QUALITY PLAN

Overview (philosophy):

This Quality Plan supports the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance. Initiatives are intended to attain optimal resident outcomes and resident and family experience, enhance appropriate utilization and minimize risks and hazards of care. The Plan is intended to provide a framework of guiding principles for all members in the facility. This structure will set the expectation and encourage staff to participate proactively in an ongoing improvement process.

I. Mission:

Our Mission is to provide a hospitable haven to all elderly citizens regardless of religious or natural background, so each person can experience a high quality of life.

II. Vision:

Board of Directors
It is the duty of the Board of Directors to assure that resident care and services are safely delivered within the guidelines established by the medical director and leadership while meeting all standards and regulations. The effectiveness of quality improvement activities is reported to the Board of Directors and evaluated at regular intervals.

Performance Improvement Committee
Composition of the inter-disciplinary Performance Improvement Committee is determined by a facility Administrator or CEO. The composition of this committee is defined in the performance improvement plan and re-evaluated no less than annually. An ideal composition includes the Board Chair, a Board member, at least one lay person the from the community, the CEO/Administrator, CNO, CMO (if on staff) or Medical Director(s), physician champions, Director of Risk and/or Quality, Director(s) Nursing, Department Chairs/Directors, Director of Pharmacy or other pharmacy representative, Dietary, Housekeeping and Maintenance representatives. The goal is to assure representation for each discipline and department on the committee.

The meetings of this Committee include review of data and sharing of best practice(s). The function of this committee is identification and removal of barriers to improvement, continued readiness, and operational improvement
in systems and processes of care and services and improvement in satisfaction and safety.

a) Planning, Measuring and Managing
Department supervisors review information relevant to individual staff performance and an improvement strategy, such as education, determined as necessary. Documentation of this action will be maintained in individual employee files by the Department supervisors and utilized in the performance evaluation process through human resources, not the performance improvement committee or functions of this committee.

Interdisciplinary QI /PI Teams
These multi-disciplinary teams are approved by the Compliance and Quality Committee after an assessment and prioritization of organizational needs and resources. Teams may be used to study processes, design new processes and make improvements in current processes consistent with/based on evidence based guidelines, best practices or by identification and eliminating root causes of identified problems.

QI/PI teams use the Plan, Do, Check/Study, Act (PDCA) methodology. Each team should have a leader and separate facilitator. Teams will be given a defined goal indicating their objective, a statement of the problem, an expected outcome(s), constraints, and a reporting schedule to the respective oversight committee(s). Upon completion of the team’s goal, teams will present a summation of their work to the relevant area and oversight committee(s). Team recognition occurs via leadership and the quality oversight structure.

Departmental Quality Improvement
Departments develop interdisciplinary measures of quality and safety in conjunction with the appropriate other disciplines. Departmental QI may include the identification of high-volume, high-risk, or problem-prone aspects of care, treatment, or services, and the development of measures that are objective, clinically valid, and measurable for use in the evaluation of care, treatment, and services provided. These measures may be process or outcome oriented. Some measures may be focused toward sentinel events requiring 100% review. Others may be sampled based on results of previous monitoring and evaluation activities. Sampling guidelines per the accreditation standards will be utilized as appropriate to assure statistically valid sampling is utilized. Clinical and ancillary departments are responsible to maintain a binder with the Quality/Patient Safety Program/Plan, any departmental quality plans or tools, and reports with completed back-up data collection tools. All Departments are encouraged to use statistical process tools for use in analysis and display of data for identifying patterns and trends. Departments are to maintain quality improvement information in a location for ongoing staff review. Departments are encouraged to maintain improvement
information in a location for ongoing resident and visitor review. Summary reports of departmental QI activities will be provided.

III. IDENTIFICATION AND PRIORITIZATION OF OPPORTUNITIES AND INITIATIVES:

Balancing the ongoing desire for improvement in multiple areas with the reality of limited resources requires criteria for determining which initiatives to prioritize. The Compliance and Quality Committee will use the following criteria to identify and prioritize quality initiatives in the organization using the following criteria:

a) Incident Reports
b) Sentinel Events
c) High volume/problem prone/high cost.
d) Low volume/high risk-problem prone/high cost
e) Top ten Medical Conditions as defined by the Institute of Medicine (and applicable to residential, assisted and nursing care provided)
f) Promotion of resident, visitor and employee safety issues
g) Initiatives consistent with mission values, strategic plan and direction
h) Availability of system resources to devote to project
i) Financial Risk

Clinical and Operational Priorities
A. CMS Clinical measures
   a) Achieve Top Quartile for Quality
      • Prevention of:
         o Skin Breakdown
         o UTIs
         o Weight Loss
         o Loss of bowel and bladder control
      • Maintain Functional Status/Independent with Activities of Daily Living
      • Infection Surveillance, Control and Prevention Program
         o Assess and administration of Influenza and Pneumococcal Vaccinations
      • Pain Management
      • Fall Prevention Program
         o Restraint Free Environment
      • Appropriate Use of Psychotropic and Antipsychotic medications
      • Antibiotic stewardship
   b) Create an Exceptional Experience
      • AHRQ or other eldercare/LTC validated survey of resident’s and family experience
• Within a year, make results available via a safe intranet site on a concurrent basis to all employees, appropriate physicians, residents and their family members.
• Additionally, telephone surveys, visiting residents via leadership and supervisory rounds and conducting focused satisfaction reviews as a part of measuring and assessing resident and family satisfaction may be completed.
• Complaints and/or quality of care or service concerns arising from the satisfaction survey process are tracked in accordance with the complaint and grievance policy and procedure.

c) Implement the Infection Surveillance, Prevention and Control Program
d) Additional specific process and outcome measures as defined by the Board of Directors, Administrator and/or Department Directors.

B. Service Infrastructure
   a) State regulatory compliance – 100% continuous readiness
   b) Safety
   c) Medication Safety
   d) Environmental Safety and Infection Prevention
   e) Measurement
   f) Top Conditions defined in A. above as priorities
   g) Communication

IV. Sources of Data for Performance Improvement:
   A. Administrative data (Ex. billing, CMS Interqual data, CMS MDS)
   B. Survey data
   C. Clinical data (Ex. assessment, medical record, clinical process and outcome)
   D. Reference Databases (Appendix A)
      a. local, state and national patient outcome database reports (including but not limited to State DHSS reports and National CMS reports) to compare performance with other facilities. This information will be utilized to determine opportunities or areas for improvement.

V. Data Collection, Analysis, and Reporting:
   A. Evaluation of collected data is completed to monitor and identify levels of performance, trends or patterns that vary significantly from the norm or that exceed threshold levels of acceptable performance.
   B. Data and findings will be reported to the appropriate quality and management groups and individuals on a monthly basis or more frequently as indicated.
   C. A Quality Dashboard will be created for use by management, the Compliance and Quality Committee and the Board of Directors.
   D. The State and national patient outcome database reports (including State and CMS reports) are used to compare performance with other facilities. This information will be utilized to determine areas for improvement and identify areas of success.
E. All quality committee minutes recorded within the organization will be documented utilizing the format to capture presenter of topic, findings/conclusions, recommendations/actions and timeframe for deliverables.

F. The Data Collection Plan should be clearly defined in each Initiative. Plans should include:
   - The period of time for data collection and reporting
   - Identify whether it is a concurrent or retrospective review. Whenever possible, incorporate concurrent data collection and analysis.
   - Sources of data for collection include, but are not limited to: electronic data bases, patient medical records, log books, surveys, direct observation, occurrence reports, complaints and grievances, and focus group discussions.
   - The appropriate population sample size. Sample size calculations are as follows:
     - Population of less than 30 = 100% of cases
     - Population of 30 to 100 = sampling of 30 cases
     - Population between 101 to 500 = sampling of 50 cases
     - Population of more than 500 = sampling of 75 cases

G. Prior to analysis, data must be validated by identifying the source(s) and process(es) for collection. Any analysis of data must be presented with a definition of the measure and identification of the type of measure (rate, ratio, raw number, etc.)

H. Aggregating and analyzing data allows the organization to draw conclusions about its performance specific to processes or outcomes. Analysis and comparison should include:
   - Performance compared internally over time (patterns/trends)
   - Performance compared with similar processes in other organizations
   - Performance compared to up-to-date external sources (benchmarking)
   - Control limits established for expected variation

I. Using statistical tools and techniques, data are systematically collected, aggregated for analysis, improve learning, and display. Data and analysis is used to:
   - Establish the performance baseline as the initial step in assessment and improvement activities
   - Determine the stability or instability of processes
   - Describe the dimensions of performance relevant to functions, processes, and outcomes
   - Identify opportunities where additional data is needed to better understand process or variation
   - Identify and celebrate successes

J. At a minimum, this organization collects and analyzes data on the measures listed below:
   - Medication safety and management
   - Utilization of restraints and seclusion
   - Operative and other procedures (ex. Wound debridement)
   - Resuscitation and its outcomes
- **Core +/or any other measures as required for public reported by the State and/or CMS**
  - Management of information including medical records
  - Staff perceptions, at a minimum:
    - Staff opinions and needs
    - Staff perceptions of risks to residents and suggestions for improving patient safety
    - Staff willingness to report unanticipated adverse events
  - Resident perceptions of care, treatment, and services. At a minimum:
    - Their specific needs and expectations
    - How well care and services meet their needs and expectations
    - The effectiveness of pain management in nursing care units
  - Infection prevention surveillance and reporting
  - Staffing effectiveness (ex. Turnover report)
  - Regulatory quality reporting requirements

**VI. Education:**

Education on improvement philosophy, strategies and tools in multiple venues throughout the organization will include:

- New employee orientation
- Formal management education in terminology, strategies and tools
- Team education on a “just-in-time” basis
- Regularly scheduled in-services open to all staff on use of tools and performance improvement processes and methodologies
- Departmental in-service programs tailored to meet the needs of a specific group
- “On the spot” education as a part of a project/department/unit meetings
- “Facilitator” training as appropriate

**VII. Evaluation/Review:**

Leadership annually reviews the effectiveness of the Quality Improvement Plan to ensure the effort is improving clinical outcomes, satisfaction, and safety. An annual evaluation is completed by the Compliance and Quality Committee and the Board of Directors to identify components of the plan that require development, revision or deletion. This evaluation will include the following:

- A description and evaluation of the role leadership played in the design and execution of the Quality Improvement Plan.
- Assessment of the key data trended with comparisons to the benchmarks, comparison and/or other best practices and the same data for the organization in the previous calendar year.
- Re-evaluation of the annual quality priorities
• The changes in processes or completed that were made as a result of the improvement activities
• An assessment of the costs or savings resulting from these changes (if applicable)
• Other evidence that the efforts are resulting in improvement or not
• A discussion of which specific initiatives to continue in the upcoming year.

Each year, specific goals will be attached to the above summary and approved for the following year.

The evaluation and goals for the following year are submitted to the Board on an annual basis. Review and discussion of the evaluation are noted in the minutes of the Board of Directors, in addition to the Board’s approval of the measures and quality goals for the following year.

VIII. **Confidentiality:**

All Quality Improvement activities and data are protected under the Health Care Quality Improvement Act of 1986. Patient Safety Organizations (PSOs) are a framework by which hospitals, doctors, and other health care providers may voluntarily report information, on a federally privileged and confidential basis, for the aggregation and analysis of patient safety events. A PSO's workforce must have expertise in analyzing patient safety events, such as the identification, analysis, prevention, and reduction or elimination of the risks and hazards associated with the delivery of patient care (see 42 CFR 3.102 for the complete list of requirements). Patient Safety Work Product (PSWP) is the information protected by the privilege and confidentiality protections of the Patient Safety Act and Patient Safety Rule. PSWP may identify the providers involved in a patient safety event, provider employee(s) that reported the information about the patient safety event, and patient information that is protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (see 45 CFR 160.103).

Confidential information may include but is not limited to:

• Quality/Performance Improvement minutes;
• Electronic data gathering and reporting;
• Sentinel event and untoward event reporting;

Some information may be disseminated on a “need to know basis” as required by agencies such as:

• Federal review agencies;
• Regulatory bodies;
• The National Practitioner Data Bank; or
• Any individual or agency that proved a “need to know basis” as approved by a Medical Executive Committee, Administration and/or the Governing Board.

Relevant information from the following is integrated into quality improvement initiatives, consistent with policies or procedures to preserve confidentiality or privileged information established by applicable law:
• Risk management currently managed via the resources of the Finance Committee of the Board of Directors

IX. Related policies, procedures, and guides:
• Annual plans for:
  ▪ Patient Safety
  ▪ Risk
  ▪ Infection Surveillance, Prevention and Control

X. Authored by: Compliance & Quality Committee

XI. Original effective date: September, 2015

XII. Last revised date: November 30, 2018

XIII. Reviewed by: Compliance & Quality Committee

XIV. Approved by: Board of Directors

XV. References:
• Barnard, Cynthia, Eisenberg, Jodi: Performance Improvement Winning Strategies for Quality and JCAHO Compliance (HCPro, 2004).
• Batalden, Paul B., MD, Stoltz, Patricia K: A Framework for the Continual Improvement of Health Care: Building and Applying Professional and Improvement Knowledge to Test Changes in Daily Work (The Joint Commission, October 1993 Journal)
• Centers for Medicare and Medicaid Services, www.cms.gov
• Institute for Healthcare Improvement, www.ihi.org
The Joint Commission, www.jointcommission.org
Veteran Administration National Center for Patient Safety, www.patientsafety.gov
Reference Databases (Appendix A)