

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 Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) True North.
- 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 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.
- H. Gathering standardized clinically relevant information about patient safety events and close calls that may adversely impact patients;
- I. Developing 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;
- J. Promoting a uniform monitoring and evaluation process for performance improvement and patient safety activities;

- K. Promoting the involvement of care providers in defining quality, establishing standards, and developing mechanisms to monitor, evaluate, and improve processes and patient outcomes;
- L. Promoting 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;
- M. Prioritizing initiatives to enhance patient outcomes/safety based on analysis and assessment of the data, and in accordance with the organization's True North, care and services provided, and the population served;
- N. Facilitating 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;
- O. Guiding ZSFG in meeting legal, professional, accreditation, and regulatory requirements; and
- P. Providing education and communication on performance improvement principles and tools.

II. STATEMENT OF POLICY

ZSFG is committed to patient safety and recognizes that patients, staff, and visitors have the right to a safe environment. It is the policy of ZSFG 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 True North. 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 ZSFG Medical Staff Bylaws.

Hospital leadership works collaboratively with the medical staff and the ~~our~~ governing body to set 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. LEADERSHIP PRINCIPLES (The ZSFG Way) - How we as leaders Align, Enable and Improve to achieve True North.

A. Align

1. We create value for the patient
2. We think systematically
3. We have a constancy of purpose

B. Enable

1. We lead with humility
2. We respect every individual
3. Transparency through visual management

C. Improve

1. Seek perfection
2. Ensure quality at the source
3. Embrace scientific thinking
4. Focus on process

IV. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) COMMITTEE

A. The Performance Improvement and Patient Safety Committee is an interdisciplinary executive and medical staff committee promoting:

1. Communication – Cross-functional learning from departmental reflection on problem solving drivers
2. Alignment – Identify common goals, challenges, opportunities, partners
3. Accountability – Ensure all levels of organization are driving true north

3.4. 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.

4.5. The PIPS Committee is a Joint Hospital Leadership and Medical Staff Committee. The Committee consists of at least seven (7) physician

representatives from the Clinical Services at ZSFG. In addition, one (1) representative from Radiology, Clinical Lab, Pharmacy, Infection Prevention and Control and Nursing are designated as Committee members. The Executive Leadership Team, including the Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Pharmacy Officer, and UCSF Vice Dean are committee members. The Director of Care Coordination 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.

- ~~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 ZSFG in meeting legal, professional, accreditation, and regulatory requirements; and~~
- ~~i) Provide education and communication on performance improvement principles and tools.~~
- 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 ZSFG. In addition, one (1) representative from Radiology, Clinical Lab, Pharmacy, Infection Prevention and Control and Nursing are designated as Committee members. The Executive Leadership Team including tThe Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Pharmacy Officer, UCSF Associate Vice Dean are committee members, Dean's Office Director of Operations, DPH Pharmacy Director,,. T the Administrative Medical Director of Utilization Management Care Coordination 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.~~

1. Functions of PIPS Committee Include:

- a) 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;
- b) 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; infection prevention and control reports, hospital claims; 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;
- c) Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and PI committees as appropriate;
- d) 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).
- e) Reports and forwards recommendations monthly to the Medical Executive Committee, Joint Conference Committee and the Health Commission (Governing Body) through the Chief Medical Officer and Chief Quality Officer.
- f) Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources.
- g) Reviews and approves the clinical and departmental performance improvement measures and patient safety initiatives of ZSFG.

- h) 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).
- i) Reviews and approves the patient safety plan;
- j) 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;
- k) Ensures integration of approved performance and safety improvement recommendations into ZSFG management accountabilities;
- l) Participates in the strategic planning process for patient safety and recommends that performance improvement findings are incorporated into goals and objectives of that process;
- m) Ensures that safety issues have priority status and are taken into account when designing and redesigning processes; and
- n) 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.
- o) Oversees the work of the Care Experience Data Review (CEDR) Committee.

2. 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. The chair of the committee reports to PIPS on a twice yearly basis.

~~Pediatric Emergency Medicine Subcommittee: Ensures ongoing compliance with the standards of the City and County of San Francisco 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. The chair of the committee reports to PIPS on a twice yearly basis.~~

- b) Risk Management SubcommitteeEvent Analysis and Systems Improvement Committee: Analyzes events that occur within the Hospital affecting patient care and patient safety. The committee is responsible for the oversight of the review process that includes, but is not limited to, identification of clinical risk, system vulnerabilities, and opportunities for quality improvement. Additionally, the committee is responsible for ensuring the implementation of action plans aimed to mitigate future

~~recurrence of similar events. The chair of the committee reports to PIPS on a twice yearly basis. 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. The chair of the committee reports to PIPS on a twice yearly basis.~~

- c) Tissue Subcommittee: Reviews selected surgical case reports. Surgical case results with pathology results will correlate pre and postoperative diagnosis and pathology findings. Discrepancies shall be presented to PIPS. all surgical case reports and makes recommendations based on results. Also reviews tissue specimens submitted to pathology to ensure proper tissue handling and adequate completion of requisition forms. documentation practices in pathology reports. The chair of the committee reports to PIPS on a quarterly basis.
- d) 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. The chair of the committee reports to PIPS on a twice yearly basis.
- e) 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. The chair of the committee reports to PIPS on a twice-yearly basis.
- f) 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. The chair of the committee reports to PIPS on a twice yearly basis.

**Note: The Chair and Co-Chair of the Trauma Operational Process Performance Improvement and Trauma Multidisciplinary Peer Review Subcommittees will present a combined Trauma report to PIPS on a twice yearly basis.

- g) Procedural Sedation Subcommittee: Oversees the administration of moderate or deep sedation and anesthesia. The activities of the Subcommittee shall include physician and registered nursing training and formulating policy and procedures for the administration of moderate or deep sedation and anesthesia at ZSFG. Also,

[will track audit data and review unusual occurrence reports to develop recommendations for the involved department or service.](#) The chair of the committee reports to PIPS on a twice-yearly basis.

V. 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](#) [other campus-wide patient safety champions](#) to concentrate on the following areas:

- A. Hospital Acquired Infections (HAI) – The Infection Control Program Manager is responsible for monitoring and reporting the following:
 - Central Line Associated Blood Stream Infections (CLABSI)
 - Central Line Improvement Program (CLIP) – Measures compliance with insertion bundle
 - Ventilator Associated Pneumonia (VAP)
 - Surgical Site Infections (SSI)
 - Catheter Associated Urinary Tract Infection (CAUTI)
 - Clostridium difficile (C. diff)
 - Methicillin Resistant Staphylococcus Aureus (MRSA)
 - Hand Hygiene Surveillance
- B. Hospital Acquired Conditions (HAC) – The Patient Safety Officer is responsible for the monitoring and reporting of the following:
 - Hospital Acquired Pressure Injuries [Ulcers](#)-(HAPIU)
 - Falls and Falls with Injury
 - Venous Thromboembolism Prevention (VTE)
 - Tubing Misconnections
- C. Patient Safety Programs – The Patient Safety Officer is responsible for the monitoring and reporting of the following:
 - -The Culture of Safety Survey
 - [Stop the Line](#)

- Sepsis Mortality
- Patient Safety Rounding
- The Patient Safety Dashboard ([key patient safety indicators](#))
- National Patient Safety Goals
- CHPSO – California Hospitals Patient Safety Organization

~~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 ZSFG.~~

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

~~Quality Council functions:~~

- ~~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 ZSFG 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.~~

VI. THE GOVERNING BODY

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

- A. Approves the ZSFG Hospital Performance Improvement and Patient Safety Program;
- B. Through the Director of Public Health and the ZSFG 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).

VII. INDIVIDUAL ROLES AND RESPONSIBILITIES

A. Director of Public Health

- 1. 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. ZSFG Executive Administrator

- 1. Assumes overall administrative accountability and responsibility for the ZSFG PIPS Program; and
- 2. Assists in identifying opportunities for improvement of the quality of patient care/safety and resolution of problems.

~~3. Co-Chairs the Quality Council with the Chief Medical Officer or the Associate Chief Medical Officer~~

C. Quality Management Department:

~~1. The Quality Management Department is responsible for the implementation of the organization-wide PIPS Program.~~

C. Chief Medical Officer and Associate Chief Medical Officer:-

- 1. Works with the Chief Quality Officer to develop and implement the Performance Improvement and Patient Safety Program;
- 2. Participates in and leads performance improvement and patient safety initiatives;
- 3. Reviews departmental and committee performance improvement and patient safety reports/ plans to identify interdepartmental and/or interdisciplinary quality issues;

4. Ensures medical staff and infection control review all patient deaths and identification of deaths that may be preventable or related to hospital-acquired infections.
5. ~~Co Chairs the Quality Council~~ Chairs the PIPS Committee;
6. Ensures that the ZSFG Medical Staff Bylaws reflect the function and role of the PIPS Committee;
7. Oversees and participates in the education of Medical Staff, nursing staff, and others regarding performance improvement and patient safety;
8. ~~Directs quality and utilization functions of the Tertiary Care Contract and managed care programs~~
9. ~~Represents the PIPS Committee on the ZSFG Quality Council; and~~
8. Presents performance improvement reports to the Medical Executive Committee and to the Joint Conference Committee.

D. Chief Quality Officer

1. Develops, implements, and monitors the Performance Improvement and Patient Safety Program and Plan under the direction of the ZSFG Executive Administrator.
2. ~~Assists the Quality Council with the coordination and integration of performance improvement activities throughout the health care delivery system;~~
2. 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;
3. Reviews departmental and committee performance improvement reports to identify interdepartmental and/or interdisciplinary quality or patient safety issues;
4. Participates in resolving patient care/safety issues as identified from unusual occurrence data and regulatory agency reports;
5. Develops pertinent reports for the Executive Administrator, Medical Staff, committees and external agencies;
6. Provides education to the Medical Staff, Hospital leadership, and others regarding performance improvement and patient safety;

7. Consults with Department of Education and Training on Hospital performance improvement and patient safety education curriculum; and
8. Serves as Vice Chair of the PIPS Committee and represents the Performance Improvement and Patient Safety Committee on the ZSFG Quality Council.

E. 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:

1. 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;
2. Develop and implement performance improvement activities in accordance with the Hospital Performance Improvement and Patient Safety Program;
3. Develop, implement and monitor performance measures within each department and report status of measure to the Quality Council-PIPS;
4. Assign representatives to participate in the PIPS Committee and to present performance improvement and patient safety activities as scheduled; and
5. Participate in Morbidity and Mortality and Peer Review to ensure safe physician practice

F. Medical Director and Associate Medical Director of Risk Management

1. 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
2. Serves as Chair of the Risk Management Committee.

G. Director of Risk Management

1. 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
2. Serves as Vice Chair of the Risk Management Committee.

H. Patient Safety Officer

1. The Patient Safety Officer collaborates with the 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;
2. Presents Patient Safety Plan to PIPS ~~the Quality Council~~ for approval and coordinates its implementation;
3. Works collaboratively with the Chiefs of Service, Associate Administrators, Infection Prevention and Control, and Department Managers in the evaluation of processes and activities implemented or noted in the Patient Safety Plan; and
4. Facilitates communication of proactive risk assessments and the results of patient safety projects to managers and staff.

I. Manager of Education and Training

1. Determines education and training needs by assessing a variety of data sources which include the Performance Improvement and Patient Safety ~~and Quality Council~~ Committee;
2. In collaboration with Performance Improvement and Patient Safety Committee ~~and the Quality Council~~, develops and implements an annual mandatory training program that addresses identified needs; and
3. 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.

J. Infection Prevention and Control Program Manager

1. Performs the annual Infection Control Risk Assessment for the Facility in collaboration with Infection Control Committee Chairs and members.
2. Develops and organizes the Infection Prevention and 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.)
3. 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.

K. ZSFG Staff

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

1. assist in identifying opportunities for improvement of the quality of patient care/safety;
2. participate in performance improvement and patient safety activities;
3. incorporate performance improvement and patient safety findings into patient care, treatment and services; and
4. report medical/health care errors and near misses through the unusual occurrences reporting system.

L. Clinical and Support Departments

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

M. Patient/Client/Resident

ZSFG 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.

VIII. 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 ZSFG Medical Executive Committee, ~~ZSFG Nursing Executive Committee, ZSFG Quality Council~~ and the ZSFG Joint Conference Committee.

IX. IDENTIFICATION OF POTENTIAL PATIENT SAFETY ISSUES

The implementation and integration of the National Patient Safety Goals (see Appendix E) are reviewed as essential elements in providing safe, quality care. As part of its planning process, ZSFG 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:

1. Conversations with patients and families during routine care and patient safety rounds
2. Comments from Patient Satisfaction surveys

X. USE OF DATA

- A. Performance monitoring and improvement activities are data driven. Data collection is prioritized by the ZSFG PIPS Committee and 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:
1. Medication errors, including near misses
 2. Adverse Drug Events
 - ~~3. Utilization Review Data~~
 3. Environment of Care data;
 4. Patient, family and staff satisfaction surveys;
 5. Staff report on medical/health and safety management errors;
 6. 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)
 - g) Performance measures data;
 - h) Restraint and seclusion use;
 - i) Core Measures and ORYX indicators required by The Joint Commission and CMS and selected by the Hospital's leadership;

- j) Outcomes related to resuscitation;
- k) Mortality and autopsy results;
- l) The Joint Commission Sentinel Event Alerts;
- m) Infection Prevention and Control Surveillance;
- n) Claims;
- o) Clinical Service and ancillary/diagnostic department performance improvement reports;
- p) Significant Event review findings;
- q) Ongoing medical record review; and
- r) Other sources as appropriate.

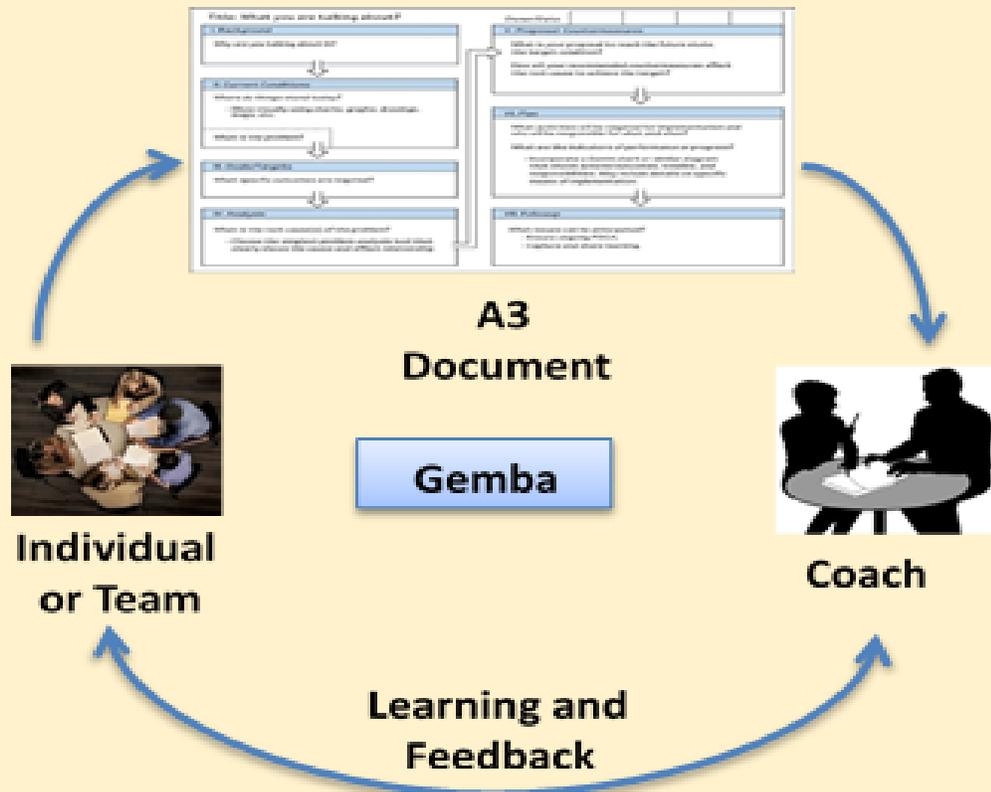
C. The ~~Quality Council and~~ PIPS Committee identifies and ensures appropriate follow-up of organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data.

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

XI. PERFORMANCE IMPROVEMENT METHODOLOGY

A. ZSFG uses *Lean* as the framework for our ZSFG performance improvement work.

Performance improvement and patient safety efforts are conducted and documented by using a Lean improvement strategy ~~called the model for improvement~~ A3 Thinking (See Appendix D). A3s are a standard language and template for problem solving and improvement plans. A3 thinking includes defining a problem, understanding root causes, considering countermeasures and studying and adjusting for results (PDSA: Plan-Do-Study-Act).



Using A3 thinking, ZSFG selects measurable gaps and targets to improve that will impact system-wide goals (True North metrics). We learn by sharing our problem solving and inviting questions. We improve continuously by focusing on performance gaps aligned with True North.

In addition to A3 thinking, ZSFG also utilizes the following tools to improve performance:

- **Value Stream Map** – A full visual representation of a specified process from start to finish, typically from the patient's perspective. This process map is developed through direct observation of patients and staff.
- **Kaizen** – a word used to describe the process of taking something apart and making it better, also referred to as a process of continuous improvement.
- **Daily Management System** - A system comprised of a set of tools designed to empower frontline staff to become problem solvers and use data to drive improvements.
- **Leader Standard Work** – A standardized approach that allows a leader to create a stable organized plan for their day, week and month. Leader standard work also creates focus on the important work of improving and sustaining.

B. The Failure Mode, Effects and Criticality Analysis (FMEA) methodology is utilized to perform proactive risk assessment.

XII. 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:
 - 1. The perceptions of risk to patients and suggestions for improving care.
 - 2. 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:
 - 1. Achievement of goals and objectives;
 - 2. Evidence of process improvement; and
 - 3. Evidence of improvement in patient care.

XIII. CONFIDENTIALITY

- 1. 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.

2. 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: PIPS Standard Work](#)

[Appendix C: PIPS Reporting Templates](#)

[Appendix D: A3 Thinking Template and Primer](#)

[Appendix E: Joint Commission 2017 National Patient Safety Goals](#)

[Appendix F: Infection Prevention and Control Annual Plan FY 2016-17](#)

CROSS REFERENCES

ZSFG Administrative Policy and Procedures:

- 1.10 [AMA, AWOL, and AWOL “At-Risk: Patients Leaving ZSFG Prior to Completion of Their 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

Nursing Executive Committee	9/6/16
Medical Executive Committee	9/15/16
PIPS Committee	9/20/16
Joint Conference Committee	10/27/16
Health Commission	11/17/16
Exec Committees B-25 Readiness	12/17/15

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