LAC+USC MEDICAL CENTER
DEPARTMENT OF NURSING SERVICES POLICY

Subject:	Original Issue Date:	Policy #
QUALITY CONTROL / IMPROVEMENT PLAN	08/91	**301**
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Departments Consulted:	Reviewed & Approved by:	Approved by:
	Professional Practice Committee Nurse Executive Council	(signature on file) Nancy Blake Chief Nursing Officer

PURPOSE

The Nursing Clinical Council (NCC) will function within the existing structures of Medical Center Quality Improvement Committee (QIC) for Los Angeles County+ University of Southern California Medical Center. The NCC Quality Management Plan is based on quality control (QC) and quality improvement (QI) activities that can generate data for Performance Improvement (PI) activities for the Department of Nursing. Meeting or exceeding the customer's expectation will continue to be the driving force in planning, evaluating, and implementing all services.

POLICY

I. Nursing Clinical Council
The administrative responsibility of the ongoing administration of NCC--QI activities are as follows:

A. The Chief Nursing Officer (CNO) has the responsibility to ensure that there is a planned, systematic process of monitoring the quality and appropriateness of nursing care provided, and that corrective action is taken when indicated.

B. The NCC is a standing committee of the Department of Nursing. The Committee meets monthly, at a minimum of ten (10) times per year The Chairperson of the Committee is appointed by the CNO. Membership consists of Clinical Nursing Directors/representatives for the following areas:

- Medical/Surgical Services
- Critical Care Services
- Pediatrics
- Obstetrics/Gynecology
- Perioperative Services
- Emergency Services
- Ambulatory Care Services
- Nursing Informatics
- Nursing Quality Management
- Nursing Education Services
- Pain Resource Nurse
- Wound Consultant Nurse
- Behavioral Medicine

C. The NCC QI Program is unit driven where QI issues are generated, monitored, and evaluated at the unit level. When the problem identified is a process or system issue, and involves other disciplines, those disciplines are brought into the process. Problem resolution is sought at the unit level using the QI process. Nursing units use PI methodology based on:

- The Institute for Healthcare Improvement Model for Improvement
- Principles of Lean

(see attachment 301-A).

II. Hospital- Wide Indicators

Hospital-wide indicators are selected for monitoring as indicated by the scope of care, high-volume, high-risk and/or problem-prone aspects of care. Indicators of quality are based on patient care standards such as protocols, policies, procedures, and standards that are consistent with professional expectations. The standards of care and protocols are consistent with current knowledge and reflect the expected levels of clinical competence. Indicators are measured by criteria that reflect system requirements that support patient care (structure), practitioner performance behaviors (process) and desired patient outcomes. Hospital-wide indicators will be monitored by independent nursing auditors. Hospital-wide indicator results will be submitted to QIC.

III. Unit Specific Indicators

D. Specific indicators will be selected by areas based on high risk or high volume problems. Areas will also select 2 PI projects strategically aligned to the Medical Center's quality goals and report on their progress as needed.

PROCEDURE

A. Collection of data

1. All indicators are due to the Department of Nursing Quality Management (NQM) by the last working day of the month at midnight. Any audits that come in late will be processed during the following month

B. Analyzing of Data

2. 1. Once the information is aggregated it will be reviewed for improvement opportunities. Data will be reported to NCC for further analysis

C. NCC Quarterly Reports

1. Unit activities will be summarized by the Clinical Nursing Director/designee and submitted on a quarterly basis to NCC. The Quarterly Report to Nursing Clinical Council is due in: November, February, May, and August

3. Any audit that did not meet the threshold for action (TFA) for either the "overall compliance" and/or "individual criteria compliance" needs to have a written corrective action. Example: The overall TFA for pain is 90%. If this threshold is not met a corrective action needs to be written. Second, the

"Pain Indicator" has 7 individual criteria listed. If criteria 2a, 2b, and 5 did not meet threshold then a written corrective action needs to be generated. The unit may meet the overall TFA but only get 25% on the individual criteria.

4. The corrective actions must be data driven to show a measure of success. Corrective actions are due to your Clinical Nursing Director by the 2nd Thursday of each month. More frequent reporting may be required on a case by case basis.

5. To encourage the fundamentals for quality improvement and patient safety activities, LAC-USC, Leadership has adopted the five pillars of the Balanced Scorecard. The leadership teams are responsible for developing goals that are congruent with the five pillars of the Balanced Scorecard

6. The five pillars are:

    - Population Health, Value Base Care & technology
    - Quality, Safety & Patient Experience
    - Workforce
    - Fiscal Sustainability
    - Community

The five pillars are the main quality goals of performance improvement projects.
On an annual basis, the leadership team, develops goals, giving priority to high-volume, high risk or problem prone processes for performance improvement.

NCC reports quarterly to the **QIC.** The report is due by the first Wednesday of September, December, March and June.

Frontline Staff Involvement

- For a Quality Improvement Program to be effective in improving patient care, all nursing personnel must be involved in the program.

REVISION DATES

1992, 1996, 1997, 05/98, 04/99, 01/01, 01/05, 03/05, 06/06, 03/08, 09/08, 02/09, 06/09, 01/11, 01/14, 12/18, 07/22