LAC+USC Medical Center

2022-2025 Quality and Patient Safety Plan

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INTRODUCTION

Our patients and their families are the highest priority at LAC+USC Medical Center. Providing them with safe, high-quality healthcare and excellent service is their right and our responsibility. Excellent quality and service is a result of purposeful commitment, shared vision, accountability, and a sound systematic approach with effective oversight, and support. We are committed to improving how we deliver healthcare and to doing so in a way that promotes "high reliability", meaning we strive to consistently perform at high levels of safety over long periods of time.

The purposes of the Quality & Patient Safety Plan (hereafter referred to as the Plan) are to:

- Describe our approach to patient safety and performance improvement including our philosophy, prioritization (including re-prioritization when necessary), methods and tools employed to ensure a coordinated, effective and systematic quality program;
- Define our reporting structures and mechanisms for providing oversight to and communication of performance improvement and patient safety activities across the organization;
- Outline how the Plan is evaluated and approved annually;
- Describe how organizational priorities and quality/safety initiatives are communicated across the organization.

I. APPROACH TO PERFORMANCE IMPROVEMENT

A. Leadership Responsibility

The leaders are ultimately responsible for the safety and quality of care for our patients and set the tone and the expectation for improving care and services. Leaders set the strategic priorities and demonstrate commitment through actions including active, personal involvement in quality initiatives, assuring adequate staff time is devoted to quality, holding staff accountable for performing quality functions and achieving outcomes, and assuring quality initiatives are widely communicated to all staff and that staff are able to speak to initiatives within their departments/services.

B. Philosophy

Quality is imbedded into the mission, vision and values of LAC+USC Medical Center and is a driving force behind everything we do. We approach performance improvement with a philosophy of inclusion, transparency and accountability, mutual respect and shared vision. All disciplines and persons, including resident and fellow trainees, are included or represented by teams and/or participation in the committee structure. Whenever possible, we encourage inclusion of patients and/or their family members and Patient Family Advisory Council (PFAC) members as they are an integral part of our healthcare team.

We value teamwork as an essential attribute of all we do, accountability in the services we provide and the just use of resources in delivering care, trust in our colleagues, our work and our accomplishments and compassion in our interactions with our patients and each other, so that we accept people as they are and foster healing and wholeness. We believe in creating an environment that promotes collaboration. We are committed to transforming our culture of patient safety so that individually and collectively we are acutely aware that even small failures in safety protocols or

processes can possibly lead to catastrophic adverse outcomes. We are resolute in identifying potential deficiencies in the safety processes and eliminating them using the powerful tools of robust performance improvement.

C. Establishing Priorities for Improving Performance

The Board of Supervisors of the County of Los Angeles (our Governing Body) through their delegate approves the County of Los Angeles' Strategic Plan with targeted initiatives designed to support the residents of Los Angeles County. In turn, the Department of Health Services develops specific goals and initiatives that are consistent with the overall County and Department of Health Strategic Plan to support the healthcare needs of the residents of the County.

D. On an annual basis, the leadership of LAC+USC Medical Center, in collaboration with individual departments and committees, develops goals for each Strategic/Quality pillar giving priority to high-volume, high-risk, or problem-prone processes for performance improvement and with thoughtful attention given to available resources. These goals are shared throughout the organization. In addition to the regularly monitored goals and objectives in each department, the organization's leadership, through the Quality Improvement Committee (QIC), prioritizes and approves projects that are consistent with the goals established for the organization. Additionally, the Patient Safety Committee selects prioritized goals for annual focus. Methods and Tools to Improve

To achieve sustainable improvement, we utilize classic quality improvement principles such as the Institute of Healthcare Improvement (IHI) Model for Improvement (MFI) and Lean Six Sigma. We understand that you cannot improve what you cannot measure. Collecting timely and accurate data as well as choosing the appropriate way to display data that facilitates analysis is critical to the success of our Plan. These methods encourage a team approach and shared ownership of process improvement.

1. Classic Performance Improvement Methods and Tools

We draw upon techniques developed by recognized leaders such as Shewhart, Deming, Codman, and organizations such as the Institute for Healthcare Improvement (IHI), Agency for HealthCare Research and Quality, National Quality Forum, Institute of Medicine and others which serve as inspiration for the Plan.

We use Shewhart's PDSA cycle (acronym for Plan-Do-Study-Act) as a tool to bring about the process improvement. The PDSA cycle serves as a roadmap to drive process improvement. To accelerate the change process, we utilize "Rapid Cycle Improvement" wherever possible and as appropriate to methodology by performing small tests of change and doing multiple PDSA cycles to achieve sustainable improvement.

Robust Performance Improvement: Principles of Lean

Lean principles have been employed successfully in industry for many decades and while relatively new to healthcare; have been successfully used to improve processes. The basic principles involve identifying key processes (value streams) and then mapping the process as it actually exists. Value is defined from the perspective of the customer (patient) and all aspects in the value stream that do not add value are considered waste and eliminated. The goal is to identify what the ideal process would look like and to use traditional tools of PDSA and rapid

cycle improvement to identify and drive out waste so that all work adds value and serves the patient's needs.

With the complexity of our healthcare system, streamlining processes, building in meaningful redundancy, and improving overall efficiencies are aligned with our objectives to build highly reliable systems that are efficient, effective and responsive to the needs of our patients; incorporating varying types and/or degrees of improvement processes in alignment with the scope and magnitude of the project

Data Collection & Display

Data display is an important tool, that when employed correctly, turns data into information which facilitates analysis, compels action while communicating progress in meeting goals. We use line graphs whenever possible, shown as run charts, annotated run charts, or control charts, in lieu of bar graphs which do not show a connection between time points from a systems perspective. Statistical quality control analysis and charts are used when appropriate. We also employ visual huddle boards to provide just in time data to healthcare teams to establish transparency and engagement in our improvement efforts.

REPORTING STRUCTURES/OVERSIGHT

A. Governing Body

The Governing Body for LAC+USC Medical Center is the elected five-member Board of Supervisors for the County of Los Angeles, with direct responsibilities for health care delegated to the Director, Department of Health Services. This structure and the functions of the Governing Body are described in the ASA bylaws and the policies of the Department of Health Services.

The medical staff is ultimately accountable to the Governing Body for the safety and quality of care, treatment and services provided at LAC+USC Medical Center. The hospital's organized medical staff is accountable to the Governing Body, by providing oversight of the quality of care, treatment and services provided by those professionals with clinical privileges. The medical staff performs its oversight duties utilizing the established Quality & Safety Reporting Structure (Figure 1)

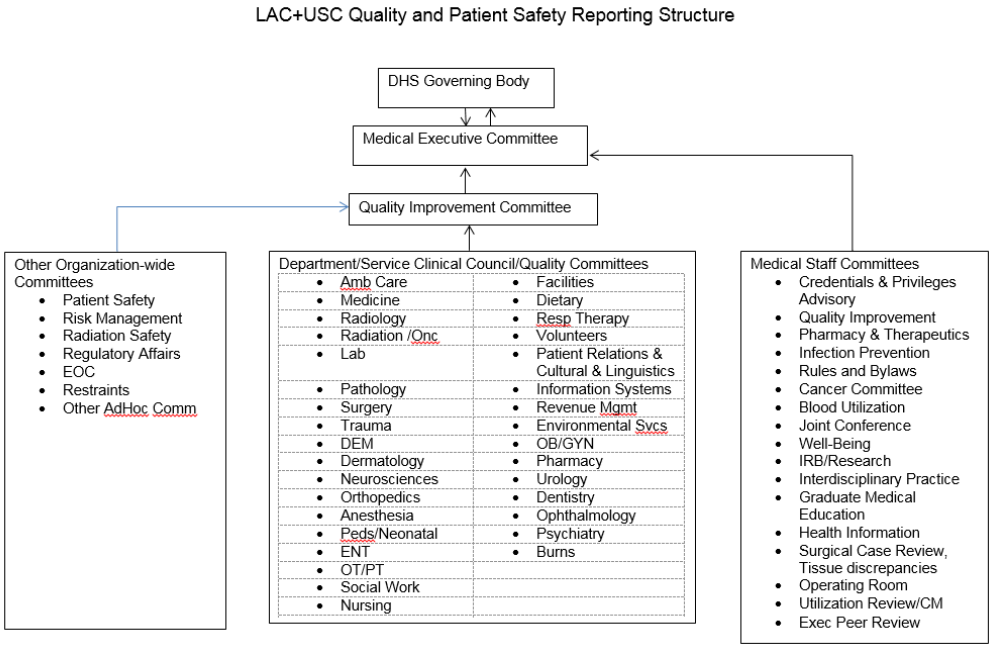

Figure 1: LAC+USC Quality and Patient Safety Reporting Structure

B. Medical Executive Committee

The Medical Executive Committee (MEC) is a standing committee of the Attending Staff Association (ASA) whose structure and function is described in the ASA bylaws.

With respect to the Quality and Patient Safety Plan, duties include:

1. Oversees the Quality Improvement Committee

2. Reviews the Quality and Patient Safety Plan annually and makes recommendations for revision to the Quality Improvement Committee as indicated;

3. Collaborates with the Quality Improvement Committee to provide oversight of the hospital-wide Quality and Patient Safety Plan and identify opportunities to improve care, safety and services.

C. Quality Improvement Committee (QIC)

The Quality Improvement Committee is a standing committee of the ASA whose structure and function is described in the ASA bylaws.

With respect to the Quality and Patient Safety Plan, duties include:

1. Maintaining operational control and implementation of the organization's quality and safety plan;

- Ensure performance improvement projects possess a defined scope, responsibilities and reporting channels;

- Assign sub-committees to conduct long or short-term quality improvement business to meet the needs of the organization; and

2. Evaluation of the Quality and Patient Safety Plan annually, including a patient safety risk assessment; incorporating recommendations as directed by the Medical Executive Committee;

3. Quality Improvement Committee reports directly to the Medical Executive Committee.

D. Patient Safety Committee

The Patient Safety Committee is a standing committee of the ASA whose structure and function are described in the ASA bylaws.

With respect to the Quality and Patient Safety Plan, duties include:

1. Implementation, oversight and coordination of the hospital-wide Patient Safety Program;

2. Fosters a just culture in which staff are encouraged to identify and communicate opportunities for improvement, report patient safety risks, disclose significant process/protocol variances ("near misses"), and participate in performance improvement activities;

3. Periodically measure the perception of patient safety (using a patient safety culture survey) and identify where patient safety improvement efforts should be focused;

4. Reviews the National Patient Safety Goals and provides oversight for the implementation of the goals facility-wide;

5. Works collaboratively with other services, departments, and committees to identify opportunities for improvement as related to patient safety; including, but not limited to, the performance of patient safety rounds, review of risk management events and support in root cause analysis, and the receipt of reports from Failure Modes and Effects Analysis (FMEA) teams;

6. Communicates and shares patient and staff recommendations regarding patient safety and improvements to clinical and administrative leadership, the governing body, as well as other staff, as appropriate.

7. Makes recommendations to the appropriate services, departments, and committees for initiatives to support ongoing patient safety that are consistent with the strategic direction of the organization;

8. Sponsors team involvement and performance improvement initiatives based on findings and educational programs for staff to improve patient safety when indicated;

9. Integrates patient safety practices into the hospital-wide Quality Improvement Program;

10. Analyzes patient safety events and monitors implementation of corrective actions; including results of analysis related to the adequacy of staffing;

11. Makes recommendations for prevention of future patient safety events;

12. Defines mechanisms for providing support to staff who have been involved in a sentinel event;

13. Advises senior leaders on patient safety issues;

14. Involves patients and their families in patient safety initiatives and the development of corrective action plans;

15. Involves residents and fellows in patient safety initiatives and corrective action plans;

16. Provides shared oversight of all facility-wide, evidence-based practices/initiatives related to the National Patient Safety goals with the Infection Control Committee; and

17. Reviews staff training materials for patient safety that are to be included in orientation and annual reorientation materials.

18. Addresses all Joint Commission Sentinel Event Alerts

    - Distribute and communicate all pertinent Sentinel Event Alerts; including any action item summaries ensued as a result.

    - Review and address each Alert released by the Joint Commission in collaboration with affected departments and staff to ensure risk reduction actions are identified and corrected as necessary.

    - Monitor correction(s) and completion of risk reduction actions accordingly.

19. Performs proactive risk assessment and action plans (FMEA)

    - At least every 18 months, one high-risk process will be selected and a proactive risk assessment, Failure Mode and Effects Analysis (FMEA) is performed. Selection of high-risk processes may be based in part on information published periodically by The Joint Commission, or other processes identified by the Organization as posing an actual and/or potential to risk to the safety of patients. Analysis of findings and results of proactive risk assessments is disseminated and used to reduce the

risk of medical error and further guide the organization's patient safety efforts.

- Completed FMEAs are reported to the Quality Improvement and Medical Executive Committee(s).
- Measurements of success will be determined by the FMEA team's assessment of the greatest opportunities to improve patient safety.
- Monitor report patient and staff perceptions of safety.

E. Department/Service Quality Improvement Committees

Department/Service QI Committees are charged with the responsibility for performing QI activities in support of overall institutional goals, including improving metrics specific to the Department/Service. The Department/Service QI Committees report to the Quality Improvement Committee.

With respect to the Quality and Patient Safety Plan, duties include:

1. Proposes and refines metrics consistent with the LAC+USC Strategic Goals and balanced scorecard with benchmarks that are specific to the Department/Service, by which quality will be monitored by the Department/Service and provided to the Quality Improvement Committee for oversight;
2. Identifies methods and supports data gathering to monitor performance;
3. Incorporates house staff into ongoing performance improvement activities and helps to provide educational support in QI to the house staff;
4. Communicates progress in meeting performance improvement goals to the Department Chair/Service Director;
5. Identifies barriers to quality of care within the Department/Service or across Departments/Services, and works collaboratively with others to identify improvement opportunities;
6. Conducts quality improvement projects, forming teams inclusive of house staff, using LAC+USC Medical Center performance improvement methodologies to improve care within their Department/Service.

II. PROGRAM EVALUATION

Ongoing assessment and performance evaluation relative to the achievement of established goals is an essential component of the improvement process; LAC+USC Medical Center incorporates multi-level evaluation procedures to ensure departments and committees remain accountable to established goals and outcomes. The multi-level evaluation procedures include;

A. Departmental & Committee Evaluation:

- Ongoing monitoring of department and committee performance improvement and patient safety activity is reviewed by Quality Improvement Committee on a quarterly basis and annually as part of the annual QI plan;

- Evaluation findings are reported directly to the Quality Improvement Committee and ultimately to the Governing Body.

B. Hospital-wide Improvement Project Evaluation:

- Ongoing monitoring of all hospital-wide performance improvement projects are reviewed by Quality Improvement Committee on a quarterly basis;

- Evaluation findings are reported directly to the Quality Improvement Committee and ultimately to the Governing Body.

- Annually, the Quality Improvement Committee determines the minimum number of projects to complete and evaluates its performance relative to achievement of projects, goals and objectives and submits a written report to the Medical Executive Committee.

C. Quality & Safety Plan Evaluation:

The Quality Improvement Committee and the Patient Safety Committee performs an annual evaluation of the hospital-wide Quality & Safety Plan, which incorporates data from each department/committee's balanced score card and progress towards meeting goals, compliance with National Patient Safety Goals, performance of a Failure Modes and Effects Analysis, and reviews and summarizes projects in process or completed. The Plan is subject to review and approval by the medical staff and the Governing Body. A copy of the yearly evaluation is appended to this plan.

IV. CONFIDENTIALITY

All data pertaining to quality improvement are protected under Sections 1156-1157 of the California Evidence Code and must be collected, managed, distributed and maintained in a confidential manner. Individuals receiving confidential medical staff or patient sensitive material, including committee minutes are responsible for handling the information in a confidential and secure manner that is consistent with the ASA Medical Staff Bylaws, hospital policy and procedures and all other regulatory requirements including the Health Insurance Portability and Accountability Act (HIPAA).

V. COMMUNICATION

Effective communication is paramount to the ongoing success of the organization's efforts to continuously improve care and service provided. Leadership is accountable for communicating priorities for performance improvement as well as quality initiatives consistently across the organization and this is accomplished in a variety of ways.

The organization's executive leadership holds supervisory staff responsible for assuring quality improvement and patient safety activities are prioritized within the departments and services throughout the organization and requests updates on progress in meeting goals in routine management meetings assuring that barriers are addressed and annual goals are met and that staff are able to speak to department/service-specific and or hospital wide quality initiatives.

In turn, department chairs, service directors, and nurse managers and other managers within the organization are held accountable for assuring that performance improvement and patient safety initiatives including progress in meeting departmental/service goals as communicated by their QI liaisons and are prioritized within their areas of accountability. They are responsible for providing support to assure barriers are addressed and goals are met and staff is able to speak to department/service-specific and/or hospital wide quality initiatives.

The Department and Service QI liaisons are responsible for communicating information regarding QI activities to their supervisory and other staff within their department or service including house staff.

Other venues that may be used for communication include, Department/Unit Meetings, Medical Center Intranet and e-mail blasts, and New Employee Orientation.

VI. APPROVALS

Signature on File
Associate Medical Director, Quality and Safety
Chair, QIC

Signature on File
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Chief Quality Officer
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Signature on File
Allison Luu, MD
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