

PROVIDENT HOSPITAL
OF COOK COUNTY
QUALITY AND PATIENT
SAFETY PLAN

2020 Patient Safety and Quality Plan of Care

Mission

To deliver integrated health services with dignity and respect regardless of a patient's ability to pay; foster partnerships with other health providers and communities to enhance the health of the public; advocate for policies which promote and protect the physical, mental, and social well-being of the people of Cook County.

Vision

In support of its public mission, CCH will be recognized locally, regionally, and nationally – and by patients and employees – as progressively evolving model for an accessible, integrated, patient-centered and fiscally-responsible health care system focused on assuring high-quality care and improving the health of the residents of Cook County.

EXECUTIVE SUMMARY

The Quality and Patient Safety Plan provides a framework upon which an integrated and comprehensive program to monitor, assess and improve the quality and safety of patient care is delivered. This plan supports the organizational mission to provide clinical excellence at a reasonable cost and continuously improve patient outcomes.

The plan uses an approach to improving clinical and service quality that includes three key processes: measurement, analysis and improvement. For the first process, patient care and service processes and outcomes are measured through the use of quality indicators and data collection techniques. Second, analysis of collected data is used to determine levels of performance and quantify variation in processes and outcomes. Third, where there is an identified opportunity for improvement, the decision to act will depend upon a prioritization process that considers factors referenced in the guiding principles. When an opportunity for improvement is prioritized for action, the Plan-Do-Check-Act (PDCA) or other proven methodologies are employed to drive change.

The quality and patient safety infrastructure supports a commitment to safe, quality, evidence-based medicine, and continuous learning in an effort to provide the highest level of care to the communities we serve. The committees and councils within the structure are multidisciplinary and include representatives from impacted entities such as providers, staff, and outpatient care area representatives where appropriate. Ultimate accountability is with the Board of Directors, which has direct oversight of the quality and safety of care delivered.

QUALITY AND PATIENT SAFETY PLAN OF CARE

Purpose

The purpose of the Quality & Patient Safety Plan supports the systematic organization-wide approach to plan, design, measure, assess and improve organizational performance.

Initiatives are designed to:

- Attain optimal patient outcomes and patient and family experience
- Support an engaged workforce and safe workspace
- Enhance appropriate utilization
- Minimize risks and hazards of care
- Develop and share best practices

The Plan is intended to provide a framework of guiding principles for all participants in the provision of care. This structure will set proper expectation and encourage all to participate proactively in the improvement process and in sustaining a safety-oriented culture. The Quality & Patient Safety Plan facilitates the identification of key functions of the organization; the assessment of the quality, safety and appropriateness of these functions; and the generation of measurable improvements.

SCOPE AND ACTIVITIES

This plan applies to all inpatient services and sites of care. The Performance Improvement and Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence and maintain and improve healthcare safety and quality. It is recognized that patients, staff, visitors and other customers have the right to expect the best possible clinical outcomes, a safe environment and an error free care experience. Therefore, the organization commits to continuous designing, monitoring performance, analyzing data, improving and sustaining performance while undertaking a proactive approach to the identification and mitigation of medical errors. The organization responds quickly, effectively, and appropriately when errors occur. We recognize that the patient has the right to be informed of the results of treatments or procedures including whenever those results differ significantly from anticipated outcome.

Additional program specifics include:

1) All departments within the organization (patient care and non-patient care departments) are responsible for on-going performance improvement and quality assurance activities. These efforts are monitored through the organizational leadership structure and key indicators are reported to the Quality and Patient Safety Committee (QPS) and the Board of Directors.

2) All departments within the organization (patient care and non-patient care departments) are responsible to report healthcare safety occurrence and potential incidence. The electronic event reporting system is available on all computers, to report unexpected events and near misses. Summary data from the event reporting system will be aggregated and presented periodically to QPS and the Board of Directors, who will determine further safety (risk reduction) activities as appropriate.

3) Upon identification of a medical/health care actual or potential care adverse event, the care delivery team will:

- Perform in accordance to the event management policy.

An effective Patient Safety Program cannot exist without optimal reporting of medical/health care errors and occurrences. Therefore, the plan adopts a just approach in its management of errors and occurrences. All personnel are *required* to report suspected and identified medical/health care errors, and should do so without the fear of reprisal in relationship to their employment. This organization supports the concept that errors occur due to a breakdown in systems and processes, and will focus on improving systems and processes. Emphasis will be placed on remedial actions and individual development to assist staff members rather than punish them.

4) Through review of internal and external data sources (including, but not limited to reports from evidence based medicine centers, The Joint Commission (TJC) and current literature), the QPS Committees will select at least one high-risk safety process to undergo Failure Mode and Effects Analysis (FMEA).

5) The Performance Improvement and Patient Safety Program includes an assessment of staff (including medical staff) opinions, as appropriate, regarding

perceptions of risks to patients and the culture of the healthcare environment to facilitate safe practices, and suggestions for improving patient safety and clinical outcomes by promoting the culture of safety surveys.

6) The Performance Improvement and Patient Safety Program includes an ongoing assessment of patient satisfaction through the use of a comprehensive survey tool.

7) Patients, and when appropriate, their families are informed about the outcomes of care, including unanticipated aftereffect, or when the results differ significantly from the anticipated outcomes, following guidelines outlined in this plan.

8) Staff will educate patients and their families about their role in helping to facilitate the safe delivery of care. Patient and family safety education interventions are documented in the patient's medical record.

9) Staff will receive education and training during their initial orientation and on an ongoing basis regarding job-related aspects of patient safety, including the need to report and reduce medical/health care errors and the methods that go about when reporting. In addition, staff will be educated and trained on the provision of an interdisciplinary and collaborative approach to patient care.

10) Medical/health care errors and occurrences, including sentinel events, will be reported in accordance with all national and regulatory body rules, laws and requirements.

11) Leaders will provide feedback to staff when they have identified a safety issue or occurrence.

Guiding Principles

- Provide safe and quality clinical services and demonstrate superior patient outcomes
- Assess performance with objective and relevant measures

- Achieve quality improvement goals in a systematic manner through collaboration with our providers, staff, patients, families, clinical programs and services and our community by means of education, goal-oriented change processes, evaluation and feedback
- Establish a culture that prevents inadvertent harm to patients as a result of our care. This culture focuses on safety where we openly report mistakes and take action to make improvements in our processes
- Identify and focus on functions that are important to our customers and implement changes which will increase satisfaction
- Optimize the allocation of resources to ensure the delivery of safe and quality care
- Enhance the national and international art and science of healthcare quality by embracing the principles of a “learning organization” and presenting key learnings and original research through professional meetings, journals, and forums
- Utilize Institute of Medicine (IOM) criteria that are as follows:
 - The **efficacy** of the procedure or treatment in relation to the patient’s condition. (Is it best practice?)
 - The **appropriateness** of a specific test, procedure, treatment, or service to meet the patient’s needs. (Is it relevant to the patient’s needs? Did it meet criteria?)
 - The **availability** of a needed test, procedure, treatment, or service to the patient who needs it.
 - The **timeliness** with which a needed test, procedure, treatment, or service is provided to the patient.
 - The **effectiveness** with which tests, procedures, treatments, and services are provided. (Did it produce the desired outcome?)
 - The **continuity** of the service provided to the patient with respect to other services, practitioners, and providers.
 - The **safety** of the patient and others to whom the services are provided. (Will it reduce risk for the patient and others, including the healthcare provider?)
 - The **efficiency** with which services are provided. (Is there a balance between resources used and outcome achieved?)
 - The **respect** and care with which services are provided. (Is the patient involved in his/her own care decisions?)

OBJECTIVES

The Quality Improvement and Patient Safety Plan is a description of the organizational, multidisciplinary, and systematic performance improvement function designed to support the Mission, Values, and Philosophy of the Provident Hospital of Cook County. The intent of the Quality Improvement and Patient Safety Plan is to identify the health system's approach to improving and sustaining its performance through the prioritization, design, implementation, monitoring, and analysis of performance improvement initiatives. Moreover, the Quality Improvement and Safety Plan is an ongoing program that demonstrates measurable improvement in indicators for which there is evidence that they will improve patient outcomes, and identify and reduce medical errors. The Quality Improvement and Patient Safety Plan, with total support of Leadership, will utilize internal and external reference databases in an ongoing effort to design, assess, measure, and improve the delivery of care process and outcomes. In accordance with TJC Standards, and the vision of the Cook County Health, the following expectations regarding healthcare delivery have been established:

- 1) Avoiding injuries to patients from the care that is intended to help them by:
 - a) Recognizing and acknowledging risks and unanticipated adverse events;
 - b) Investigating factors that contribute to unanticipated adverse events;
 - c) Focusing on processes and systems with minimization of individual blame or retribution for involvement in a medical/healthcare error;

- 2) Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit by:
 - a) Reviewing reported risks to identify underlying causes and system changes needed to reduce the likelihood of recurrence;
 - b) Initiating actions to reduce these risks and minimize unanticipated adverse events;
 - c) Internally reporting risk reduction initiatives and their effectiveness;
 - d) Analyzing selected healthcare services before an adverse event occurs to identify system redesign that will reduce the likelihood of error;
 - e) Integrating Quality Improvement and Patient Safety priorities into the new design and redesign of all relevant organization processes, functions and services;
 - f) Researching ways to improve patient safety and quality of care;

g) Conducting systematic planning, analysis and monitoring of performance to improve and sustain advances of processes and outcomes of patient care through interdisciplinary teamwork;

3) Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions by:

a) Assuring public transparency of information;

b) Meeting and exceeding people's needs and expectations;

c) Incorporating the patient's and care-team's perspectives in developing care delivery processes;

4) Reducing wait times and delays for both those who receive and provide care by:

a) Monitoring performance improvement priorities continuously.

5) Avoiding waste of equipment, supplies, ideas and energy by:

a) Implementing evidence based care utilizing standardized order sets, protocols and clinical pathways;

b) Utilizing the high reliability principles and PDCA when developing and evaluating processes;

c) Assuring the application of Process Improvement priorities to medical/healthcare errors and organization learning;

d) Assuring organizational learning regarding medical/health care errors and the application of performance improvement principles for resolution;

6) Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status by:

a) Assuring the highest standard of care is delivered to each patient every time regardless of personal characteristics

PERFORMANCE SAFETY PLAN PRIORITIES & GOALS

The approach to performance improvement is continuously assessed and revised to meet the goal of ensuring that patient outcomes are continually improved and safe patient care is provided. Examples of information utilized to achieve this goal include: variance related data such as medication errors and falls; infection prevention surveillance; sentinel event alerts; and The Joint Commission Quality Measures data, as well as, patient satisfaction reports. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Patient Safety
- Strategic plan goals/objectives
- Mission/vision
- Quality outcomes
- Patient care operations
- Efficiency of care
- Customer satisfaction

Provident Hospital of Cook County recognizes that to be effective in improving patient safety there must be an integrated and coordinated approach to reducing errors. While taking into consideration high risk, high volume, high cost and problem prone processes this plan establishes the following Quality Improvement/Patient Safety goals:

1. Achieve a Patient Safety conscious environment integrated throughout the facility.
2. Improve the reporting of medical errors by establishing a policy focusing on corrective actions through staff education rather than punitive or disciplinary actions for those who report their own errors.
3. Maximize confidential electronic Event Reporting process that includes documentation of follow-up and reporting processes.
4. Expand the implementation of evidence-based practices.
5. Monitor system-wide indicators for established areas of focus.
6. Reduce the number of medication errors.
7. Monitor patient safety indicators related to each facilities specific to “Scope of Service.”

8. Conduct proactive risk assessment utilizing the Failure Mode, Effects Analysis Methodology.

9. Monitor and improve areas identified through Patient Satisfaction Surveys.

Performance improvement priorities and activities may be reprioritized based on significant organizational performance findings or changes in regulatory requirements, patient population, environment of care, and expectations and needs of patients, staff, or the community. Priorities may be reset by the multidisciplinary Quality Improvement and Patient Safety committee in consultation with Senior Management and Medical Staff leadership.

SCOPE

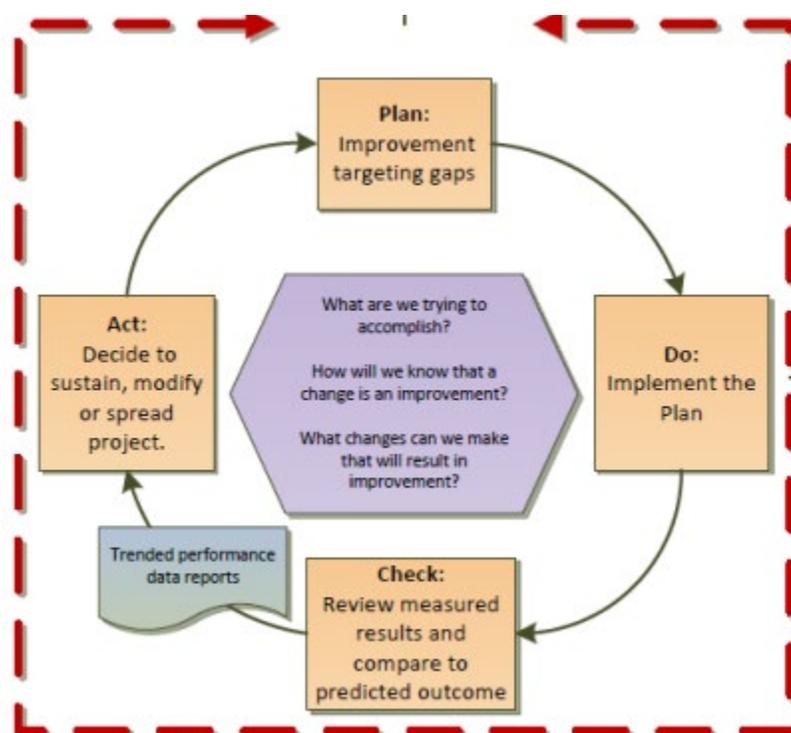
The plan integrates all clinical services and facilities impacting patient care including contracted services. Facilities develop annual goals to address and support improvement of the care, treatment, service and safety outcomes that align with the organizations mission. These goals become the essence of the organization-wide Quality & Patient Safety improvement activities.

GUIDELINES FOR IMPROVEMENT PROJECTS

Methodology

Quality & Patient Safety plan will measure and monitor quality outcomes and implement appropriate changes using the following the guidelines:

- Use data to identify and quantify areas of improvement opportunities (QI) and areas that we are maintaining or improving (QA)
- Use reporting structure to perform ongoing risk assessment
- Analysis and comparison may 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)
 - Statistical process established for expected variation
- Identify gaps using one of more of the IOM criteria (see guiding principles)
- Implement quality improvement cycles (PDCA) with all appropriate stakeholders:



Source: Intermountain Health

The organization may also employ tools for process improvement and/or redesign, cause-mapping as well as incorporating the concepts of statistical process control, Six Sigma, and Lean systems thinking to reduce system variation, delays, and complexity that is detrimental to patient care and safety.

PLAN:

In order to plan and develop effective processes, functions or services, the following key elements, when relevant and available, are considered:

1. The process design is based on the organization's mission, vision and organizational strategic KPI's.
2. Consideration is given to the needs and expectations of patients, staff, and others, as well as, the direct effect or criticality of the design on patient care.
3. Research of current literature and practice guidelines are reviewed for successful or best practice(s).
4. Development is consistent with sound business practices.
5. Baseline performance expectations are utilized to guide measurement and assessment activities.

Performance monitoring and evaluation standards are department, division, service line and/or population focused. Certain processes are measured on an ongoing basis both in response to occurrences and proactively. Selected processes which are high

volume, high risk, high cost and problem prone are measured, analyzed and improved on an ongoing basis.

Performance Improvement projects that are designed or redesigned to monitor expected performance within the hospital are developed to measure, assess, improve and maintain process improvements. Performance levels may be established through comparison performance with other “like” facilities to identify variations or “failure modes.” Comparative data is used from the multiple sources e.g. Cerner, CDC, NHSN, TJC, AHRQ or current/past department performance. Each activity monitored has an established performance level or threshold to measure expected performance. A strategy for maintaining the effectiveness of the redesigned process over time is also implemented.

DO:

Data collection is the basis of all Performance Improvement activities and provides a means of measuring performance through which informed decisions can be made.

1. Program data is collected for a comprehensive set of performance measures based on the priorities and frequency established by the leaders of the organization in order to:

- a. Establish a baseline when a process is implemented or redesigned.
- b. Describe process performance or stability.
- c. Describe the dimensions of performance or stability.
- d. Describe the dimensions of performance relevant to functions, processes and outcomes.
- e. Identify areas for improvement including the effect on patients.
- f. Determine whether changes in a process have met objectives
- g. Implement a strategy for maintaining the effectiveness of the redesigned process over time.

2. Data is collected as a part of continuing measurement, in addition to data collected for priority issues.

Check:

Program activities involve the assessment process, which includes the necessary disciplines of departments to draw conclusions about the need for more intensive measurement. A systematic process is used to assess collected data in order to determine whether specifications for newly designed processes were met and the level of performance and stability of important existing processes are observed. Priorities for possible improvements or redesign of existing processes, actions taken to improve the performance improvement processes and whether changes in the processes resulted in improvement are also assessed.

Ongoing data collection and PI activities are regularly reported as follows:

- Hospital Quality Improvement and patient safety committee
- Executive Medical Staff
- Board of Directors

When data analysis identifies a problem or trend, a corrective action plan will be developed and implemented. These actions may include:

1. **System Changes** – Changes in communication channels, changes in organizational structure, adjustments in staffing and changes in equipment or chart forms.
2. **Knowledge Enhancement** – In-service education, continuing education and circulating informational material.
3. **Intensive Reviews/Focus Studies** – When a medical/health care system error-related occurrence is identified; proactive risk assessment activities are implemented including intensive review and/or a focused study. A data collection tool is developed to address processes, functions, and services that can be designed or redesigned to prevent trends that may have contributed to the problem. Once all charts are reviewed, a summary report is compiled to document and communicate conclusions.
4. **Root Cause Analysis** – When a medical/health care error is classified as a Sentinel Event, the recommended Root Cause Analysis format by TJC is used to detect the underlying causes of the variation. Upon approval by the Chief Quality Officer, the outlined action plan is implemented.
5. **Causal Analysis** – When a medical/health care error is established as a near miss, a causal analysis is completed to determine the underlying causes of the potential variation, the outlined action plan is implemented.
6. **Failure Mode Effects Analysis** – In accordance with TJC published information regarding the most frequently occurring types of sentinel events and patient safety risk factors, at least one high-risk process is selected annually for proactive risk assessment.
7. **Behavior Changes** – Informal or formal counseling, consulting, changes in assignments, and disciplinary action.
8. **Policy Revisions** – Policies are developed or revised for significant organizational issues that are interdepartmental or mandated to be system-wide by accreditation agencies or state regulation. Any potential policy revisions are presented to the QPS Committee to identify the appropriate entity for development, and ensure that input is obtained and incorporated into a final policy statement. Once completed, QPS will submit the policy to the Quality subcommittee for approval, who will then forward it to the Board of Directors for final approval.
9. **Multidisciplinary Process Teams** – Teams are formed as needed and oversight is provided by the CQO to investigate and make recommendations when organization-wide performance becomes unacceptable or when a process has been identified to be proactively redesigned. The process team presents the recommendations to QPS for approval.
10. **Operational Changes** – Any activity that may need to be performed differently in order to expedite a process or improve overall patient care will be examined and changed if appropriate.

The assessment process includes the use of statistical process control techniques/tools as appropriate. When assessment of data indicates a variation in performance or potential risk to patient safety, more intensive measurements and

analysis will be conducted, and in addition, the department/service or team will reassess its performance measure.

When a performance measurement does not reach the predetermined optimal threshold, or if it is attained but further evaluation indicates that performance is not acceptable, the Performance Improvement process should continue. If the level of performance shows no improvement for the time frame established by the identified department/service or team plan, an intensive evaluation should be conducted with input from the CQO regarding the need for continued measurement and additional corrective action.

When any process remains stable or minimal variation is demonstrated in overall performance after two quarters of data collection, the performance measure should be re-evaluated to determine the need to continue measurement, and if re-prioritization of performance measurements should occur.

ACT:

When opportunities for improving performance are identified, a systematic approach is used to redesign the involved process, or to design a new process. The leadership will establish hospital-wide priorities and provide adequate resources to be effective.

1. When a department or service identifies an opportunity for improvement, the department/service will determine if other disciplines or departments will have an impact on the design/redesign of the process. If other disciplines or departments are involved, the opportunity for improvement will be referred to an appointed team.

2. The assigned team/department will establish priorities for improvement based on the guidelines established in this plan. When necessary, the CQO will assist the team or department/service in establishing priorities.

The Quality Improvement and Patient Safety Plan will be reviewed, evaluated, and revised as necessary to incorporate the most current TJC standards. A summary of evaluation results will be presented to the Hospital Quality Improvement and Patient Safety Committee. The annual review will assess, at least, the objectives, scope, organization effectiveness and appropriateness of the program. The plan will be modified as needed based on the results of the annual evaluation. Individual committees and departments will review, evaluate and revise their performance improvement activities and plans as part of an annual system-wide review.

QUALITY IMPROVEMENT AND PATIENT SAFETY PLAN PRIORITIES & GOALS

The approach to quality improvement will be continuously assessed and revised to meet the goal of ensuring that patient outcomes are continually improved and safe patient care is provided. Examples of information utilized to achieve this goal include: variance related data such as medication errors and falls; infection prevention surveillance; sentinel event alerts; TJC Core Measures data, as well as, patient satisfaction reports. The criteria used to prioritize opportunities for improvement include, but are not limited to:

- Patient Safety
- Strategic plan goals/objectives

- Mission/vision
- Quality outcomes
- Patient care operations
- Efficiency of care
- Customer satisfaction

The following sources and criteria will be used to identify and prioritize quality initiatives in the organization:

- Event Reports
- Sentinel Events
- High volume/problem prone/high cost
- Low volume/high risk-problem prone/high cost
- Alerts and Recalls notifications
- Serious adverse events
- Escalation of patient safety issues
- Published evidence-based practice
- Initiatives consistent with mission values, strategic plan and directions
- Mortality data
- Those consistent with mission values and strategic direction
- Availability of resources
- Stroger transparency
- Clinical program and Services initiatives e.g. Press-Ganey, TJC, LeapFrog.
- Patient engagement and experience
- Hospital Acquired Conditions

At a minimum, the organization collects and analyzes data on the measures listed below:

- Medication safety and management
- Utilization of blood and blood products

- Utilization of restraints and seclusion
- Operative and other procedures
- Resuscitation and its outcomes
- Organizational key performance measures
- Utilization management/transition planning
- Patient flow and access
- Management of information including medical records
- Staff perceptions of the Culture of Safety
- Patient perceptions of care, treatment, and services
- Autopsy results
- Infection prevention surveillance and reporting
- Staffing effectiveness
- Regulatory quality control reports and survey findings

Data Sources include but are not limited to the following:

- Administrative data (financial, credentialing, human resource, etc.)
- Internal and external survey data
- Risk Management Event System
- Adverse Drug Event Reports
- Alert and Recall management system
- Clinical data (EMR, Enterprise Data Warehouse, etc.)

Effective Use of Data

Collecting Data

When hospitals collect data or measure staff compliance with evidence-based care processes or patient outcomes, they can manage and improve those processes or outcomes and, ultimately, improve patient safety. The effective use of data enables hospitals to identify problems, prioritize issues, develop solutions, and track to determine success. Objective data can be used to support decisions, influence

people to change their behaviors, and comply with evidence-based care guidelines.

Analyzing Data

Effective data analysis can enable a hospital to “diagnose” problems within its system similar to the way one would diagnose a patient’s illness based on symptoms, health history, and other factors. Turning data into information is a critical competency of a learning organization and of effective management of change. When the right data are collected and appropriate analytic techniques are applied, it enables the hospital to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the hospital not only understand the current performance of hospital systems but can also help it predict its performance going forward.

Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts help a hospital determine what has occurred in a system and provide clues as to why the system responded as it did.

Source: CAMH Update 2, January 2016

1. OVERVIEW OF SENTINEL EVENTS

a. When a patient experiences a sentinel event (SE), an unanticipated outcome or adverse event, near miss, or unsafe condition, the following will collaborate to identify, analyze, and appropriately report these events: QA, risk management, and patient safety (under the umbrella of the Chief Quality Officer Group) and subject matter specialists. This integrated, collaborative relationship fosters organizational efforts to reduce risks to patients and improve the quality of care through fundamental principles and practices incorporated into healthcare delivery. Though QA, risk management, and patient safety personnel collaborate to reduce healthcare risk, each has distinct functions and activities as described here.

The Joint Commission Sentinel Event Definitions

A **sentinel event** is an unanticipated occurrence involving death or serious physical or psychological injury. Serious physical injury specifically includes loss of limb or function. Such events are called sentinel because they signal the need for immediate investigation and response. Each hospital establishes an operational definition of a sentinel event that includes at least

- a. an unanticipated death, including, but not limited to,
 - death that is unrelated to the natural course of the patient’s illness or underlying condition (for **example**, death from a postoperative infection or a hospital-acquired pulmonary embolism);

- death of a full-term infant; and
 - suicide;
- b) major permanent loss of function unrelated to the patient's natural course of illness or underlying condition;
- c) wrong-site, wrong-procedure, wrong-patient surgery;
- d) transmission of a chronic or fatal disease or illness as a result of infusing blood or blood products or transplanting contaminated organs or tissues;
- e) infant abduction or an infant sent home with the wrong parents; and
- f) rape, workplace violence such as assault (leading to death or permanent loss of function); or homicide (willful killing) of a patient, staff member, practitioner, medical student, trainee, visitor, or vendor while on hospital property.

The hospital's definition of a sentinel event includes a) through f) above and may include other events as required by laws or regulations or viewed by the hospital as appropriate to add to its list of sentinel events. All events that meet the definition of sentinel event must be assessed by performing a credible root cause analysis.

Accurate details of the event are essential to a credible root cause analysis thus the root cause analysis needs to be performed as soon after the event as possible. The analysis and action plan is completed within 45 days of the event or becoming aware of the event.

The goal of performing a root cause analysis is for the hospital to better understand the origins of the event. When the root cause analysis reveals that systems improvements or other actions can prevent or reduce the risk of such sentinel events from recurring, the hospital redesigns the processes and takes whatever other actions are appropriate to do so. It is important to note that the terms sentinel event and medical error are not synonymous. Not all errors result in a sentinel event, nor does a sentinel event occur only as a result of an error. Identifying an incident as a sentinel event is not an indicator of legal liability.

The management of adverse events, near misses, or unsafe conditions, is a component of the CQO. The program encompasses identification and mitigation of risk to patients, family members, visitors, and staff as well as the oversight and review of the effectiveness of organizational risk reduction strategies.

2. IDENTIFICATION OF ADVERSE EVENT, NEAR MISS, OR UNSAFE CONDITION

a. Processes must be in place to identify all adverse events. Immediate action must be taken to make sure those patients, staff, and visitors are protected from additional injury and to minimize the effects of the event. All adverse events, near misses, or unsafe conditions, must be entered in the patient safety reporting system (EMERS).

REPORTS AND INTERVENTION TECHNIQUES FOR MONITORING PROBLEM-PRONE AREAS

a. Patient Safety Reports

(1) Patient Safety Reports will be submitted to the Chief Quality Officer. The data, information, and format will be in accordance with CQO guidance.

(2) In order to facilitate timely and accurate reports and analysis, information submitted to the CQO will include identification of the reporting facility. All personal patient and individual provider information will be redacted before being sent to the Chief Quality Officer.

b. EMERS:

(1) EMERS is a standardized, automated reporting system which allows all users across each facility the ability to report, aggregate, and analyze adverse events.

(2) All adverse events, near misses, or unsafe conditions must be reported to the EMERS.

c. Proactive Risk Assessment (PRA)

(1) Requirement to Complete a PRA. Productive Risk Assessment is a process for the analysis and improvement of any at-risk system process. All facilities will complete a PRA on a high-risk process in accordance with requirements established by their accrediting organization and individual organizational guidance. PRAs may be conducted at any time and are appropriate for all processes

(2) PRA Submission

(a) All facilities must submit each PRA to the regulatory affairs and accreditation director staff within 30 days of completion. The regulatory affairs and accreditation director staff must forward all completed PRAs to the QPS Committee within 45 calendar days of receipt from the facility. The reporting facility will be fully identified and included on the PRA. Any requests for additional or clarifying information required from the facility by the QPS committee will be coordinated through the regulatory affairs and accreditation director staff.

(b) PRA materials produced are not intended for public release and must be maintained as confidential records

Tools for Conducting a Proactive Risk Assessment

A number of tools are available to help conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. The FMEA asks “What if?” to explore what could happen if a failure occurs at particular steps in a process.

Hospitals have other tools they can consider using in their proactive risk assessment.

Some examples include the following:

- Institute for Safe Medication Practices Medication Safety Risk Assessment: This tool is designed to help reduce medication errors. Visit <https://www.ismp.org/self-assessments/default.asp> for more information.
- Contingency diagram: The contingency diagram uses brainstorming to generate a list of problems that could arise from a process. Visit <http://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit/all-workflowtools/contingency-diagram> for more information.
- Potential problem analysis (PPA) is a systematic method for determining what could go wrong in a plan under development. The problem causes are rated according to their likelihood of occurrence and the severity of their consequences.
- Process decision program chart (PDPC) provides a systematic means of finding errors with a plan while it is being created. After potential issues are found, preventive measures are developed allowing the problems to either be avoided or contingency plan to be in place should the error occur.

d. Root Cause Analysis

(1) An RCA is used to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an SE. RCA focuses on systems and processes, not individual performance.

(2) Patient Safety RCA data are used internally for improving healthcare systems and processes that impact quality and patient safety. At all levels of the organization, information obtained through a Patient Safety RCA, to the greatest extent possible, will not be used in adverse administrative, privileging, or other personnel actions, including disciplinary action. In cases where possible disciplinary action could result, the QPS committee will conduct two separate and independent investigations.

(3) An RCA must be completed by the facility on all SEs, including TJC reviewable SEs, within 45 calendar days of the facility becoming aware (i.e. discovery) of the SE. Extensions for reviewable RCA completion will not ordinarily exceed 90 calendar days. RCAs conducted on non-reviewable SEs or other less serious events should be completed as soon as practicable or as dictated by the respective facility CEO.

(4) RCA Submission

(a) Electronic or hard copies of RCAs from SEs should reach the CQO not later than 45 days after discovery of the event. The data provided must not contain any identifying information related to the patient(s) or the individual healthcare provider(s). The reporting facility identification will be included on the RCA. These copies must be maintained as confidential CQO records.

(b) Copies of additional updates or changes to the RCA (such as those required by TJC, CQO or the Board of Directors) will be forwarded through the CMO to CQO within 30 days of completion. Any requests for additional or clarifying information required from the facility by CQO will be coordinated through the CMO.

e. Notification

(1) Provident Hospital of Cook County adopts TJC's list of reviewable SEs.

(2) All adverse events, including near misses and unsafe conditions will be reported within the EMERS. CMO will be notified within 24 hours of the facility learning of a TJC reviewable SE or other SE involving serious harm to a patient. The CMO will report such SEs. The report will include the event type or category, facility identification, date of event discovery, brief summary of the event, date the RCA was chartered, the CMO point of contact and any unique identifiers or codes for the report.

f. Intentional Unsafe Acts

(1) The investigation and consideration of corrective actions on intentional unsafe acts are not within the primary authority or responsibility of the CQO. If in the course of the activities of the EMERS information about intentional unsafe acts is revealed, the original report must be referred to CEO for criminal investigation and action as appropriate. Primary authority to investigate and consider corrective actions on the matter must be outside of the CQO.

(2) Some events meet the definitions of both "adverse events" and "intentional unsafe acts." When an event appears to be both an "adverse event" and an "intentional unsafe act," primary authority and responsibility is outside the CQO. The CQO must proceed with a review, including an RCA, if applicable, of the systems and processes of the facility implicated in the actual or potential intentional

unsafe act, but will defer to the separate investigation and consideration on any matter of responsibility of any person involved in the act.

COMMUNICATION WITH PATIENTS AND FAMILIES/PATIENT'S RIGHT TO BE HEARD

1. GENERAL. This section describes a patient's right to be heard in any QPS program review of care provided by a facility.

2. PATIENT'S OPPORTUNITY. Any patient who believes he or she suffered a personal injury due to a perceived failure of a facility to provide quality medical care must have the right to submit his or her concerns as part of a QA review of the care provided.

3. PROCEDURES

a. The CEO or designee will ensure that the patient has notice of this opportunity and must advise the patient whether the opportunity must be through personal presentation or written presentation.

b. The opportunity provided in accordance with this section may be provided in association with the healthcare resolutions program in accordance with Provident Hospitals of Cook County policy. However, the opportunity must be provided without regard to whether the healthcare resolutions program is involved and without regard to whether the patient has filed a claim for compensation or retained legal counsel.

c. A patient is entitled to the assistance of legal counsel of the patient's choosing not at government expense.

d. In the case of a patient's death or incapacitation, or if the patient is a child, the opportunity to submit concerns must be available to the next of kin or other close family member.

e. In any case in which a patient (or legal representative) submits concerns in accordance with this enclosure, those concerns must be considered as part of a QA review of the care provided. However, the results of any QA review are protected in accordance with policy.

f. Patients and families are encouraged to express safety concerns by speaking directly with front-line clinicians, department managers or patient relations representatives.

COMMUNICATION WITH MEDICAL STAFF

- Medical Staff receive an orientation when they join the medical staff. The orientation includes how to use the Event Reporting System to report patient safety issues. It also describes how medical staff performance is monitored as outlined in the Medical Staff Bylaws.
- Medical Staff receive information about safety and quality through medical staff leadership, department meetings, and organization management on a regular basis.

COMMUNICATION WITH STAFF INCLUDING VOLUNTEERS

- Staff receive information about safety during initial orientation and on a regular basis.
- Staff are encouraged to resolve concerns directly with their supervisor. If concerns are not adequately addressed, the Chain of Command should be followed. Staff are also encouraged to report concerns.
- Staff are informed how to contact The Joint Commission.
- Communication and education on improvement philosophy, strategies and tools in multiple venues throughout the organization may include but is not limited to:
 - a. New employee orientation
 - b. Formal management education in terminology, strategies and tools
 - c. Team education on a “just-in-time” basis
 - d. Regularly scheduled computer-based training on improvement initiatives impacting their clinical accountability
 - e. Departmental in-service programs tailored to meet the needs of a specific group

COMMUNICATION WITH CONTRACTED SERVICES AND STUDENTS

- Provident Hospital of Cook County provides communication and education on safety in initial orientation of the organization.
- Business owners coordinate with the contracted services to manage organizational expectations and priorities.
- Provident Hospital of Cook County monitors expectations and provides feedback on a regular basis.

COMMITTEE MEMBERS

Pierre Wakim, DO, Emergency Medicine

Arnold Turner, MD, Medical Director

Tanya Seaton, Operating Officer

Gennadiy Voronov, MD, Anesthesiology

Steven Bonomo, MD, Surgery

Suja Mathew, MD, Internal Medicine

Valerie Hansbrough, MD, Gynecology

Mark Pisanechi, MD, Radiology

Mark Loafman, MD, Family Medicine

Nadeem Ahmad, MD, Internal Medicine

Marin Sekosan, MD, Pathology

Joyce Miller, MD, Psychiatry

Hugo Solari, MD Psychiatry

Leslie Frain, RN, Director of Quality Improvement

Nkiru Okolo, RN, 8-West Nursing

Chineze Nkemeh, RN, Emerg. Med Nrsg

Beverly Alexander, RN, Peri-Operative Nrsg

Rosario Onorato, RN Infection Control

Doris Kelley, RN, Quality Clinical Excellence

Gary Kersting, Laboratory

Angela Espinosa, Health, Information & Records

Lezah Brown-Ellington, EOC/Life Safety

Joseph Price, Senior Director, Radiology

Kary Raines, Environmental Services

Chuck Bloom, Plant Operations

John Sedivy, Manager of Clinical Imaging

Sonya Watkins, System Director Regulatory Affairs and Accreditation

Carolyn Ballard, Clinic Manager

Suzy Harrington/Tuesday Rooney Rehab. Services

Beronica Woodson, Patient Access

Victor Pelaez, MD, Cardiology

Maria Castillo, Behavioral Health

Anita Giuntoli, Director Patient Safety

Tony Leung, RPh, Pharmacy

David Greenbaum, Food & Nutrition

SUMMARY

The Quality and Patient Safety Plan provides the framework to implement quality performance improvement and safety activities at Provident Hospital of Cook County. These activities improve patient outcomes and reduce harm in a comprehensive, methodical and systematic manner. Quality & Patient Safety is a system-wide priority and compliments the mission to deliver clinical excellence.