NORTH MEMORIAL AMBULATORY SURGERY CENTER, LLC
QUALITY IMPROVEMENT / RISK MANAGEMENT PLAN

PURPOSE

The North Memorial Ambulatory Center employees, affiliated medical staff and the Board of Governors are committed to establishing and maintaining the highest quality of care and service through collaboration of multi-disciplinary teams. The purpose of the Organizational Quality Improvement / Risk Management Plan is to ensure that the organization measures, analyzes and tracks quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services offered in the facility. The plan provides a framework for principles of quality improvement and risk management. To accomplish our objectives, staff members and leaders are empowered to initiate improvements, eliminate waste, and add value to processes and systems on behalf of its customers-internal and external.

MISSION, VISION & VALUES

Mission: Our Mission is to provide compassionate, exceptional surgical care to our patients and their families.

Vision: We will be the best surgery center in the Midwest in customer service, quality, and patient experience.

Values:

- ***Continuous Improvement*** **-** We seek to relentlessly improve our performance in every area – clinical, operational, and financial – constantly pushing ourselves to new heights.
- ***Quality*** **-** We are committed to outstanding patient care and clinical outcomes.
- ***Professionalism*** **-** We do what is right, no matter how difficult, without exception. We say what we mean, and we do what we say.
- ***Teamwork*** **-**We work together, helping and supporting one another and the customers we serve.

GOAL

The primary goal of the Quality Improvement / Risk Management Plan is to maintain a philosophy of continuous improvement within our organization.
The three primary objectives are:

A. Quality and Safety: use best practice approaches to provide the highest quality or care in a safe manner.
B. Patient Satisfaction: use of measurement tools to assure the best possible patient experience and to provide feedback to the staff to improve patient care.
C. Efficiency: use of productivity and other efficiency measures to maintain reasonable cost for service.

QUALITY IMPROVEMENT/RISK MANAGEMENT/ INFECTION CONTROL COMMITTEE

The Quality Improvement / Risk Management / Infection Control Committee shall be comprised of the ASC Medical Director, the ASC leadership, and designated staff members. Individuals within the team will represent the entire facility, providing a cross functional group that possesses an overall knowledge and understanding of the surgical center. The committee shall act as the organizational body responsible for infection control, quality improvement and risk management activities.

Members shall include, but not be limited to:

1. Medical Director (who also represents anesthesia)
2. Clinical Director
3. Supervisors
4. One representative from each of the following departments:
    - Front office
    - Pre and Post-Op
    - Operating room

The Quality Improvement/Risk Management/Infection Control Committee shall review the following at meetings:

1. Analysis of the results of peer review activities.
2. Benchmarking Data
3. State, Federal, AAAHC Regulation Data
4. Any improvement study data.
5. Monthly infection/hospitalization rates.
6. Patient Satisfaction Data.
7. Patient Variances and Grievances.
8. Recommendations regarding prevention / improvement of safety hazards.
9. Adverse Events or Near Misses
10. Safety

AUTHORITY AND RESPONSIBILITY

THE NORTH MEMORIAL AMBULATORY SURGERY CENTER BOARD OF GOVERNORS

1. Has oversight and accountability for the quality assessment and quality improvement program.
2. Is responsible for overall care at the NMASCMG.
3. Evaluates and approves the overall Quality Improvement Plan.
4. Evaluates and approves the annual Quality Improvement and Risk Management work plan.
5. Receives and reviews Quality Improvement Committee minutes and reports.
6. Oversees the peer review process.
7. Participates in the review of credentials as well as quality of care issues and concerns of all active staff prior to their reappointment.

8. Ensures that facility policies and programs are administered to provide quality health care in a safe environment.
9. Develops and maintains a disaster preparedness program.
10. Ensures that the Quality Improvement program:
    - Is defined, implemented, and maintained.
    - Addresses NMASCMG's priorities and that all improvements are evaluated for effectiveness.
    - Specifies data collection methods, frequency, and details.
    - Clearly establishes its expectations for safety.
    - Adequately allocates sufficient staff, time, information systems and training to implement the program.

MEDICAL DIRECTOR AND ANESTHESIA REPRESENTATIVE

1. Contribute to medical staff quality assurance activities.
2. Provide input in the development of criteria to be monitored to evaluate the quality and appropriateness of clinical performance.

CLINICAL DIRECTOR

1. Is responsible for and accountable to the Board of Governors for the facility's Quality Improvement program.
2. Acts as the Chairperson for the Quality Improvement Committee.
    a. Is responsible for coordinating the activities of process improvement, coordinating team efforts to monitor and evaluate patient care.
3. Designs and implements the Quality Improvement plan for the NMASCMG.
4. Prepares Quality Improvement reports and minutes for review. Tabulates, aggregates, summarizes, and displays pertinent data.
5. Assists the department supervisors with policy and procedure development.
6. Assists the Executive Director and facilitates with the promotion of organizational wide philosophical commitment to quality.
    a. Promotes and supports systems and processes to achieve safe, cost effective, high quality health care.
7. Conducts Quality Improvement activities in a manner that complies with regulatory standard.
8. Educates new staff and provides on-going educational activities for the facility to support quality initiatives.
9. Investigates, track and trends surgical outcomes.
10. Investigates and trends all surgical site infections and reports information to appropriate personnel.
11. Acts as a liaison between the Board of Governors and organizational departments for matters affecting operations.
12. Reporting improvement activities to the Board of Governors.

13. Assure that staff in-services and drills related to safety and emergency preparedness are held in compliance with state, federal and regulatory agency requirements.
14. Assure all new employees are oriented to the Quality Improvement Program.
15. Responsible to develop and maintain oversight of Infection Control Program.
16. Responsible for the new employee orientation of infection control practices.
17. Responsible for the annual mandatory in-service of blood borne pathogens.
18. Support and nourish the improvement efforts of every group and individual in the organization.
19. Monitor activities of biomedical and facility maintenance.
20. Promote process improvement for the ongoing prevention and reduction of risk.
21. Ensures compliance with all environmental health and safety standards promulgated by all local, state, and federal agencies through development and implementation of on-site inspection and monitoring programs.
22. Reviews and investigates all adverse events, incident reports and/or close calls reported.
23. Investigates incidents regarding malfunctioning medical devices.
24. Develops and recommends new procedures and approaches to safety and loss prevention based on reports of incidents, accidents, and other relevant information.
25. Promotes a non-punitive culture of patient safety.

ALL MEMBERS

1. Meet quarterly to review Quality Improvement Data; data shall coincide with the schedules of committee members and staffing needs of Minnetonka Ambulatory Surgery Center. Electronic meetings can be utilized twice a year.
2. Assist in the preparation of the annual quality improvement work plan.
3. Evaluate the scope, organization, and effectiveness of the quality improvement plan.
4. Assist in the identification and monitoring of Quality Improvement activities.
5. Coordinate a system of problem identification, problem resolution and re-evaluation.

EMPLOYEES

1. Be knowledgeable of and actively participating in and supporting the Quality Improvement process.
2. Be involved in a daily search for improvements in all services, products, and organizational processes.
3. Contribute to the achievement of improvement goals through individual action or in partnership with others.
4. Communicate and work together to achieve the mission statement, values, and goals of North Memorial Ambulatory Surgery Center.
5. Develop a teamwork relationship with all customers and suppliers.
6. Focus on the Quality Improvement process to exceed the needs and expectation of the customers, suppliers.
7. Commit to making customer satisfaction and safety top priority.

CUSTOMER SERVICE AND SATISFACTION

Patient satisfaction evaluations will be utilized and completed to determine facility and staff strengths and weaknesses. Data will be analyzed to identify specific areas which need improvement and /or trending patterns. Questionnaires will be assessed regarding care received, patient perceptions and outcomes.

PEER REVIEW

Evaluating the health care provided ensures that the health care professionals are providing the quality of patient care that the North Memorial Ambulatory Surgery Center makes every effort to achieve.

Peer review shall be completed to assist in credentialing and reappointment as well as being a mechanism for evaluating the quality of patient care in an environment that is safe, convenient, and comfortable.

Peer review shall involve a continual, routine gathering of information. Objective and systematic monitoring will be utilized in the evaluation of documentation and unexpected outcomes. Staff members as well as physicians shall be engaged in this process.

Quality Improvement Committee will address peer review activity to monitor, evaluate, and recommend actions to improve the delivery and quality of services, including the review and evaluation of competency, character, activities, conduct and performance of any health professional at the North Memorial Ambulatory Surgery Center. Staff peer review will be incorporated into employee performance appraisal.

QUALITY IMPROVEMENT STRUCTURE

A. The review of patient care shall include the following characteristics:

1. Planned and Systematic Process
    a. Tracking data over time and evaluation of this data determines what elements of patient care best reflect the overall care provided by the department, what kinds of information needs to be collected about these elements of care, and how often the information should be collected and evaluated. This approach is outlined in the yearly work plan and is evaluated and updated annually.

    b. A systematic process for data collection and evaluation means that information about various elements of patient care and clinical performance is collected as part of the daily functions of the department when appropriate. The information is collected at the various agreed on intervals of time and is representative of the practitioners involved and the type of service provided.

2. Monitoring

a. Ongoing monitoring of information about important aspects of patient care and patient outcomes. This monitoring of care and outcomes shall be comprehensive, not limited to problem focused studies, and shall utilize statistical methods and Total Quality Management (TQM) tools to interpret data accurately and produce meaningful information in order to adequately address the full scope of services provided including high risk, high volume, new procedures and problem prone areas.

b. Methods of assessment, monitoring and problem identification shall include, but not be limited to:
   1. Observation-Monitoring specific activities and recording a measurement
   2. Interview- Questions are asked to obtain information
   3. Record Review- A review of medical records.
   4. Concurrent Monitors-A review performed during a patient's stay.
   5. Brainstorming- A problem-solving idea creation technique that involves generating a wide variety of concepts.
   6. Retrospective Monitors- Looking back in time, a monitor occurs after the services have been provided.
   7. Benchmarking-The comparison of key performance measures with other like organizations or with best practice of national or professional targets. Tracking accurate facility historical data that can be compared now and, in the future.

c. Identification of problems and/or opportunities may be revealed by utilizing the following sources:
   1. Policies and Procedures
   2. Standards of care
   3. Guidelines for documentation
   4. Current literature teaching
   5. Cost of care

d. Other means of problem identification utilized in the continued effort to improve patient care includes that which comes through:

   Internal methods
   - Medical Records Review
   - Case Review
   - Peer Review
   - Infection/Hospitalization follow up
   - Incident Reports
   - Historical Benchmarking
   - Ongoing tracking and trending of key indicators
   - Staff suggestions

e. Quality Improvement activities will be prioritized with consideration given to the incidence, prevalence and severity of the problems identified as well those that will affect health outcomes, patient safety and quality of care.

External Methods

- Regulatory Agencies (CMS, AAAHC)
- Federal Legislation
- Professional Organizations (ASCA, APIC, AORN, AAMI)
- Networking
- Benchmarking (Ambulatory Surgery Center Association (ASCA) and Surgical Management Professionals (SMP) Benchmarking Data)

3. Evaluation and Problem Identification
   Each department participates in the development and application of the objectives used to evaluate the care they provide. They shall identify problems that have an impact on patient care and outcomes, clinical performance, and overall process. Observe clinical performance and identify patterns or trends and be constantly on the lookout for ways to improve.

   a. The primary approaches/methods of problem assessment and evaluation are:

      Structure
      Structure is the arrangement of the care system or elements that facilitate care; resources, staff, equipment, policies etc.; evidence of the facilities ability to provide care; the care environment.
      Process
      Refers to the method, means, sequence of steps or procedures for providing care and producing outcomes. There may be many or few processes directed towards the evaluation of activities carried out by health care personnel in the delivery of patient care.

      Outcome
      Directed toward the evaluation of a patient's health status as a result of patient care delivered. It is retrospective as the patient's chart is reviewed following discharge. The audit is done with a focus on a specific problem or concern identified, or specific processes, as well as any potential problems that could affect the patient's outcome.

   b. Analysis of monitors and/or identified problems utilizing, but not limited to the following tools.
      1. Process Improvement Teams
      2. Brainstorming
      3. Control Charts
      4. Flow Charts
      5. Pie Charts
      6. Pareto Charts
   c. If problems are suspected; problem focused studies may be performed to determine the cause, magnitude, and impact of the problem.

d. In some cases, a combination of any or all of the approaches/methods may be used. The method chosen for monitoring/evaluation/improvements is determined by the type of problem identified.
    1. Procedural (process-observation)
    2. Documentation (outcome / process record review)

4. Action

Action is taken as appropriate when negative findings; trends, special cause variation, problems, or opportunities to improve care are identified. Actions may include:

a. Changes or modification of equipment/supplies.
b. Process improvement
c. Development / review / revision of policy, procedures, standards, and guidelines.
d. Assessment and / or modification of contracted services.
e. In-service education
f. Re-evaluating identified problems or concerns is performed to assure that the corrective measures have achieved demonstrable improvement. Alternative corrective actions are taken as needed with continuing re-evaluation.
g. Documentation of findings, conclusions, recommendations, action taken and results of action taken will be documented in:
    1. Quality Improvement Committee meeting minutes.
    2. Reports and monitors to the Quality Improvement Committee
    3. Reports and minutes to the Executive Director and Management Board.
    4. Updates related to projects should be reviewed with staff at staff meetings.
i. Corrective actions take into account the following:
    1. Resources available
    2. Time involved
    3. Cost
j. Implement strategies that target adverse patient events and ensure all staff are familiar with the strategies.
k. If a problem would be escalated, NMASCMG would seek guidance and provide notification to the liability provider.

MEASURES OF EFFECTIVNESS

The Clinical Director and/or Designee is responsible for the facilitation, documentation, and reporting of the day-to-day functions of the overall quality program.

The objectives, scope, organization, and effectiveness of the activities of the Quality Improvement Program are evaluated at least annually and revised as necessary. This review of the overall quality plan and annual work plan evaluates the effectiveness of the program. Emphasis will be placed on areas monitored, evaluated, identified problems, opportunities for improvement, success of actions taken toward problem resolution and improvements made in patient care. Efficiency and cost-effectiveness will also be evaluated. Revisions to the program will be effective upon approval of the Management Board.

CONFIDENTIALITY

All copies of minutes, reports, and worksheets will be handled in a manner ensuring strict confidentiality. Results of quality assurance activities and reports will not contain identifiable client information. Information may be coded or reported in aggregate.

_____	_____
Board of Governors	Date
_____	_____
Medical Director	Date
Jennifer Cornelius, RN	3.2.2022
_____	_____
Clinical Director	Date