NORTH MEMORIAL AMBULATORY SURGERY CENTER AT MAPLE GROVE
2018 ANNUAL QUALITY IMPROVEMENT WORK PLAN

| | | | | | | Timeline | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Activity | Owner | Purpose | Measures/Actions | Goal/Std/benchm | Data Source | Q1 | Q2 | Q3 | Q4 | Results |
| **Mandatory Requirements** | | | | | | | | | | |
| Compliance with MDH ASC regulations and CMS CfC's | All-NMASCMG | Remain compliant with all state and federal regulations, specifically the ASC CfC's and MN ASC Regulations. | All Management team will be knowledgable and kept abreast of current and any revisions of standards. Education provided to staff as needed | Regulatory Compliance – Maintain compliance with CMS CFC's and MN Regulations. | CMS CfC's MN Regulations Survey Outcomes | X | X | X | X | Ongoing compliance with Regulatory Standards |
| Compliance with CDC Infection Control Guidelines | All-NMASCMG | Remain compliant with CDC infeciton control guidelines in an effort to remain compliant with ASC infection Control CFC | CFC and IC guidelines reviewed periodically to assure compliance . Staff education as needed. | Maintain Regulatory Compliance | Infection Rates/Observational Audits | X | X | X | X | Incorporate into Infection control Program. Decrease risk of infection for nmascmg patients |

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| Compliance with all mandated reporting requirements. | Director of Regulatory Affairs | Ensure ongoing reimbursement increases from Medicare and seek to improve scores where appropriate. | Claims-based submission for Medicare requirements.<br><br>Annual submission of remaining measures for both CMS and MN Community Measurement. | Submission for all measures by deadlines and on every claim. | EPIC and Provation. Measures to be reported through Quality Net, NHSN or are claim based reported via SMP | X | X | X | X | Timely reporting of mandated measures will provide maximum financial reimbursement. |
| Annual Evaluation | QI | Review the effectiveness of the annual plan for the previous year. | Completed evaluation. | BOG reviews and approves evaluation. | Various program description work plan. | X | | | | Completion of annual evaluation completed by end of q1, 2018 approved per BOG |
| Quality/Risk Program Description | QI | Annual review of the program incorporating changes identified in evaluation. | Review and revise program and structure to reflect improvements. | BOG reviews and approves program description. | Various | X | | | | Review and revison occurred _____Q1 2018 board meeting and QAPI and infection control Committee members |
| Annual Work Plan | QI | Outline the planning, monitoring and improvement activities for the year. | Work plan is completed. | Work plan is reviewed and approved by BOG. | Various | X | | | | Completed and approved by QI/IC and Board. Review quarterly at QI/IC committee meetings. |
| Biannual Review of Policies and Procedures | Department Managers | Assure P&P's are updated to reflect current performance parameters. Next comprehensive review is due in June 2019. | Policies and procedures reviewed and revised as needed.<br><br>Staff will review policies per mandatory requirements and/or with changes. | Applicable policies updated.<br><br>Policy reviewed by staff with new implementation and or edits. | K: drive Policies and Procedures | X | X | X | X | ongoing |

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| Employee Education | Managers | Comprehensive training and education to facilitate and promote the commitment to quality of care and service. | HealthStream Online learning.<br><br>Provide additional modules for other mandatory educational needs. | 100% staff completion with 80% score.<br><br>Additional mandatory educational modules provided. | Health Stream Reporting<br>Continued education and inservice training as needed | X | X | X | X | Meet Regulatory compliance knowledgable staff who provide exceptional care. |

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| **Quality Indicator Monitoring** | | | | | | | | | | |
| Infections/SSI, Implants and HAI | Director of Regulatory Affairs/ Clinical managers and assigned committee members | Track/trend and analyze to prevent/minimize infections. Monitor adherence to infection control practices | Infection rate monthly (per 1000 cases).<br><br>Follow-up on all patients sustaining post-op infection. 30days and 90 days for implants.<br>Initiate peer review on patients who develop infections<br>Ongoing environmental audits<br>Initiate peer review on patients who develop infections. | ASCA mean 1.1:1000. Benchmark with SMP and MNASCA<br><br>Analyze and report any deviations from established norms. Correct action items noted with environmental audits. Audit endoscopy cleaning process on annual basis to ensure compliance due to complexity of process. housekeeping audits | EPIC Reporting<br><br>K: drive infection control folder Physician Surveys Environmental and houekeeping audits. Endoscopy cleaning competency audits, monthly monitoring of sterilization process audits. | X | X | X | X | |
| Transfers/ Hospital Admissions | Clinical Director/executive Director/ Clinical Management Team and Director of Regulatory Affairs | Track/trend and analyze to prevent/minimize occurrences. | Monthly rate (per 1000 cases) for direct transfers from ASC to acute-care facility.<br>Monthly rate (per 1000 cases) for hospital admission w/in 72 hours from surgery.<br>Provide education for physician during initial appointment. All transfers to be reviewed per peer review process | ASCA mean 1.1:1000<br><br>Benchmark with SMP/MNASCA<br><br>Internal Benchmark = 1.0:1000<br><br>Analyze and report any deviations from established norms. | EPIC reporting, Surveillance forms, occurrence reports , post op phone calls, patient surveys. | X | X | X | X | 72 hour admission will continue to track and trend even though not required reporting CMS measure. Continue with peer review for all tx and admission. |

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| Patient/Visitor and Employee Occurrences | Safety and Quality Committee, clinical managersq | To prevent and/or minimize potential risk to patients and employees. | Track/trend pt/visitor occurrences.<br><br>Track/trend employee occurrences. | Any trends noted will be given consideration for a quality improvement study and need for improvement. | Occurrence Reports | X | X | X | X | |
| Patient Satisfaction | Bright Ideas Committee,Executive director, Clinical Managers, Director of Regulatory Affairs | Improve patient satisfaction with care received at NMASCMG. | Overall Satisfaction, Confidence in Care and Recommend Facility Patient Satisfaction Results | Goal for Overall Satisfaction, Confidence in Care and Recommend Facility to be above National Average by 0.1 each quarter. | Symphony Reports | X | X | X | X | Bright Ideas continue to work on specific patient satisfaction initiatives. |

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| Maintain Normothermia | Quality Rep/Clinical managers/Director of regulatory affairs | To maintain normothermia within 15 minutes post op for general and neuraxial anestehsia patients under anesthesi for > 60 minutes. To provide better patient outcomes, i.e. less infections, increase comfort levels, faster recovery times, | track and trend patient temperatures within first 15 minuts post op for general and neuraxial patients whose anesthesia has been greater than 60 minutes. | Temperature within first 15 minuts of arrival in phase 1 will be at or >96.8 degrees F 95 % of time. Normothermia measure will be reported for 2018 data per quality net portal | EPIC Patient REPORT | X | X | X | X | New reporting measure for 2018. run quarterly reports to monitor compliance with normothermia criteria |
| Contracted Services | Laurie Daniels | To assure that all contracted services are maintaining quality standards and following appropriate guidelines. | Documented evidence of quality measures will be kept on file for all contracted services. It will be updated annually. | Documented evidence of quality will be kept on file for 100% of vendors. | QI Contract Manual | X | X | X | X | Quality Committee Review due March 2018 |

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| **High-Volume, High-Risk, or Problem-Prone Processes – Improvement Activities** | | | | | | | | | | |
| Infection Control-Hand Hygiene IUSS Monitoring SPD audits | Director of Regulatory Affairs/ Lisa /Clinical Managers | To decrease the risk of infection from the hands of health care workers. Comply with current CDC Hand Hygiene Guidelines and improve hand hygiene compliance. | Monitor compliance rates and provide feedback of rates to staff and committees.<br><br>Yearly Infection Control Education and on as need basis.<br>Monitor frequency of Iuss | Achieve 90% pre and post-hand hygiene compliance<br>Based on IUSS frequency purchase and or add to budget new equipment and supplies | Hand washing Audits<br>IUSS Monitoring | X | X | X | X | HH education demonstration 3rd quarter. Monthly hand hygiene audits, physician, contract and EE education<br>Add to budget items needed to decrease IUSS frequency. |
| Discharge Instructions | Clinical manager and sub-committee | Increase patient satisfaction with discharge instructions. | Monitor rates of dc patient satisfaction. Continue to update epic instructions per individual offices and physicians. | Exceed National Average by 0.1 | Symphony monthly and quarterly tracking | X | X | X | X | Improve Patient under |
| Consents | Jennifer C/Task force | To ensure completion of consents in order to avoid wrong site surgery or adverse health events | Monitor completion of consents as outlined in policy. Reconvene consent task force with members from all departments. | 95% accuracy of consent completion per policy. | Consent audits per EPIC and paper consents and /good catches | x | x | x | x | Accurate completion of consents to avoid adverse health events. |

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| Medication Errors | Clinical Managers | To Provide accurate medication administration using the 5 rights. | Track and trend all medication occurrences. | Goal <or=1.1:1000 internal benchmark Benchamrk with SMP and MNASCA | Via Occurrence reports and Good catches | X | X | X | X | ongoing TRACKING TO ASSURE MAINTENANCE OF COMPLIANCE WITH MED ADMINISTRATION |
| Time-Out Process/ Correct site surgery | Jennifer C/Clinical Managers | To assure safety of all patients by following Universal Protocol policy. | 10 Random monthly observational audits of time-out process for surgical patients<br>Random time out audit for endo in 6 months to measure for continued compliance.<br><br>Appropriate actions will be initiated based on results of the above actions. | 100% compliance with all indicators on observational audits. | Chart Audits Audits by observation | X | X | X | X | Ongoing compliance with Time out Process. Endo audits 2nd quarter 2018 to ensure compliance. |

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| Anesthesia | Dr. Monahan Clinical manger pre post and OR Manager | NIDDM and blood sugar management with Regular insulin pathway | Ongoing monitoring and measurement of blood surgars pre and post op following anesthesia pathway for administration of insulin monitoring in place | Maintain acceptable levels of insulin. Monitor for post op infection and complication | Patient record, post op phone calls, infection surveillance forms | X | X | X | X | Provide patients with coverage for blood sugars in order to maintain optimum healing |

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| Endoscopy:improvement in scheduling Surgical : improvement in scheduling | Management team | To manage both endoscopy and surgical schedules in an efficient manner; maintaining on time starts thereby enhancing patient, physician and staff satisfaction | Run reports for first quarter 2017; collecting data regarding on time starts and first case of day. Analyze data collected and develop plan. | Surgical: On Time start (all Cases) Goal = 70% On-Time Start (1st Case of Day) Goal=70% Endoscopy: On Time start (all Cases) Goal = 70% On-Time Start (1st Case of Day) Goal=70% | Epic Reports Provation Reports | X | X | X | X | see goals in order to achieve patient satisfaction with wait time and to run efficient schedule. |

**APPROVALS:**

QAPI Committee Approval: Signature: Approved per committee Diane Lulic Date: Jan-18

Board of Governor Approval: Signature: _____ Date: _____

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