I. INTRODUCTION

The Quality and Patient Safety Plan describes the multidisciplinary, systematic performance improvement framework developed by the University of Toledo Medical Center (UTMC) to improve patient outcomes and reduce the risks associated with patient safety in a manner that embraces the mission of the hospital.

MISSION

The mission of UTMC is to improve the human condition by providing patient-centered, university quality care.

General objectives of the 2011 Quality and Patient Safety Plan are:

• To provide a framework for defining quality and performance improvement opportunities, implementing actions, and evaluating results.
• To facilitate communication, reporting, and documentation of all performance improvement and patient safety activities to staff, administration and appropriate governing members.
• To focus and coordinate the organization wide performance improvement and patient safety initiatives.
• To achieve the appropriate balance between good outcomes, excellent care and services and costs.
• To enhance effective organizational and clinical decision making.
• To promote teamwork and group responsibility in identifying and implementing opportunities for improvement.
• To encourage an environment that supports safety, encourages blame free reporting, addresses maintenance and improvement in patient safety issues in every department through out the facility and establishes mechanisms for the disclosure of information related to errors.

II. STRUCTURE

Key employees are responsible for the development and implementation of the Quality and Patient Safety Plan. These individuals, the UTMC Vice President and Executive Director, the Associate Vice President and Associate Executive Director and the Administrator of Hospital Development, are joined by the hospital Medical Director to fully represent the spectrum of hospital services. These individuals are supported by a structure of formal and informal committees and/or work groups where the components of the program are defined, implemented, refined and monitored. These work groups are structured around basic tenets of the hospital services, See Diagram - Appendix 2 (Equitable and patient centered care, timely care, effective care, appropriate care, safe care and efficient care). These different groups that consist of physicians, staff and management are represented via a reporting process to the Quality and Patient Safety Council, which acts as the "oversight committee". The Quality and Patient Safety Council (a Medical Staff Committee comprised of physicians, administrators, and management) reports to and is supported by the Medical Staff Executive Committee which in turn reports to the Clinical Affairs Committee of the Board of Trustees. Refer to Organization Chart Appendix 1.
III. QUALITY PERFORMANCE IMPROVEMENT PROCESS

The process for identifying quality performance improvement initiatives is first, to identify leadership objectives along with regulatory requirements, opportunities identified in external benchmark projects, opportunities identified through analysis of occurrence report data and opportunities identified through sentinel events or “Sentinel Event Alerts”. These objectives or topics are then displayed in a matrix to better understand which areas of importance and relevance they cross (high risk, high volume, problem prone, mission, internal and external customer satisfaction, clinical outcome, safety, and regulatory). See Appendix 4 where the priorities of the objectives are defined. Next, work groups or committees define the metrics (indicators, goals and benchmarks) for each topic. Data is then gathered and studied. The work groups discuss data analysis and determine what initiatives must be implemented to attain the desired outcome. Generally, implementation begins and re-measurement occurs with refinement in actions if the desired outcome is not achieved or the outcome is not maintained. Quarterly, reports are submitted to and reviewed by the Quality and Clinical Safety Department. Annually or more frequent as necessary, the performance is reviewed at the Quality and Patient Safety Council.

IV. QUALITY PERFORMANCE IMPROVEMENT MODEL

The quality performance improvement model developed internally and adopted by UTMC is the “Plan, Measure, Analyze, Act and Review Quality Cycle”. See Appendix 3. This cyclical model incorporates defining the opportunity, identifying the objective, collecting and measuring the data, analyzing performance while comparing with objectives, determining action steps and initiatives as appropriate based on performance, educating and re-measuring.

V. CONTENT/SCOPE OF QUALITY AND PATIENT SAFETY PLAN

The Quality and Patient Safety Plan integrates all departments within the organization. Each department links to one of the main topics defined for improvement. All departments develop annual objectives to address and support improvement of the care, treatment, service and safety outcomes that align with the UTMC mission. These objectives become the essence of the Quality Performance Improvement activities organization-wide.

The Quality Performance Improvement topics established for 2011 are as follows:

**Improve Patient Safety & Quality**
- Monitor compliance with National Patient Safety Goals
- Monitor risk reports for trends in safety issues
- Improve compliance with influenza/flu vaccination administration
- Evaluate process for DVT assessment on admission

**Improve Resource Utilization**
- Improve patient flow in ED
- Reduce readmissions
- Optimize staffing

**Improve Patient Satisfaction**
- Improve operations in Ambulatory clinics, decrease wait times and achieve 24 hour appointments
- Implement iCare University and Standards of Behaviors and Accountability
Reduce Infection Rates
- Monitor compliance with VAP bundle
- Monitor compliance with Central Line Bundle
- Hand-washing surveillance/performance
- Surgical site infections
- Monitor urinary tract infections

Monitor external regulatory compliance indicators
- Core Measures (Acute MI, CHF, Pneumonia, Surgical Care Improvement Program and Outpatient Prospective Payment System measures)
- Restraints
- Falls
- Medication Errors
- Adverse Drug Reactions
- Blood Utilization (Transfusion Reactions)
- Pain
- Culture of Safety
- Resuscitation
- Organ conversion rates
- Operative/Invasive procedures
- Occurrence/Sentinel/Never Event report trends
- Sedation Analgesia
- Seclusion
- Behavioral Management and Treatment
- Mortality and Autopsy
- Hazard Management
- Operative Diagnosis Concurrence

Unusual Changes or Events

The Quality and Patient Safety Plan is flexible to accommodate significant services changes, structure changes, unusual events or other similar elements. Objectives and topics can be introduced at any time to be prioritized and included in the scope of the Quality and Patient Safety Plan.

Safety

The patient safety program is integrated with all quality and performance improvement activities. It encompasses risk assessment and avoidance tactics such as conducting a “Failure Mode Effect Analysis” (FMEA). FMEA is proactive risk assessment which examines a process in detail including sequencing of events, assessing actual and potential risk, failure or points of vulnerability and through a logical process, prioritizes areas for improvement based on the actual or potential impact on patient care. UTMC’s Quality and Patient Safety Council selects at least one high risk process every 18 months for analysis and possible improvement.

The safety program proactively institutes action plans based on findings from the “Sentinel Event Alert” documentation which is provided periodically by the Joint Commission on Accreditation of Health Care Organizations. Use of this resource for initiatives is another proactive approach to patient safety.
All occurrence reporting data are used in the safety program to track and trend or initiate activities that address process, system, protocol or equipment events. This includes near miss occurrences as well as findings from adverse events. As the entire organization reports occurrence data, this component integrates all departments into the safety program.

Additionally, all developments from Root Cause Analysis activities including those from Sentinel Events are implemented and monitored through the safety program.

The Quality and Patient Safety Program is also engaged in the following patient safety initiatives which will continue over the next few years.

- A multidisciplinary group determined by P&T Committee to oversee standardization of the anticoagulation and monitoring of patients who are on anticoagulation agents in both inpatient and outpatient settings.
- Formation of a multidisciplinary group to evaluate the prevalence of DVT/PE in hospitalized patients.
- A multidisciplinary shared governance council (Nurse Practice Council) to oversee medication management and implement strategies to reduce errors.

VI. OVERSIGHT AND SHARING OF INFORMATION

As part of the oversight process, the quality performance improvement initiative information flows from the work groups and committees to the Quality and Patient Safety Council, with a selected Quality Dashboard report distributed to the Medical Staff Executive Committee and ultimately to the Clinical Affairs Committee of the Board of Trustees. Through this process an annual review of the entire Quality and Patient Safety Plan content and results occurs. The various duties of these oversight committees are further defined below:

1. **The Board of Trustees of the University of Toledo** establishes, maintains, supports, and exercises oversight of the performance improvement function of UTMC. The Board of Trustees fulfills its responsibilities related to the quality performance improvement and safety functions through the specific activities and interactions of its Clinical Affairs Committee with the Hospital Administrative Services staff (HAS) and with the medical staff.

2. **The Clinical Affairs Committee of the Board of Trustees** reviews and provides feedback related to the Quality Report submitted to the committee and the Board of Trustees. The Clinical Affairs Committee also makes recommendations related to the provision of necessary financial resources and training to maintain and enhance the quality and patient safety program and initiatives.

3. **The Executive Committee of the Medical Staff** provides oversight and support to the medical staff committees, oversees medical staff by-law functions, credentialing process, and reviews contracts for outside clinical services.

Additionally, as a mechanism to share performance improvement activities with institution staff and visitors, the following activities also take place:

- Departmental in-services on special quality performance improvement topics;
- Lectures and presentations to students and residents;
- Articles in communications newsletters;
- Reports of clinical data distributed to the Clinical Affairs Committee of the Board of Trustees, Executive Committee of the Medical Staff, members of management and leadership teams and the Hospital Administration Staff.
VII. RESOURCES

The Quality Management Department supports and facilitates ongoing organizational quality performance improvement and patient safety activities. Resources within the Quality Management Department are provided to assist hospital staff and physicians with identification of appropriate data resources, retrieval of data, development and coordination of quality performance improvement activities and analysis of data to support and evaluate quality performance improvement efforts.

The primary functions of this department include:

- Promoting patient safety through engagement of evidence based clinical programs and initiatives;
- Monitoring regulatory standards compliance data;
- Clinical data management and analysis;
- Quality improvement training and education;
- Quality improvement reporting to the Board of Trustees and to other key groups in the organization;
- Coordination of internal and external databases that are used for QPSI projects or quality data analysis
- Dissemination of occurrence report data to departments, Quality and Patient Safety Council and other key groups in the organization and resolution coordination as needed;
- Occurrence/sentinel event and never event report tracking and analysis;
- Coordination of root cause analysis for sentinel events and other occurrences requiring intense analysis;
- Coordination of Action Plans related to sentinel events or failure mode effect analysis (FMEA) projects;
- Quality performance improvement project initiation relative to issues found in occurrence reports; and
- Process or procedure modifications related to findings from occurrence report trends and/or FMEA projects.

VIII. SUMMARY

The Quality and Patient Safety Plan provides the framework for UTMC to implement quality performance improvement activities. These activities improve patient outcomes and patient safety in a comprehensive, methodical and systematic manner and compliment the Hospital Plan for the Provision of Collaborative Patient Care Services.

IX. IMMUNITY/CONFIDENTIALITY CLAUSES

The Quality and Patient Safety Council is the UTMC quality assurance committee as referenced in the Ohio Revised Code. Those sections of the Ohio Revised Code pertaining to immunity and confidentiality apply to the Quality and Patient Safety Council.

A. Ohio Revised Code §2305.24

Any information, data, reports, or records made available to a quality assurance committee or utilization committee of a hospital...shall be confidential and shall be used by the committee and the committee members only in the exercise of the proper functions of the committee.
B. Ohio Revised Code §2305.251

No health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of a peer review committee of the health care entity. No individual who is a member of or works for or on behalf of a peer review committee of a health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the peer review committee.

Original Date: 9/87
Revised:
Utilization Management Plan 4/90
Quality Assessment Plan 6/90
Quality Assessment and Improvement Plan 7/92
Patient Care and Service Improvement Plan 1/93
Quality improvement Plan 1/94
Quality improvement Plan 1/95
Quality improvement Plan 1/96
Quality improvement Plan 1/97
Quality improvement Plan 1/98
Quality improvement Plan 1/99
Performance Improvement Plan 4/99
Performance Improvement Plan 6/99
Performance Improvement Plan 9/00
Performance Improvement Plan 3/02
Performance Improvement Plan 5/03
Performance Improvement Plan 12/04
Performance Improvement Plan 6/06
Performance Improvement Plan 11/07
Quality and Patient Safety Plan 12/08
Quality and Patient Safety Plan 2/2010
Quality and Patient Safety Plan 2/2011

Scott Scarborough, PhD
Interim Executive Director and
Senior Vice President for Finance and Administration

Ronald McGinnis, M.D.
Medical Director
Associate Dean for Clinical Affairs

John Kane, M.D.
Chief of Staff
Appendix 1

Organization Framework
Appendix 2
Flow of Quality and Patient and Safety Flow of Information
Quality & Patient Safety Initiative: Care and Safety Oversight

**Care is Equitable & Patient Centered**
- Patient Satisfaction/Complaints
- RUGS (Observation)
- Resource Utilization

**Care is Efficient**
- Fiscally Responsible
  - RUGS (Observation)
  - Resource Utilization

**Care is Safe**
- Patient Care Safety
  - NPSG
  - Restraints
  - Falls
  - Moderate/Deep Sedation
  - Medication/Drug Reactions
  - Patient Perceptions
  - Adequacy of Staffing
  - Decubitus
  - FMEA

**Care is Effective**
- Access
  - ED
  - OR
  - Bed Flow
  - Clinics

**Care is Appropriate**
- Guidelines/Outliers
  - Behavioral Management
  - Readmission/Infections
  - Resuscitation
  - Core Measures

**Medical Staff Executive Committee**
Appendix 3

Quality Performance Improvement Model and Process
PMAAR

Quality & Patient Safety Cycle

Plan

- Define opportunities
- Determine what is to be accomplished
- Identify performance indicators, how they will be obtained, how frequently they will be measured, what comparison values will be used
- Identify responsible parties

Review

- Did actions produce desired results?
- Why or why not?
- Are additional actions necessary?
- Is the “right” thing being measured?
- What has been learned?
- Continue the cycle; modify based on findings

Act

- Determine an action that will impact the trend in the desired direction
- Plan for actions to be executed appropriately
- Communicate, initiate

Analyze

- Conduct quantitative analysis
  - How much – which direction?
  - How does this compare to benchmark?
  - Is the process in control or is variation excessive?
- Conduct qualitative analysis
  - Why is this happening?
  - What are contributing factors?
  - What does this mean?

Measure

- Collect measurement data
- Display data over time on a “run chart”
- Comparative data displayed simultaneously
QUALITY PERFORMANCE IMPROVEMENT QUARTERLY REPORT
THE PMAAR QUALITY CYCLE

Team/Disciplines: ____________________________

Plan: (Define your work using priorities from the Quality and Patient Safety Annual Plan or issues identified as impacting important outcomes of care, treatment or service. Determine what is to be accomplished, what indicators will be used, how they will be obtained, where the benchmarks and other comparative data will come from, how frequently monitoring will occur and who are the responsible parties.)

Measure: (Use existing data where possible. Indicators should reflect the issue at hand. Display the data over time, on a "run chart" and against a comparative, an internal or external goal or benchmark.)

Analyze: (Conduct quantitative and qualitative analysis. Quantitative: Which way is the experience moving - up down or static over time? Is this desirable or undesirable? Is the process in control, or does it have lots of variation? Is this special cause variation? How does the experience compare to the Goal or Benchmark. Qualitative: Why is this happening? (Consider all reasons) How do I know for sure? What are the contributing factors? What does this mean?)

Act: (Determine an action or actions that will impact the trend in the desirable direction. Invent, brainstorm, and cogitate. Plan for the actions to be carried out appropriately; communicate, assign responsibility and effective dates)

Review: (A successful intervention should cause a noticeable change in the experience within a reasonable period of time. Are the actions attaining the desired results? If yes, are additional actions needed? What will it take to sustain improvements? If no, was enough time allowed? Are additional actions necessary? Is the “right” thing being measured? Should this continue to be measured? Should another indicator be introduced? What has been learned? Continue and or modify based on how these questions have been answered)

Contact Person Completing Form: ____________________________ Dept. ____________________________

Return completed form to Quality and Patient Safety, Room 2216, Dowling Hall.

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Emergency Department Bypass Time
Ambulances Diverted Elsewhere

Implemented Bed
Flow Process

High census - holding admitted patients

Holding pts.
No ICU beds

Implemented Access Process

EXAMPLE

10 hrs utility failure 5/27.
Census

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Appendix 4

Annual Departmental and Hospital Goals
# PRIORITIZATION MATRIX - 2011

## Quality and Patient Safety Goals

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