance activities.

(See Appendix A for process for PI)

Responsibility / Accountability

**Everyone** at Penrose-St. Francis Health Services is responsible for continuous quality/performance improvement and patient safety.

**Leadership** –

* The Community Board has the ultimate responsibility for the quality of care provided to patients at Penrose-St. Francis.
* The Community Board has delegated to the Medical Executive Committee the responsibility for assuring that Quality Improvement throughout Penrose-St. Francis physician community is accomplished in an effective manner.
* The Community Board has delegated to the Clinical Effectiveness Committee (CEC - a leadership team comprised of members from the governing body, senior administration, medical staff, and nursing leaders), responsibility for prioritization and monitoring progress to results, including setting deadlines and removing barriers, for all quality improvement activities. The CEC is responsible for the organization-wide patient safety and care plan.
* Community Board, Medical Staff, Nursing, Ancillary, non-nursing support, and Administrative leadership are involved in quality/performance improvement activities.

**Department Directors and Medical Staff Department Chiefs** –

Department Directors and Medical Staff Department Chiefs are responsible for improvement activities and patient safety issues related to their department.

* Directors are responsible for being actively involved in PI activities including setting goals, selection and prioritization of activities, implementing actions, monitoring results, and communicating results to the appropriate people.
* Medical Staff Department Chiefs are responsible for monitoring the quality of patient care provided by members of their department. Those in management positions are responsible for participating in cross-department quality/performance improvement activities and for providing time for staff participation.

**Hospital Departments / Services** –

Departments / services are responsible for demonstrating participation in PI activities. Each department / service is responsible for establishing good documentation records from PI team activities and from any department specific measures. Minutes, reports and improvements are documented in each team. It is the responsibility of each team member to assure that they receive copies of these documents for inclusion in their department manual for PI activities.

SECTION 3: APPROACH

Priorities for Quality/Performance Improvement Activities

Performance Improvement project requests are managed by the Facility Six Sigma Black Belt/Process Improvement Facilitator. Priority of process improvement projects is set using a project funnel according to the following criteria. Requests for process improvement come from CEC, Hospital Leaders, Department Directors and Medical Staff Department Chiefs and Hospital Departments/Services. Opportunities for improvement that affect one or more of these criteria set by the CEC are prioritized for action/follow-up. Priority will be assigned to issues that impact the following areas (these items are NOT listed in any priority order):

* Mission and Values of Penrose-St. Francis and Centura Health
* Customer Service / Community Perception
* High Risk
* High Volume
* Problem-prone
* Patient and customer Safety
* Results demonstrating variation from other healthcare organizations
* Regulatory/Accreditation concerns
* Charges/cost/reimbursement
* Health promotion/education and Prevention
* Physician Satisfaction Patient Satisfaction
* Associate Satisfaction
* Financial Impact

The CEC will be responsible for setting specific quality/performance goals each year based on these priorities. When reviewing and setting priorities, the CEC, in addition will consider emerging needs such as those identified through data collection and assessment, unanticipated adverse occurrences affecting patients, changing regulatory requirements, significant patient and staff needs, changes in the environment of care, or changes in the community. These goals are communicated to the Facility Six Sigma Black Belt/Process Improvement Facilitator so that they may be incorporated into the prioritization of projects meeting these goals and so that the appropriate facilitator (Black Belt, Green Belt or Master Change Facilitator) can be assigned.

Approach to Quality/Performance Improvement

Centura Health and Penrose St. Francis Health Services have adopted Lean/Six Sigma as the main approach to process/performance improvement. Other methodologies such as Rapid Decision Making and FOCUS PDCA (Find a Process, Organize a Team, Clarify the process, Understand sources of variation, Select an improvement, Plan, Do, Check, Act) are utilized for less complex, non-data-driven projects. These methodologies provide a systematic approach to improvement. Staff orientation to this process is done through the Clinical Effectiveness department by the Six Sigma Black Belt/ Process Improvement Facilitator. This model is the basis for all improvement processes and is described as follows. The Six Sigma Black Belt/Process Improvement Facilitator, in conjunction with Centura Health Process Improvement Department, provides education for methodologies in this approach and may also provide consultation and project management for performance and process improvement opportunities while facilitating the most complex projects in the project funnel. Education for Six Sigma includes certification of associates as Six Sigma Green Belts strategically placed throughout the hospital who can facilitate process improvement projects within their own departments as part of their normal job functions.

SECTION 4: PLANNING and DESIGNING

In order to provide strategic planning of performance improvement activities, each department / service of the hospital is required to develop a plan to guide their improvement efforts. Input is obtained from the medical staff when appropriate.

A business plan and a PI plan is required of a new department/ service prior to commencing operations.

These plans include the following elements.

* **Responsibility** for improvement activities in the department/service
* **Scope of services**
* Identification of any **Patient Safety Issues**

and plans to address those issues including:

* Information from within the organization

and from other organizations about

potential risks to the patients, including

the occurrence of sentinel event in

order to minimize risks to patients

affected by the new or redesigned

process, function or service.

* **Assessment** of the needs of individuals served, staff and others
* **Goals** (should be consistent with Business Plans and stated goals/objectives
* Definition of **key processes and outcomes** for that department/service
* **Departments and services that impact** the department/service
* **Department-specific indicators**

The QI Department works with the department / service to create and revise the Plan as needed.

SECTION 5: STRUCTURE

**COMMUNITY BOARD:**

The Community Board routinely reviews summarized results of quality/performance improvement activities. This information includes but is not limited to:

 Any new problems

 Developing trends / patterns

 Identified areas for improvement

These leaders meet approximately every two months to:

* Assure processes are in place that encourage quality and safe patient care
* Assure ultimate accountability for the organization's quality/performance improvement activities
* Review priorities, results, activities, policies and plans recommended by the CEC
* Assure compliance with TJC Standards and expectations
* Review and discuss risk management issues and information.
* Measure and assess the effectiveness of their own contributions to improving performance and improving patient safety.

**MEDICAL EXECUTIVE COMMITTEE**:

The Medical Executive Committee reviews the summarized results of medical staff peer review and quality/performance improvement activities. These activities are reviewed according to a planned reporting schedule.

**CREDENTIALS COMMITTEE:**

The Credentials Committee meets monthly to review the training, education, competency and privileges of the Medical Staff. Each Department Chief makes recommendations to the Credentials Committee for appointment and reappointment based on evaluation of peer review, quality/performance, and outcomes data. A Credentials Committee member also reviews the file, recommendations, quality/performance data and makes a recommendation to the Board regarding the appointment or reappointment.

**MEDICAL STAFF DEPARTMENTS:**

The Medical Staff is organized into departments to monitor and improve patient care. In addition, the medical staff is involved in various Performance Improvement Teams in the organization.

**Medical Staff Peer Review:**

The Medical Staff is involved in monitoring and evaluating clinical care. Refer to the list of current Peer review committees and the Medical Staff Rules and Regulations located in Medical Staff office.

**The CEC**:

The Clinical Effectiveness Committee is comprised of members of the Community Board, Senior Administration, Medical Staff, Quality Improvement, and Nursing leaders. These leaders meet on a regular basis, usually monthly, to:

* Set priorities for improvement activities in the organization.
* Review quality indicator data and send information to Centura Health to improve quality of care across the continuum.
* Provide a system for overall evaluation of the quality/performance of care in the organization.
* Assign responsibility for follow-up with specific time frames.
* Establish, ensure implementation and monitor an integrated patient safety program throughout PSF.
* Assure comparable care is given to patients with similar diagnoses or procedures.
* Remove barriers to improvement including financial and cultural barriers.
* Assure the organization is in compliance with TJC and other regulatory agencies.
* Receive and discuss risk management reports, issues and information (see Section VI).
* Assess the adequacy of the allocation of human, information, physical, and financial resources in support of their identified performance improvement and patient safety improvement priorities.

Annually, CEC is also responsible for:

* selection of at least one high-risk process for proactive risk assessment,
* selection to be based, in part, on information published periodically by the Joint Commission that identifies the most frequently occurring types of sentinel events and patient safety risk factors
* evaluation shall include:
* assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation (“failure mode”)
* for each “failure mode” identification of the possible effects on patients and how serious those possible effects could be to the patient
* for the most serious effects, a CEA will be conducted to determine reasons for the variation
* a possible redesign of the process to minimize the risks and protect patients
* a test of the redesign
* where the redesigned process is warranted - implementation and measurement of the effectiveness of the redesign and on-going review of the effectiveness of the redesigned process
* Review data/recommendations from the Patient Safety Sub-Committee.

**Accreditation Readiness Group(ARG)** is comprised of Senior Administration, Directors, Managers, and Quality Improvement Staff. It exists as a forum for multi-disciplinary discussion for coordination of regulatory and accreditation standard compliance.

* report recommendations to the CEC, MEC and Community Board.
* Maintains a constant state of regulatory readiness
* Information is disseminated to individual departments to ensure compliance with regulatory standards.

Refer to the Regulatory Readiness Plan for details

**Nursing Council:**

The Nursing Leadership Council functions as a decision making body, evaluating the practice of Nursing and making recommendations in regard to delivery of direct patient care services across the continuum. Core membership consists of Directors or other representatives from Nursing, Respiratory Care, Care Management, Human Resources, Infection Control, Risk Management, Educational Resources, Perioperative Services, St. Francis Out-Patient Services and Information Services. Laboratory, Radiology, and Pharmacy are included in the council as needed.

Nursing Council is responsible for the development, implementation and periodic review of the hospital's Plan for Providing Patient Care, assuring input and coordination with other patient care services.

Nursing Council is responsible for coordinating consistent quality of care and practices between all PSFHS campuses.

**HOSPITAL DEPARTMENTS / SERVICES:**

Hospital departments / services participate in a systematic process for quality/performance improvement. The process is flexible and allows a department / service to monitor department-specific indicators and to participate in cross-departmental teams.

Structure for Quality/Performance Improvement

**Clinical Excellence Teams (CET):**

Clinical Excellence Teams focus on patient care, service and safety within a particular service line. These teams focus on improvement of care / service in their areas. Activities are reported to relevant committees, leadership, and posted in unit on a regular basis.

**Ad Hoc Performance Improvement Teams:**

PI Teams are formed to improve a particular process. When the goals are met, the team is disbanded. Staff who are most involved in the process or outcome participate.

SECTION 6: PATIENT SAFETY/RISK MANAGEMENT

Summary

This plan describes the intent of Penrose – St. Francis Health Services (PSF) to provide care to patients in a safe and effective manner. The PSF organization fosters a culture which encourages the patient, patient’s family and significant others, associates, volunteers and medical staff to participate in maintaining safe patient care and in improving the safety of patient care delivery when opportunities are identified.

Penrose – St. Francis Health Services Patient Safety/Risk Management Plan is in place to accomplish the following:

1. Recognize, prioritize and address risks of patient safety related to medical or health related occurrences.
2. Initiate actions to reduce these risks.
3. Monitor and measure the effectiveness of the actions.
4. Support a mechanism for reporting the findings and the actions taken.
5. Focus on processes and systems.
6. Minimize placing blame on individuals involved in a medical/health care occurrence.
7. Establish a culture in which associate reporting of occurrences will not result in personal corrective action against them unless the investigation indicates the occurrence was a result of the individual’s failure to follow the established practices and/or protocols, or demonstrates at risk behavior.
8. Support the sharing of lessons learned to effect changes throughout the system.
9. Provide organizational education about occurrences.
10. Provide follow-up support to staff involved in occurrences as deemed appropriate.
11. Ensure disclosure to patients/families about the results of care, including unexpected outcomes.

Scope

This plan applies to the patient population, visitors, associates, volunteers and medical staff. The Patient Safety/Risk Management Plan addresses maintenance and improvement in patient safety issues in every department throughout the facility with an emphasis on the following hospital and patient care functions of:

• Patient Rights

• Assessment of Patients

• Care of Patients

• Patient/Family Education

• Continuum of Care

• Leadership

• Improving Organization Performance

• Management of Information

• Management of Human Resources

• Management of the Environment of Care

• Surveillance, Prevention, and Control of Infection

Plan

**Multi Department Participation**

Patient safety is a collaborative effort between all departments and disciplines that collaborate to establish the plans, processes, and mechanisms of the patient safety activities at PSF. The Patient Safety/Risk Management coordinator is responsible for the plan oversight along with the Patient Safety officer and Director of Clinical Effectiveness. The plan is derived from priorities set by the Centura and PSF strategic plans, Centura Quality plan, Risk Management incentive plans, IHI initiatives, National Patient safety goals, culture of safety surveys, and other patient safety initiatives

Plan Coordination Responsible

1. Administration
* Promote a just culture that encourages reporting of occurrences without retaliation toward the individuals involved.
* Ensure that patient safety issues are given a high priority and addressed when processes, functions, or services are designed or redesigned.
1. Patient Safety/Risk Management Coordinator, Chief Medical Officer (Patient Safety Officer), Chief Nursing Officer and Clinical Effectiveness Director:
* Develop the plan
* Act as administrators of the plan
* Provide education and training for the implementation of the plan
* Provide ongoing education in patient safety and critical event analysis for all associates
* Participate in and utilize FMEA for high risk processes
* Oversee the Cause Analysis activities ( Critical Event Analysis or Apparent Cause Analysis) in occurrence investigations
* Analyze occurrence reporting data and communicate the system actions to the CEC and the Patient Safety Committee.
* Coordinate evaluation of the effectiveness of the plan by doing periodic audits and surveys
1. All departments
* Provide education to patient, patient families, and significant others about their part in helping ensure patient safety
* Report and document patient safety occurrences
* Participate in follow-up activities to improve the process(es)
* Clinical Effectiveness Council/Patient Safety Committee
* Multidisciplinary committees which oversee patient safety initiatives
1. Medical staff
* Practice safe medicine
* Notify and disclose to the patient, patient family or significant other when an occurrence has occurred and explain what, if any, effect the occurrence has on the patient’s course of treatment.
1. Governing board and MEC
* Endorse and support the patient safety program

**Data Sources**

Patient safety or medical/health care issues may include data analysis from:

1. Patient assessment/documentation
2. Medication administration
3. Adverse Drug Reaction
4. Transfusion Reaction
5. Patient falls
6. Security
7. Surgery
8. Hazardous Conditions
9. Any set of circumstances, exclusive of the disease or condition for which the patient is being treated, which significantly increases the likelihood of a serious physical or psychological adverse patient outcome
10. Restraints
11. Other incident reports

Reporting

**Internal Reporting**

All departments within the organization (patient care and non-patient care departments) are responsible for reporting patient safety occurrences and potential occurrences to Patient Safety/Risk management by following the PSF occurrence reporting process.

Patient Safety/Risk Management and CE Staff will aggregate occurrence information and periodically present a report to the CEC and Patient Safety Committee. The report will contain aggregated information:

* Type of occurrence
* Severity of occurrence
* Number/type of occurrences per department
* Occurrence impact on the patient
* Remedial actions taken
* Patient outcome

The Patient Safety Committee will analyze the report information and determine further patient safety activities as appropriate.

**External Reporting**

External reporting will be performed in accordance with all state, federal and regulatory body rules, laws and requirements. Report adverse clinical events to the Centura Quality and Patient Safety Department.

**Risk Assessment**

**Risk Identification:** The collection of information about patient care occurrences and other situations presenting a potential loss to the system.

**Risk Analysis:** The evaluation of past experience and current exposure in order to assure appropriate remedial and preventative measures have been taken.

**Risk Control:** Respond to areas assessed as having significant risk to decrease the likelihood of an occurrence.

**Sentinel Events/Critical Issues:** Intense analysis of sentinel events or critical issues, as defined by TJC, will be conducted by the Chief Medical Officer, Chief Nursing Officer, Patient Safety/Risk Management and the Clinical Effectiveness Department with involved parties and departments. See Sentinel event policy(S-01-m)

**ProActive Risk Management**

The Patient Safety Committee will select at least one high-risk safety process annually for proactive risk assessment. The proactive risk assessment will include:

1. FMEA: Assessment of the intended or actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients, and how serious the possible effect on the patient could be
2. Cause Analysis: Conduct a Critical Event Analysis for the most critical effects, to determine the undesirable variation in process leading to an unanticipated outcome.
3. Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation.
4. Test and implement the redesigned process (including education of staff and physicians, as indicated)
5. Identify and implement measures of the effectiveness of the redesigned process
6. Implement a strategy for maintaining the effectiveness of the redesigned process over

 time

**Internal Notification**

Any individual in any department identifying a potential patient safety issue will immediately:

1. Notify his or her supervisor and document the findings on an occurrence report.
2. Submit the occurrence report to the Patient Safety/Risk Management Department per

 organizational policy

1. Communication to Senior Leadership regarding the event

**Administrative Response**

1. All sentinel events and near miss occurrences will have a cause analysis conducted.
2. The Patient Safety Committee will determine follow-up based on internal and external data analysis and the severity of the patient safety issue.
* Further remedial action activities
* Proactive occurrence reduction activities
* Necessity and benefit of cause analysis of the identified occurrences

**Non-punitive Approach**

1. Penrose – St. Francis Health Services has a non-punitive approach in its management of occurrences.
2. All personnel are *required* to report suspected and identified occurrences, and should do so without the fear of reprisal in relationship to their employment.
3. This organization supports the concept that occurrences happen due to a breakdown in systems and processes, and will focus on improving systems and processes, rather than disciplining those involved in occurrences.
4. A focus will be placed on corrective actions to assist rather than punish staff members.
5. Staff members, the Patient Safety Committee and the individual staff members’ department supervisor determine the appropriate course of action to prevent repeat occurrences.

**Staff Post-Incident Support**

1. The Patient Safety Committee encourages the staff member’s involvement in the cause analysis and action plan processes to allow the staff member an active role in process resolution.
2. Additionally, any staff member involved in a sentinel event or other occurrence may request and receive supportive personal counseling from the Employee Assistance Program, Human Resources Department and/or his or her department supervisor.

**Patient and Family Education**

1. Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care.

**Staff and Education and Training**

1. Staff will receive education and training during their initial orientation process and on an ongoing basis regarding job-related aspects of patient safety.
2. Training includes the need and method to report medical/health care occurrences.

Staff will be educated and trained on the provision of an interdisciplinary approach to patient care

Statutory Protection

Quality Improvement and Patient Safety/Risk Management activities are undertaken to evaluate and improve patient care and are, therefore, confidential and protected from discovery by Colorado Revised Statute 25-3-109. Peer Review and Attorney Client privilege is also extended with actions as appropriate.

SECTION 7: MEASUREMENT

Data Gathering and Measurement:

Data for quality/performance improvement activities is available from a variety of sources (See Appendix A for flow chart).

Data for each department / unit / CET is kept on file within the department and/or in the QI/CE/Patient Safety department. Department Directors, and CET team leaders communicate the information for which they are responsible to their respective directors and/or vice presidents and the CEC.

Each team reviews their data, identifies opportunities for improvement and communicates with the appropriate department, service, committee or team for further evaluation and action.

SECTION 8: EVALUATION

Annual Evaluation of the Performance Improvement Process

An annual evaluation of our quality/performance improvement process is an important component of assessing the effectiveness of the process. Feedback from the evaluation can assist us in revising and improving our program.

* A survey of customers is done periodically to gather information about their perception of the quality/performance of the hospital.
* CMS and TJC indicators are tracked and evaluated for evidence of measurable improvement and to identify process improvement opportunities..
* QI/CE staff are a resource for hospital and medical staff.

Appendix A

