

Administrative Policy Number: 17.01

TITLE: PERFORMANCE IMPROVEMENT AND PATIENT SAFETY PROGRAM (PIPS)

I. PURPOSE

The intent of the Performance Improvement and Patient Safety Program is to promote a culture of safety and provide a systematic, coordinated and continuous approach to optimizing clinical outcomes and patient safety. This is achieved by:

- A. Collaboration of the Governing Body, Joint Conference Committee and Hospital Leadership to establish annual performance goals directly linked to the San Francisco General Hospital & Trauma Center (SFGH) strategic goals.
- B. Creating a culture of safety to anticipate, identify and acknowledge risks and errors and promote error reporting as part of the provision of care and safety of the patient.
- C. Assessing the perceptions of patient safety by administering the AHRQ Culture of Safety Survey at least every ~~24~~24 months.
- D. Establishing a “just-culture” frame work that addresses both systems issues and human behaviors that can undermine performance and patient safety.
- E. Aggregating data to identify trends and high-risk activities while defining measures to address identified safety issues.
- F. Educating staff to their role in identifying and resolving errors and involving staff in proactive risk assessments and behavioral improvements.
- G. Ensuring that proactive risk assessments (e.g. Failure, Mode, Effect and Analysis) and process improvements are communicated to managers and those directly involved when appropriate.

II. STATEMENT OF POLICY

SFGH is committed to patient safety and recognizes that patients, staff, and visitors have the right to a safe environment. It is the policy of SFGH to establish and maintain an ongoing, systematic, and proactive organization-wide process to measure, assess, and improve patient care and safety based on the organization's mission and its strategic planning goals and objectives. Identifying, analyzing, and resolving systems and human behavior risks sets a foundation grounded in patient safety. The Performance Improvement and Patient Safety Program provides the framework to achieve and maintain a safe environment by promoting a culture that encourages error identification,

reporting and prevention through education, system redesign and human behavior management.

The Medical Staff, through the Medical Executive Committee, is responsible for the establishment, maintenance and support of an on-going, organization-wide Performance Improvement and Patient Safety Program in accordance with The Joint Commission standards, state and federal regulations, professional regulations, and the SFGH Medical Staff Bylaws.

Hospital leadership, through the Quality Council, sets expectations for performance improvement and manages processes to ensure that the Performance Improvement and Patient Safety Program is meeting the hospital's goals as well as meeting all Joint Commission standards and regulatory requirements.

III. PROGRAM DESCRIPTION

A. The Performance Improvement and Patient Safety (PIPS) Program

1. The objectives of the PIPS program are to:

- a) Gather standardized clinically relevant information about patient safety events and close calls that may adversely impact patients;
- b) Develop solutions to systemic patterns and practices that place patients at risk and to stimulate, initiate and support interventions designed to reduce risk of errors and to protect patients from harm;
- c) Promote a uniform monitoring and evaluation process for performance improvement and patient safety activities;
- d) Promote the involvement of care providers in defining quality, establishing standards, and developing mechanisms to monitor, evaluate, and improve processes and patient outcomes;
- e) Promote a culture geared toward proactive risk assessment by increasing the reporting of medical errors and adverse events and expanding opportunities to reduce errors and adverse outcomes;
- f) Prioritize initiatives to enhance patient outcomes/safety based on analysis and assessment of the data, and in accordance with the organization's mission, vision, care and services provided, and the population served;
- g) Facilitate an interdisciplinary, collaborative approach to improving the quality of care, patient safety, and utilization of resources through the designation of continuous performance improvement and patient safety initiatives;
- h) Guide SFGH in meeting legal, professional, accreditation, and regulatory requirements; and

- i) Provide education and communication on performance improvement principles and tools.

2. Performance Improvement and Patient Safety (PIPS) Committee

a) The PIPS Committee is responsible for implementing the objectives of the organization-wide performance improvement and patient safety program. The PIPS Committee takes an interdisciplinary and proactive approach in the prevention of adverse events, medical errors and near misses, and promotes patient outcomes/safety as a core value in providing quality patient care.

b) The PIPS Committee is a Medical Staff Committee. The Committee consists of at least seven (7) physician representatives from the Clinical Services at SFGH. In addition, one (1) representative from Radiology, Clinical Lab, Pharmacy, Infection Control, Nursing and the Behavioral Health Center are designated as Committee members. The Chief Nursing Officer, the Administrative Director of Utilization Management and the Patient Safety Officer are also members (See Medical Staff Bylaws). The Chief Medical Officer or Associate Chief Medical Officer serves as Chair of the PIPS Committee, and the Chief Quality Officer serves as Vice Chair.

Functions of PIPS Committee include:

1. On an annual basis, reviews the effectiveness of the Hospital Performance Improvement and Patient Safety Program in meeting the organization-wide purpose, goals and objectives and revises the program as necessary;
2. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from: focused reviews and sentinel events including The Joint Commission Sentinel Event Alerts; patient case reviews; risk management reports; hospital claims; staff patient safety suggestions tool; patient and staff surveys; patient/visitor concerns; clinical service and ancillary/diagnostic department performance improvement reports; ongoing medical record review, and other sources as appropriate;
3. Reviews performance improvement reports from clinical laboratory services and diagnostic radiology services as part of the annual report;
4. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and PI committees as appropriate;

5. Makes recommendations based on an evaluation of the care provided (e.g. efficacy, appropriateness) and how well it is done (e.g. availability, timeliness, effectiveness, continuity with other services/practitioners, safety, efficiency, and respect and caring).
6. Reports and forwards recommendations monthly to the Quality Council and Medical Executive Committee through the Chief Medical Officer and Chief Quality Officer.
7. Reports and forwards recommendations monthly to the Governing Body/Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer.
8. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources.

PIPS Subcommittees include:

- a. Code Blue Subcommittee: Oversees the organization and operations of the Code Blue Team. All findings from review of code activities related to performance improvement and patient safety activities are reported to this committee for evaluation and recommendations.
- b. Pediatric Emergency Medicine Subcommittee: Ensures compliance with the City and County of San Francisco Emergency Department approved for Pediatrics standards. Ensures ongoing compliance with the standards of the Emergency Department Approved for Pediatrics (EDAP) program. Reviews the Hospital's internal capabilities for providing emergency pediatric care not addressed by the EDAP standards, including inpatient critical care and trauma services. The committee evaluates potential problems, identifies resources and establishes performance guidelines. This process includes establishment of a quality improvement mechanism.
- c. Risk Management Subcommittee: Identifies general areas and specific cases of potential risk in the clinical aspects of patient care and safety; recommends action plans for problems in the clinical aspects of patient care and safety identified by risk management activities; and designs programs to reduce risk in the clinical aspects of patient care and safety.

- d. Tissue Subcommittee: Reviews all surgical case reports and makes recommendations based on results. Also reviews documentation practices in pathology reports.
- e. Transfusion Subcommittee: Reviews transfusion-related issues in the Hospital, including the appropriateness of the use of blood and blood components, incidents of avoidable blood wastage, and all transfusion reactions.
- f. Trauma Operational Process Performance Improvement Subcommittee: Evaluates trauma systems and medical performance through objective and systematic monitoring; identifies, analyzes and tracks problems; develops and implements plans for improvement; trends and measures the effectiveness of corrective action.
- g. Trauma Multidisciplinary Peer Review Subcommittee: Assures the quality and appropriateness of trauma care as it relates to performance of individual providers and the interaction between providers of different disciplines.

3. Patient Safety Plan

The Patient Safety Plan is approved and reviewed at least every 6 months through PIPS [and Quality Council](#). The Patient Safety Officer works collaboratively with the Infection Prevention and Control Program Manager and together they concentrate on the following areas:

a) Hospital Acquired Infections (HAI) – The Infection Control Program Manager is responsible for monitoring and reporting the following ~~to the MEC and PIPS every 6 months, therefore is not required to report to Quality Council~~:

- Central Line Associated Blood Stream Infections (CLABSI)
- Central Line Improvement Program (CLIP) – Measures compliance with insertion bundle
- Ventilator Associated Pneumonia (VAP)
- Surgical Site Infection (SSI) – Infection Prevention Measures
- Catheter Associated Urinary Tract Infection (CAUTI)
- Clostridium difficile (C. diff)
- Methicillin Resistant Staphylococcus Aureus (MRSA)
- Hand Hygiene Surveillance

- Surgical Care Improvement Program (SCIP)

b) Hospital Acquired Conditions (HAC) – The Patient Safety Officer is responsible for the monitoring and reporting of the following: ~~to PIPS, therefore is not required to report to Quality Council:~~

- Hospital Acquired Pressure Ulcers (HAPU)
- Falls
- Venous Thromboembolism Prevention (VTE)
- Tubing Misconnections

c) Patient Safety Programs – The Patient Safety Officer is responsible for the monitoring and reporting of the following ~~to PIPS, therefore is not required to report to Quality Council:~~

- Fair and Just Culture
- Stop the Line
- Sepsis Mortality
- ~~Surgical Care Improvement Program (SCIP)~~
- Staff Development
- Culture of Safety Survey
- Patient Safety Rounding and the patient safety dashboard
- National Patient Safety Goals
- CHPSO – California Hospitals Patient Safety Organization
- ~~EOC Committee Members~~ EOC Committee Member

4. The Quality Council

a) The Quality Council is a hospital committee responsible for reviewing and approving the clinical and departmental performance improvement measures and patient safety initiatives of SFGH.

b) The membership of the Quality Council is the hospital's Executive Staff including the Chief Executive Officer Administrator, Chief Nursing Officer, Chief of Medical Staff, Chief Medical Officer, the Associate Dean and Hospital Associate Administrators. The Chief Executive

[Administrator Officer](#) and the Chief Medical Officer serve as the Co-Chairs of the Quality Council.

c) The Quality Council focuses on performance improvement activities pursuant to the mission, vision, values and strategic goals of SFGH.

Functions of the Quality Council functions: include:-

1. Identifies, prioritizes, implements, and evaluates opportunities to improve organizational functions and systems, and designates Performance Improvement Task Forces to facilitate interdisciplinary, collaborative approaches to improving the quality of patient care and safety;
2. Identifies and prioritizes patient safety initiatives and performance improvement opportunities in accordance with the hospital's mission, vision, care and services provided, and the population served;
3. Annually reviews and approves hospital-wide performance measures, including the evaluation of performance by patient care services provided through contractual agreement ([Admin: 3.28 Contracting: Patient Care Services](#)).
4. Reviews and approves the patient safety plan;
5. Develops recommendations for performance improvement activities according to potential impact upon patient outcomes and safety and in accordance with the hospital's mission, vision, care and services provided, and the population served;
6. Ensures integration of approved performance and safety improvement recommendations into SFGH management accountabilities;
7. Participates in the strategic planning process for patient safety and recommends that performance improvement findings are incorporated into goals and objectives of that process;
8. Ensures that safety issues have priority status and are taken into account when designing and redesigning processes; and
9. Ensures appropriate review, analysis and follow-up of performance improvement opportunities, including analyses of staffing adequacy related to undesirable patterns, trends, or variations pertaining to safety or quality.
10. [Oversees the work of the Care Experience Data Review \(CEDR\) Committee.](#) ~~Oversees the work of the Service Excellence~~

Committee ~~(no longer a committee at SFGH to ensure our patients, workforce, and visitors' experience on campus is positive; oversees the SFGH Grievance Process. (QC doesn't do this.)~~

5. Utilization Management Committee

a) The Utilization Management Committee (UMC) that shall consist of at least seven (7) members of the Active Medical Staff, including the Medical Director of Utilization Management, Chief of Staff, and representatives from a range of medical and surgical clinical services, including at least one member from COPC. Additional members include the Director of Utilization Management, Chief Operating Officer, Chief Pharmacy Officer or designee, and representative of the UCSF Dean's Office. Other individuals from the clinical, administrative, and support services whose participation is deemed necessary to increase the effectiveness of the work of the committee are invited to meetings as needed. The Medical Director of Utilization Management or designee shall serve as Chair and the Chief Operating Officer or designee shall serve as Vice Chair.

b) The purpose of the UMC is to provide oversight for all Utilization Management functions, and make rational, system-coordinated, and evidence-based recommendations on the priority of clinical services provided at SFGH for use in managing limited resources.

c) This committee shall meet monthly and shall maintain records of its proceedings and activities. UMC shall report on its activities quarterly to the Medical Executive Committee and Joint Conference Committee (Governing Body).

d) This Committee will review data reports related to Utilization Management on a regular basis, including, but not limited to:

- Medical necessity/appropriateness of hospital admissions
- Medical necessity/appropriateness of continued stay and treatment authorizations
- Lengths of stay variations and timeliness of discharge
- Professional services furnished, including drugs and biologicals
- Appropriate availability and use of ancillary services
- Overuse, underuse, and timeliness in provision of services
- Therapeutic procedures

- Adequacy of medical record documentation
- Third party payer denials
- Utilization of the Tertiary Care Contract
- San Francisco Health Plan and Anthem Blue Cross utilization and cost data
- Out-of-network referral costs
- Utilization Review Plan (review and approve annually)

6. The Governing Body

The San Francisco Health Commission is ultimately responsible for maintaining the quality of patient care and safety. Through the SFGH Joint Conference Committee of the Health Commission, this governance is achieved as follows:

- a) Approves the SFGH Hospital Performance Improvement and Patient Safety Program;
- b) Through the Director of Public Health and the SFGH Executive Administrator, supports performance improvement and patient safety initiatives and mechanisms by employing specific staff to provide technical and consultative support to the various departments and programs;
- c) Ensures quality planning is incorporated into the strategic planning process; and
- d) Through the Joint Conference Committee, Quality Council and the PIPS Committee, regularly reviews reports on performance improvement and patient safety activities and acts upon them when appropriate.
- e) Annually reviews and approves hospital-wide performance measures, including the evaluation of performance by patient care services provided through contractual agreement ([ADMIN: 3.28 Contracting: Patient Care Services](#)).

7. Individual Roles and Responsibilities

a) Director of Public Health:

- i. Provides support and facilitates communication throughout the Department of Public Health in regard to activities and mechanisms for monitoring and evaluating the quality of patient care/safety, identifying and resolving problems, and identifying opportunities for improvement.

b) SFGH Executive Administrator:

- i. Assumes overall administrative accountability and responsibility for the SFGH PIPS Program; and
- ii. Assists in identifying opportunities for improvement of the quality of patient care/safety and resolution of problems.
- iii. Co-Chairs the Quality Council with the Chief Medical Officer.

c) Quality Management Department:

- i. The Quality Management Department is responsible for the implementation of the organization-wide PIPS Program.

d) Chief Medical Officer and Associate Chief Medical Officer:

- i. Works with the Chief Quality Officer to develop and implement the Performance Improvement and Patient Safety Program;
- ii. Participates in and leads performance improvement and patient safety initiatives;
- iii. Reviews departmental and committee performance improvement and patient safety reports/ plans to identify interdepartmental and/or interdisciplinary quality issues;
- iv. Reviews all patient deaths and identifies deaths that may be related to a hospital-acquired infection;
- v. Co-Chairs the Quality Council and Chairs the PIPS Committee;
- vi. Ensures that the SFGH Medical Staff Bylaws reflect the function and role of the PIPS Committee;
- vii. Oversees and participates in the education of Medical Staff, nursing staff, and others regarding performance improvement and patient safety;
- viii. Directs quality and utilization functions of the Tertiary Care Contract and managed care programs;
- ix. Represents the PIPS Committee on the SFGH Quality Council; and
- x. Presents performance improvement reports to the Medical Executive Committee and to the Joint Conference Committee.

e) Chief Quality Officer:

- i. Develops, implements, and monitors the Performance Improvement and Patient Safety Program and Plan under the direction of the SFGH Executive Administrator.
- ii. Assists the Quality Council with the coordination and integration of performance improvement activities throughout the health care delivery system;
- iii. Offers technical assistance in regards to performance and patient safety activities to the Medical Staff, Hospital staff, Committees, performance improvement and patient safety teams, and Associate Administrators;
- iv. Reviews departmental and committee performance improvement reports to identify interdepartmental and/or interdisciplinary quality or patient safety issues;
- v. Participates in resolving patient care/safety issues as identified from unusual occurrence data and regulatory agency reports;
- vi. Develops pertinent reports for the Executive Administrator, Medical Staff, committees and external agencies;
- vii. Provides education to the Medical Staff, Hospital leadership, and others regarding performance improvement and patient safety;
- viii. Consults with Department of Education and Training on Hospital performance improvement and patient safety education curriculum; and
- ix. Serves as Vice-Chair of the PIPS Committee and represents the Performance Improvement and Patient Safety Committee on the SFGH Quality Council.

f) The Chief of Service, Associate Administrators, and Department Managers:

It is recognized that all leaders have a major role in performance improvement and patient safety. Chiefs of Service, Associate Administrators, and Department Managers are responsible for the continuous, effective operation and improvement of their respective departments. The Chiefs of Service, Associate Administrators, and Department Managers:

- i. Define the scope of services provided and identify key functions and indicators to monitor practice. Communicate monitoring, evaluation, and improvement results to other disciplines and departments as appropriate. Incorporate strategic planning goals into PI activities, as appropriate;

- ii. Develop and implement performance improvement activities in accordance with the Hospital Performance Improvement and Patient Safety Program;
- iii. Develop, implement and monitor performance measures within each department and report status of measure to the Quality Council;
- iv. Assign representatives to participate in the PIPS Committee and to present performance improvement and patient safety activities as scheduled; and
- v. Participate in Morbidity and Mortality and Peer Review to ensure safe physician practice

g) Medical Director of Risk Management:

- i. Provides medical oversight of the management of Sentinel Events, the Unusual Occurrence system and the process for around-the-clock reporting of patient safety events; and
- ii. Serves as Chair of the Risk Management Committee.

h) Director of Risk Management:

- i. Provides administrative oversight of the management of Sentinel Events, the Unusual Occurrence system, and the process for around-the-clock reporting of patient safety events; and
- ii. Serves as Vice Chair of the Risk Management Committee.

i) Patient Safety Officer:

- i. The Patient Safety Officer collaborates with the [Director of Quality Management](#), [Chief Quality Officer](#), [Director of Performance Improvement](#), Safety Officers, Director of Risk Management, Chief Medical Officer and Manager of Education and Training in developing and planning the hospital's Patient Safety Plan;
- ii. Presents Patient Safety Plan to the Quality Council for approval and coordinates its implementation;
- iii. Works collaboratively with the Chiefs of Service, Associate Administrators, Infection Control, and Department Managers in the evaluation of processes and activities implemented or noted in the Patient Safety Plan; and

- iv. Facilitates communication of proactive risk assessments and the results of patient safety projects to managers and staff.

j) Manager of Education and Training:

- i. Determines education and training needs by assessing a variety of data sources which include the Performance Improvement and Patient Safety and Quality Council committees.
- ii. In collaboration with Performance Improvement and Patient Safety Committee and Quality Council, develops and implements an annual mandatory training program that addresses identified needs.
- iii. Provides assistance and consultation to managers and supervisors hospital-wide to determine educational needs and to enhance the competency and performance level of all employees.

k) Infection Control Program Manager:

- i. Performs the annual Infection Control Risk Assessment for the Facility in collaboration with Infection Control Committee Chairs and members.
- ii. Develops and organizes the Infection Control Annual Plan using results of the risk assessment. The Annual Plan will identify educational activities, plan for investigating unusual infectious events, and develop other routine program activities. (See Appendix F.)
- iii. Assumes responsibility for surveillance and investigation of infectious exposure incidents or outbreaks and prepares and utilizes statistical analysis as appropriate to judge significance of -data.

l) SFGH Staff:

The responsibility for providing quality services is shared by all staff.
The staff:

- i. Assist in identifying opportunities for improvement of the quality of patient care/safety;

- ii. Participate in performance improvement and patient safety activities;
- iii. Incorporate performance improvement and patient safety findings into patient care, treatment and services; and
- iv. Report medical/health care errors and near misses through the unusual occurrences reporting system.

m) Clinical and Support Departments:

- i. The clinical and support departments are responsible for developing and maintaining performance improvement and patient safety activities based on the SFGH's prioritized initiatives.

n) Patient/Client/Resident:

- i. SFGH recognizes that the Patient/Client/Resident is an integral part of the healthcare team. Upon admission and throughout their hospitalization, the Patient/Client/Resident is informed of his/her rights, responsibilities and role in patient safety. This includes providing accurate information about their current health, allergies, current medications and their past medical history.

8. Communication Pathways and Reporting

- a) Communication pathways are established to provide feedback to all committees, task forces, departments, and services responsible for performance improvement and patient safety activities (See [Appendix A](#)).
- b) Hospital, Departmental, and Medical Staff Committees have functions related to the improvement of patient outcomes and safety, development of standards of care and/or improvement of organizational systems and functions, and report to the Performance Improvement and Patient Safety Committee at least annually.
- c) The Chief Medical Officer and/or the Chief Quality Officer report performance improvement activities and issues to the SFGH Medical Executive Committee, SFGH Nursing Executive Committee, SFGH Quality Council, and the SFGH Joint Conference Committee.

9. Identification of Potential Patient Safety Issues

The implementation and integration of the National Patient Safety Goals (see [Appendix D](#)) are reviewed as essential elements in providing safe, quality care. As part of its planning process, SFGH annually reviews the scope and breadth of its services. During this review, attention is paid to

systems and processes that may have a significant negative impact on the health and well-being of patients if an error or 'near miss' occurs. Sources used to identify potential patient safety issues are:

- a) Performance improvement data, including performance measures.
- b) Unusual occurrence, sentinel event, staff patient safety suggestion tool, patient complaint and medical device failure reports.
- c) Regulatory and/or accrediting agencies survey reports and changes in their regulations and/or standards.

Input is solicited from patients and families for improving patient safety by:

- a) Conversations with patients and families during routine care and patient safety rounds
- b) Comments from Patient Satisfaction surveys

10. Use of Data

- a) Performance monitoring and improvement activities are data driven. Data collection is prioritized by the SFGH Quality Council based on the organization's mission, care, treatment and services provided, and the population served. Data collection for performance improvement activities focuses on patient flow and processes that have a major impact upon patient outcomes (e.g. high risk, high volume, problem prone). All data and information containing protected health information (PHI) is secured to protect patients' privacy in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.
- b) The PIPS Program encompasses data and information collected from the following established processes:
 - i. Medication errors, including near misses
 - ii. Adverse Drug Events
 - iii. Utilization Review data;
 - iv. Environment of Care data;
 - v. Patient, family and staff satisfaction surveys;
 - vi. Staff report on medical/health and safety management errors;

vii. Unusual Occurrence reports (UORs), including but not limited to:

- a. Medication errors,
- b. Death and complications,
- c. Violence,
- d. Patient abuse,
- e. Falls,
- f. Absent Without Leave (AWOL)

viii. Performance measures data;

ix. Restraint and seclusion use;

x. Core Measures and ORYX indicators required by The Joint Commission and CMS and selected by the Hospital's leadership;

xi. Outcomes related to resuscitation;

xii. Mortality and autopsy results;

xiii. The Joint Commission Sentinel Event Alerts;

xiv. Infection Control Surveillance;

xv. Claims;

xvi. Clinical Service and ancillary/diagnostic department performance improvement reports;

xvii. Significant Event review findings;

xviii. Ongoing medical record review (e.g. pain management data), and

xix. Other sources as appropriate.

c) The Quality Council and PIPS Committee identify and ensure appropriate follow-up of organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data.

d) The PIPS Committee selects at least one process annually for proactive risk assessment.

11. Performance Improvement Methodology

- a) Performance improvement and patient safety efforts are conducted and documented by using a process improvement strategy called the Model for Improvement (See [Appendix B](#)).
- b) The Failure Mode, Effects and Criticality Analysis (FMEA) methodology is utilized to perform proactive risk assessment (See [Appendix C](#)).

12. Risk Assessment and Performance Measurement to Ensure Patient Safety

- a) Annually, a system or process identified as having the potential to impact patient safety will be selected for a 'proactive risk assessment' using the FMEA process. Internal/external data sources and The Joint Commission publications are used to determine which system or process is to be assessed.
- b) The process is assessed to determine steps where there is or may be undesirable variations (failure modes). Information from internal or external sources is used to minimize risk to patients affected by the new or redesigned process.
- c) For each failure mode, possible effects on patients, as well as the seriousness of the effect, are identified.
- d) The process is redesigned to minimize the risk of failure modes.
- e) The redesigned process is tested and implemented.
- f) Measures to determine effectiveness of the redesigned process will be identified and implemented. Strategies to maintain success over time are identified. In addition, the following are measured:
 - i. The perceptions of risk to patients and suggestions for improving care.
 - ii. The level of staff reluctance to report errors in care.
- g) The PIPS Program is reassessed by the PIPS Committee on an annual basis. Elements to be evaluated include but are not limited to:
 - i. Achievement of goals and objectives;
 - ii. Evidence of process improvement; and
 - iii. Evidence of improvement in patient care.

13. Confidentiality

- a) All monitoring results, abstracted data, related records, correspondence, and all reports developed for quality improvement purposes are confidential to the fullest extent permitted by law.
- b) Discussions, deliberations, records and proceedings of all medical staff committees having responsibilities for evaluation and improvement of quality of care rendered in this Hospital are confidential to the fullest extent permitted by law.

APPENDICES

- [Appendix A: PIPS Program Reporting Pathways](#)
- [Appendix B: The Model for Improvement](#)
- [Appendix C: Sample of Failure Mode, Effects, and Criticality Analysis \(FMECA\)](#)
- [Appendix D: National Patient Safety Goals](#)
- [Appendix E: PIPS Report Template -- Subcommittees](#)
- [Appendix F: PIPS Report Template – Clinical Indicator](#)
- [Appendix G: Infection Control Annual Plan](#)

CROSS REFERENCES

SFGH Administrative Policy and Procedures:

- 1.10 [AMA, AWOL, and Elopement/AWOL “AT-Risk: Patients Leaving SFGH Prior to Completion of Treatment Evaluation or Treatment](#)
- 3.05 [Claims](#)
- 3.28 [Contracting: Patient Care Services](#)
- 16.05 [Pharmaceutical Services: Adverse Drug Reaction \(ADR\) Reporting and Monitoring Program](#)
- 16.25 [Pharmaceutical Services: Medication Errors](#)
- 21.01 [Unusual Occurrences \(UOs\): Management, Reporting and Investigation](#)
- 21.02 [Sentinel Event Review Policy](#)

APPROVAL

<u>Nursing Administrative Forum</u>	<u>9/2/14</u>
<u>Medical Executive Committee</u>	<u>9/18/14</u>
<u>Quality Council</u>	<u>9/16/14</u>

Date Adopted: 04/01/86

Reviewed:

Revised: 10/92, 11/95, 04/99, 11/00, 11/01, 08/02, 9/2003, 10/2004, 10/2005, 12/2006,
12/2007, 3/08, 9/08, 9/09, 9/10, 11/10, 10/11, 10/12, 10/13, [9/14](#)

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