PERFORMANCE IMPROVEMENT

Module 4

2016 Annual Orientation Program
Objectives

- The employee will be able to identify a sentinel event.
- The employee will be able to identify methods used to assist in performance improvement
  - Departmental Tracers
  - Performance Improvement Boards
  - HCHAPS Scores
  - Hospital Core Measures
- The employee will be able to identify areas they can improve customer service
- The employee will see that they are an important part of improving the patient’s experience at IMH
Sentinel Event

“A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. “

Administration Policy:
Sentinel Event

- The following are classified as sentinel events even if they are a “near miss” event.
  - Unanticipated death
  - Major permanent loss of function
  - Infant abduction
  - Infant discharged to the wrong family
  - Rape by another patient or staff
  - Hemolytic transfusion reaction
  - Surgery on the wrong patient or wrong body part
  - Health care associated infection

- Refer to the Administration Policy Manual for further review.

- Variance reporting and communication of unanticipated outcomes will be discussed further in Module 7
IMH has a performance improvement (PI) program. PI is defined as the continuous study of the organization’s functions and processes to increase desired outcomes to better meet the needs of individuals.

IMH has an organization wide PI Plan that is approved annually by the Medical Staff and Board of Trustees.

Departments have individual PI plans that help to implement the goals and objectives of safe, quality care across the organization.

Each individual is to be aware of the PI goals in their department as well as the overall improvement goals for IMH.
Risk Management/Patient Safety Review Committee

- The committee meets every other week to review variance reporting for trends and patient safety issues.
- The committee identifies an issue for process improvement and ensures that individuals involved in reporting receive feedback on those improvements.
- This is a non-disciplinary committee focused on improving patient care at Iroquois Memorial Hospital.
- If the committee finds an area for improvement the variance report is assigned to a key person who will then review it with either the employee or the department director to address any additional concerns and if needed implement lean tools.
Performance Improvement

What is a lean tool?

- A process that proactively identifies potential weaknesses in a process to achieve performance improvement targets and eliminate wasteful practices in any customer service environment.
- Focuses on respect for all people as well as continuous performance improvement.
- The following processes follow the same basic structure:
  - Observing the problem first hand in order to understand it
  - Mapping out the current process visually
  - Imagining or looking into ways the process can be improved for the problem being addressed
  - Creating an action plan, implementing and tracking results
Performance Improvement

**Plan-Do-Check-Act (PDCA) Process**

- **PLAN:** Identify and create a plan for change, define steps needed to make the change and predict the results.
- **DO:** Solutions are implemented on a trial or pilot basis.
- **CHECK:** The results are evaluated before the solution is fully implemented, if it is deemed that the trial has failed the process is started again.
- **ACT:** The process is fully implemented.
FMEA is a procedure for analysis of potential failure modes for classification by severity and likelihood of the failures.

FMEA helps a team to identify potential problems for each step of a process based on past experience, enabling the team to design those problems out of the system.

A FMEA asks:
- What steps are in the process?
- What could go wrong?
- Why would the failure happen?
- What would be the consequences of each failure?
Performance Improvement

Root Cause Analysis (RCA)

- A Root Cause Analysis (RCA) is a structured performance improvement tool that helps to identify what went wrong and why.
- A RCA looks at the systems and processes where the error occurred and not individuals that were involved in the error.
- Looks at where errors occur between humans and the healthcare system.
- Looks at hidden problems that may contribute to events.
Our goal at IMH is to provide excellent, safe, quality care for all patients.

In order to provide this care, IMH encourages all employees to use the non-punitive internal reporting process for quality care concerns.

See IMH Administrative Policy Manual:

- NON-PUNITIVE REPORTING OF ERRORS AND EVENTS
- COMMUNICATING UNANTICIPATED OUTCOME
- CHAIN OF COMMAND The chain of command policy enables anyone to question treatment that might be questionable without fear of retaliation.
Performance Improvement

Departmental Tracers

- Directors/supervisors are assigned a department to survey every quarter. Once a month for 3 months the person surveys the unit.
  - Month 1 – Unit is surveyed, findings are documented, a copy is given to the department director and the PI Director
  - Month 2 – Unit is surveyed, Findings from month 1 should be corrected, if not, the surveyor and the director talk to see what the stumbling blocks/barriers are, findings are documented, copies given to department director and the PI Director.
  - Month 3 – The unit is surveyed, findings documented, If problems are not corrected copies are sent to the department director, the PI Director and the VP of that unit.
- Every person is then assigned a new department to survey for the next 3 months.
- These efforts are to help us be in continuous readiness for a Joint Commission Survey.
Hospital Quality Initiatives or Core Measures focus on performance improvement in the following areas:

- Acute Myocardial Infarction
- Heart Failure
- Surgical Care Improvement Project
- Immunizations
- Patient Satisfaction
- Stroke
- Venous thromboembolism (VTE)
- Colonoscopies
- Sepsis
This data is obtained during the patient intake or initial interview.

There are certain treatments identified per diagnosis to improve the patient’s outcome for both inpatients and outpatients.

Guidelines for each of the conditions listed are driven by evidence based practice.

These guidelines ensure every patient is treated appropriately with interventions proven to improve/manage the acute and chronic illness and reduce morbidity.

In addition there are components that need documented to meet “meaningful use” of the electronic health record associated with these core measures.
IMH has been asked to participate as a small rural hospital in:
**Illinois Surgical Quality Improvement Collaborative (ISQIC)**
- Part of American College Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP)
  - Tracks data of pre-op risks per patient
  - Tracks data of intra-operative data per patient
  - Follows the patient post-operatively for 30 days:
    - It is a research project to identify areas of needed improvement
    - Plans and processes will be put in place as needed to improve patient care

These types of studies contribute towards Centers for Medicaid and Medicare Services (CMS) core measure guidelines.

Blue Cross and Blue Shield has provided IMH with a grant to cover expenses incurred during the project.
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

“a standardized survey instrument and data collection methodology for measuring patient’s perspectives of hospital care.”

This is a nationally used report that is then refined by the Center for Medicare and Medicaid Services (CMS) to match IMH’s patient population.

These scores are publically reported
Why do we look at patient perception scores?

To see how the patient’s perception of services compare in relation to other industries in the area in order to improve customer service.

To identify areas in patient safety that from the patient’s perspective need improved i.e.:

- Nurse & Provider communication
- Response to needs expressed
- Pain management
- Medication education
- Cleanliness
- Noise
- Discharge education
- Likely hood to recommend
How do we rate?

reduce noise
communication
hourly rounding
cleanliness

pain management
discharge phonecalls
discharge instructions
staff responsiveness
customer service training
leadership rounding
responsiveness of staff
communication with nurses
hcahps scores
bedside shift report
safety
excellence
discharge process
communication about medications
purposeful rounding
overall rating
discharge phone calls
quiet at night
communication with doctors
employee education
employee satisfaction
leadership rounding
nurse leader rounding
nurse communication
physician communication
advisory council
call light response
nurse leader rounding
service recovery
access
advisory council
elderly care
HCAHPS scores are posted quarterly on the IMH Intranet webpage under “HealthStream” on the left hand side of the screen.

Scores are also posted on department PI boards.

It is important for the employees to know their departments score.
We Set the Standards High

- We expect very high levels of satisfaction on customer surveys.
- Scores we want: Always, Definitely Yes, Strongly Agree, 10!
Iroquois Memorial Hospital Scorecards

- Quality and Patient safety data submitted for performance improvement is compiled into a viewable document.
- It is updated monthly and quarterly depending on indicators tracked.
- This is also found on the Intranet under PI ScoreCard

PI ScoreCard
YOU KNOW YOU’VE MADE AN IMPRESSION WHEN...

YOUR name ends up in the comment section of a patient survey!

Leaders notice! When your name is mentioned in a survey or by a member of the leadership team in morning huddles you might receive a little thank you or see your name in the Good News bulletin.

NEW 2016: Wall of Fame
References

- Iroquois Memorial Hospital and Resident Home Administration Policies and Procedures Manual
- Iroquois Memorial Hospital and Resident Home Human Resources Policies and Procedures Manual
- http://app.ihi.org/Workspace/tools/fmea/