

Improving Organizational Performance

<p>1. Question:</p> <p>What is the goal of improving organizational performance?</p>	<p>Answer:</p> <p>The goal of improving organizational performance is to ensure that the organization designs processes well and systematically monitors, analyzes, and improves its performance to improve patient outcomes. It involves measuring the functioning of important processes and services, and, when indicated, identifying changes that enhance performance.</p>
<p>2. Question:</p> <p>What planned systematic, organization wide approach has the Quality Leadership Team (QLT) implemented to monitor performance improvement?</p>	<p>Answer:</p> <p>Each Clinical and Support Department develops a scope of service which is updated annually. Each year from January to December the department/ clinic/unit monitors performance indicators to measure the actual performance based on their scope of service. Monthly data is submitted to the Quality Management Department. Quarterly, the Quality Management Department compiles the data and submits the report to the Quality Leadership Team for review. If an indicator does not meet the expected level of performance, the Supervisor/Department Head submits a plan of action to be implemented to improve performance. Quarterly, results of each indicator monitored are submitted to each Clinical Chief and Medical Director for review and inclusion in maintaining performance.</p> <p>Annually, each area submits a review of all performance activities. The report includes a review of the past years performance and what goals are to be set for the next year. These are compiled into a report to reflect the impact on patient care as it relates to operational improvements, financial risk, and risk related improvements.</p>

<p>3. Question:</p> <p>How does the Performance Improvement (PI) Plan demonstrate collaboration and/or other disciplines?</p>	<p>Answer:</p> <p>Quarterly, as the Quality Leadership Team reviews their respective areas of performance, problems or areas that need to be improved are identified. If internal, the department/unit/clinic may develop an action plan which may include the appointing of a team of employees within the department to investigate the problem and determine how it can be improved.</p> <p>If the problem or area that needs improving involves many departments, a cross functional team may be appointed by the Quality Leadership Team to research the identified area or problem and recommend actions to implement to correct the problem.</p>
<p>4. Question:</p> <p>How are performance expectations established for the indicators selected to be monitored?</p>	<p>Answer:</p> <p>Performance expectations are established through many ways, including past performance, benchmarking with other facilities, using national or associational measures of outcomes, etc.</p> <p>Also, indicators selected to be measured are based on the services an area provides, and/or activities that are high volume, problem prone, high risk or high cost. Hospital Administration has asked that all departments monitor one indicator related to patient safety if applicable.</p>

<p>5. Question:</p> <p>Can you define sentinel event and give an example? What do you do in case of a sentinel event?</p>	<p>Answer:</p> <p>A sentinel event is an event that has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.</p> <p>Examples might include, suicide of a patient, infant abduction or discharge to the wrong family, rape, hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, surgery on the wrong patient or wrong body part, equipment malfunction resulting in paralysis or loss of life, medication error resulting in death or near death, nosocomial infection resulting in unanticipated death or major permanent loss of function, etc.</p> <p>In case of a sentinel event, you notify the Quality Management Department (Ext. 5030) immediately. The staff of Quality Management investigates the event and completes a root cause analysis.</p> <p>The Hospital Medical Director and the Hospital Administrator review the root cause analysis and determine if the event should be reported to the JCAHO.</p>
<p>6. Question:</p> <p>How are Medical Staff included in performance improvement?</p>	<p>Answer:</p> <p>Medical Staff serve on appointed teams and have their departmental peer review activities which may identify operational issues which are referred to Hospital Administration or the appropriate department for resolution. Medical Staff also serve on Hospital Committees which provide recommendations in policy development and monitoring of activities as appropriate.</p>

<p>7. Question:</p> <p>What processes are measured hospital wide? Who reviews the results?</p>	<p>Answer:</p> <p>Quarterly, the Quality Leadership Team reviews reports monitoring hospital wide performance, such as, patient satisfaction, patient complaints, variance reporting, medication variances, etc.</p> <p>Specific indicators reported by departments and reviewed quarterly would include conscious sedation, code survival rates, and restraint management.</p>
<p>8. Question:</p> <p>What are Core Measures?</p>	<p>Answer:</p> <p>Core Measures are diagnosis the JCAHO/CMS has established expected levels of performance when caring for patients. These include Congestive Heart Failure, Community Acquired Pneumonia, Acute Myocardial Infarction, Pregnancy and Related Conditions and Surgical Infection Prevention. Data on these 5 core measures is reported to the JCAHO/CMS through our approved vendor, the University Health System Consortium. Our performance is compared to other like institutions to ensure that we are providing care within the standard of acceptable practice as defined by JCAHO/CMS.</p>
<p>9. Question:</p> <p>What system do we use to report results meeting compliance?</p>	<p>Answer:</p> <p>The Coordinators in QM abstract the data and upload results quarterly. We use the Clinical Data Base from the University Health System Consortium.</p>

<p>10. Question:</p> <p>What core measures do we report?</p>	<p>Answer:</p> <p>Currently we report indicators related to three core measures. These include:</p> <ul style="list-style-type: none">-Congestive Heart Failure<ul style="list-style-type: none">Discharge instructions for CHF include level of activity, diet, medications, weight monitoring, and worsening of symptomsDocumentation of LVEF assessment done or planned post dischargeDocumentation of ACEI prescribed at discharge for patients with LVSD (LVEF < 40%)-Pregnancy and Related Conditions<ul style="list-style-type: none">Documentation of discussion of vaginal birth after Cesarean SectionDocumentation of causes of neonatal deathsDocumentation of third and fourth degree laceration for subsequent childbirth-Acute Myocardial Infarction<ul style="list-style-type: none">ASA prescribed upon arrivalASA prescribed at dischargeBeta blocker prescribed upon arrivalBeta blocker prescribed at dischargeTimeliness of intervention (Thrombolysis)Timeliness of intervention (PTCA)ACEI ordered at dischargeDocumentation of smoking history, cessation of smoking advice/counseling
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<p>11. Question:</p> <p>How has the hospital performed using these measures?</p>	<p>Answer:</p> <p>The results have been excellent. The Medical Staff Departments (primarily the Department of Medicine, Family Practice, Obstetrics & Gynecology and Emergency Medicine) involved have worked hard to improve their performance. Actions taken include the development of a standard discharge form for patients with CHF, revised Clinical Pathways, standing orders for those patients with pneumonia, pocket cards for House Staff to use as reminders, fliers posted on units, etc.</p>
<p>12. Question:</p> <p>What actions have been taken to improve performance based on these results?</p>	<p>Answer:</p> <p>Actions taken include the development of a standard discharge form for patients with CHF, revised Clinical Pathways, standing orders for those patients with pneumonia, pocket cards for House Staff to use as reminders, fliers posted on units, etc.</p>
<p>13. Question:</p> <p>How does the hospital collect data on indicators for all departments?</p>	<p>Answer:</p> <p>All departments select indicators based on the scope of services provided. We use the JCAHO 4 Step Cycle for Improving Organizational Performance, Design, Measure, Assess and Improve. Each month departments submit their performance results to QM. If performance does not meet the expected threshold an action plan is submitted to demonstrate how the department will improve performance. The Quality Leadership Team, the department's respective administrator, reviews quarterly results and actions taken to improve performance are discussed. If problems are identified that cross functional lines the QLT may appoint a team to research and make recommendations to improve performance.</p>

<p>14. Question:</p> <p>Does the hospital collect data on the perceptions of care, treatment, and services of patients?</p>	<p>Answer:</p> <p>The hospital collects data through Patient Satisfaction Surveys to determine if services provided are meeting the needs of our patients. The survey results include if we met their specific needs and expectations, patient safety and effectiveness of pain management.</p>
<p>15. Question:</p> <p>Is data collected that measures performance on potentially high risk processes, including medication management, blood and blood products, restraint use, seclusion use, operative and other invasive procedures, resuscitation and its outcomes, risk management, utilization review, quality control, infection control surveillance and reporting, research and autopsies.</p>	<p>Answer:</p> <p>Each of the elements listed are monitored and reported as follows:</p> <ul style="list-style-type: none"> -Medication Management is monitored through the Pharmacy and Therapeutics Committee, Antibiotic Committee, and monthly reporting of variances. -Blood and blood products use is monitored through the Blood Utilization Review Committee. -Restraint Use and Seclusion Use are monitored by all departments via Performance Improvement. Performance is reported monthly and submitted to the Quality Leadership Team quarterly. We also participate in a benchmarking study coordinated by UHC on restraint and seclusion. Results are reported quarterly to Nursing and the QLT. Operative and Other Invasive Procedures are monitored via the Operative and Other Invasive Procedure Review Committee. The committee reviews invasive procedures and diagnosis based on pathology reports preoperatively and postoperatively to ensure compliance with the applicable standards. -Risk Management is monitored through variance reporting monthly and quarterly to the Clinical Board. -Utilization Management is monitored via the Utilization Review Committee to ensure resources are used appropriately.

	<ul style="list-style-type: none">-Quality Control is used in the applicable departments, such as, sections in the Clinical Lab, Nutritional Services, etc.-Infection Control Surveillance is performed on a regular basis by the Infection Control Department and reported to the Infection Control Committee and the Clinical Board.-Research is monitored by the Investigational Review Committee (IRB) to ensure compliance with the applicable standards.-Autopsies are monitored on a regular basis and reported to the Clinical Board monthly.
<p>16. Question:</p> <p>How are data systematically aggregated and analyzed?</p>	<p>Answer:</p> <p>Data collected monthly by all departments is reported to the Quality Leadership Team quarterly. Results are compared internally overtime or to an outside source as appropriate.</p>
<p>17. Question:</p> <p>How is undesirable performance addressed?</p>	<p>Answer:</p> <p>When undesirable performance is identified action are taken to improve performance. A department may develop an action plan; policies may be reviewed and revised, teams appointed, etc. Performance continues to be monitored to ensure performance is improved.</p>

<p>18. Question:</p> <p>How is analysis in performance improvement accomplished?</p>	<p>Answer:</p> <p>Analysis is performed by each department when comparisons indicate that levels of performance, patterns, or trends vary substantially from those expected. All departments monitor and report conscious sedation, restraint and seclusion and one patient safety monitor as it relates to the scope and services provided by the department. All confirmed transfusion reactions are reviewed by the Blood Committee and actions taken as appropriate. Serious adverse drug events are reviewed by the Pharmacy and Therapeutics Committee and appropriate actions are taken when identified. The Operative and Other Invasive Procedure Review Committee monitor discrepancies between preoperative and postoperative diagnoses and actions are taken when problems are identified. Conscious Sedation is monitored hospital wide. When adverse events occur the case is reviewed and actions taken as appropriate. The Environment of Care Committee (previously known as the Safety Committee) monitor hazardous conditions as a part of the Hazard Management Plan. Actions are taken as appropriate when issues are identified. The Quality Leadership Team reviews staffing effectiveness quarterly. Four indicators are monitored for all departments. These are, Patient Complaints, Employee Injuries, Patient Falls, and Employee Turnover. Actions are taken when issues are identified.</p>
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<p>19. Question:</p> <p>What processes are in place for identifying and managing sentinel events?</p>	<p>Answer:</p> <p>LSU has adopted the JCAHO definition for sentinel event. The definition basically includes any death or serious injury-permanent dysfunction that occurs to a patient because of an action taken that would not have otherwise occurred.</p> <p>All sentinel events, as with all variances, are reported within the shift of occurrence. When a sentinel event occurs Hospital Administration is notified immediately. The Medical Director and Hospital Administrator decide if a Root Cause Analysis (RCA) is to be completed. QM coordinates the completion of the Root Cause Analysis when assigned using the JCAHO format. Risk reduction strategies are recommended in the RCA. Once accepted by the department and Hospital Administration risk reduction strategies are implemented. The Hospital Administrator notifies appropriate external agencies.</p>
<p>20. Question:</p> <p>How is the information used to improve performance and patient safety and reduce the risk of sentinel events?</p>	<p>Answer:</p> <p>When performance is not what is expected, whether department specific or hospital wide actions are taken as appropriate to improve performance. Patient Safety and the prevention of sentinel events is a hospital priority—processes involving these risk reduction strategies take priority. (Ask your respective Department Head for an example of an improvement. You must be able to provide one example) Once actions have been taken performance is continued for a minimum of 6 months to ensure expected results are maintained. If performance is not maintained other actions are taken to improve performance and monitoring continues to establish expected performance has been achieved.</p>

<p>21. Question:</p> <p>What proactive activities are taken to reduce risks to patients?</p>	<p>Answer:</p> <p>Several actions are taken by Hospital Administration and/or the Quality Leadership Team to reduce risks to patients. These include, but are not limited to the following:</p> <p>One high-risk procedure is selected annually and a team appointed to complete a Failure, Modes, Effects, Analysis (FMEA). These have been Marking of Surgical Sites and Pain Management and the use of PCA Pumps. The team describes the chosen process using a flow diagram and identifies potential breakdown steps. The team identifies when breakdowns could occur in the process or fail to perform its desired function. From the process flow diagramed the team identifies possible effects that a breakdown of failure of the process could have on patients and the seriousness of the possible effects. Potential process breakdowns are prioritized by the team. The team identifies why the prioritized breakdowns or failures could occur, which may include performing a hypothetical root cause analysis. The team redesigns the process or underlying systems to minimize the risk of the effects on patients. Recommendations include implementing steps to prevent the breakdown. Monitoring of the actions taken is completed as recommended by team in the FMEA analysis.</p>
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