Performance Improvement Plan: PARTIAL HOSPITAL / INTENSIVE OUTPATIENT PROGRAM

STATEMENT OF PURPOSE

This Performance Improvement Plan reflects the commitment of the Psychiatric Partial Hospital and Intensive Outpatient Program to the provision of safe, effective, efficient, and comprehensive psychiatric care to its patients' population. This program provides a systematic process to monitor and evaluate the Performance Improvement and appropriateness of patient care and resolve identified problems. In addition, the Performance Improvement Plan provides a means to support and promote continuous improvement in the quality of patient care. The plan fosters continuous performance improvement by facilitating necessary change, organizing effective communication, ensuring comprehensive staff involvement, and developing effective strategic, program and resource plans.

GOALS

1. Promotion of the philosophy, goals, and objectives of the Department of Psychiatry.

2. Assurance that all psychiatric care provided is of a high level of quality.

3. Use of planned and systematic procedures to objectively assess the quality of care provided.

4. Implementation of corrective actions when problems or opportunities for improvement are identified.

5. Attainment and maintenance of the desired level of quality.

6. Integration of information from quality assurance activities within the Psychiatry Department and between departments and services.

7. Promotion of continuous performance improvement.

COMPONENTS OF THE PERFORMANCE IMPROVEMENT PLAN:

1. Monitoring and evaluation of important aspects of care:

A major component of the Performance Improvement Plan is the monitoring and evaluation of important aspects of care - those which are high risk, high volume, and/or problem prone. Monitoring and evaluation will be accomplished by utilizing three types of indicators:

A. Rate-based indicators

B. Sentinel event indicators

C. Performance Improvement control indicators

2. Tracking of Quality /Safety Indicators:

This component of the Performance Improvement Plan, which is also part of the Nursing Safety Plan, includes the tracking of medication errors, patient falls, employee injuries, needlestick injuries, AMA discharges, administrative discharges, serious suicide attempts or self-inflicted injury, and assaultive incidents. These indicators are tracked for unit-specific trends. In addition, unique patient identifiers, suicide risk assessment, medication reconciliation, read back of critical test results, hand-off communication and call out safety plan are tracked.

3. Identification of problems which affect the quality of care:

This component of the Performance Improvement Plan gives Nursing staff the opportunity to identify problems or opportunities to improve patient care.

THE DEPARTMENT OF NURSING PERFORMANCE IMPROVEMENT PLAN IS WRITTEN ACCORDING TO THE JCAHO TEN STEP MODEL:

STEP ONE: ASSIGN RESPONSIBILITY

The overall responsibility for the PHP/IOP Performance Improvement Plan is assigned to the Program Manager, in turn, delegates the responsibilities of performing quality activities to other members of the Department. The delegation of responsibilities is as follows:

A. Unit Quality Representative: Performance Improvement Resource Management

1. Delineates the scope of care for their units/programs.
2. Identifies and prioritizes important aspects of care.
3. Develops monitors which identify appropriate structure, process, and outcome indicators.
4. Identifies a threshold for evaluation for each indicator.
5. Develops a Performance Improvement-monitoring calendar.
6. Coordinates the collection of Performance Improvement data.
7. Reviews and analyzes the data collected.
8. Initiates appropriate follow-up action.
9. Reviews unit Performance Improvement/Safety indicator data to identify trends.
10. Identifies problems which affect quality of care on the unit and initiates corrective action.
11. Reports Performance Improvement results to the manager and Performance Improvement Committee.
12. Establishes and maintains a filing system for Performance Improvement records.
13. Evaluates the unit Performance Improvement plan annually and makes appropriate revisions.
14. Attends scheduled Psychiatry Department Performance Improvement Committee meetings.

B. Program Manager:

1. Facilitates the implementation of the unit Performance Improvement plan.
2. Promotes unit-based quality by ensuring staff participation in Performance Improvement activities.
3. Establishes ongoing communication with staff regarding Performance Improvement activities.
4. Facilitates the attendance of the Performance Improvement representative at the Psychiatry Department Quality meetings.
5. Assists the unit Performance Improvement representative and staff in monitoring activities, problem identification and problem solving activities.
6. Assures that appropriate follow-up action is taken to resolve identified problems.

7. Assures intensive review and follow-up of any sentinel events which occur on the unit and maintains documentation of such investigations.

8. Reviews unit quarterly Performance Improvement reports.

C. PHP/IOP Staff:

1. Maintains an awareness of the unit Performance Improvement plan and Performance Improvement activities.

2. Participates in all phases of the Performance Improvement process as appropriate: identifying important aspects of care, developing monitors, collecting and analyzing data, identifying and solving problems, identifying and pursuing opportunities to improve patient care.

D. Unit Interdisciplinary Performance Improvement Committee:

All interdisciplinary staff and the Nursing Manager meet on an as needed basis to discuss interdisciplinary performance issues.

E. Departmental Performance Improvement Review:

On a quarterly basis, the data is reviewed by the Department of Psychiatry Performance Improvement Committee and feedback is provided.

STEP TWO: DELINEATE SCOPE OF CARE

The Psychiatric Day Treatment Program provides interdisciplinary psychiatric day treatment services to a population of adult psychiatric patients who are in need of comprehensive treatment to foster and support increased independent functioning. The services provided include group, individual and family therapy, psychoeducation and vocational guidance and support. These services are delivered in the context of three distinct treatment programs which include a full-time, 5-day partial-hospital program, and two part-time intensive outpatient programs. One program targets on a general psychiatric population while the other program targets a dual-diagnosis population. The care is provided on the 5th floor of the John Dempsey Hospital.

STEP THREE: IDENTIFY IMPORTANT ASPECTS OF CARE

Based upon the scope of care, important aspects of care are identified – those which are high risk, high volume and/or problem prone. At least two important aspects of care are selected by each unit for Performance Improvement monitoring. Refer to Appendix 2 for a list of unit-specific important aspects of care. Unit-specific Performance Improvement Plans will identify rate-based indicators, sentinel event indicators, and quality control indicators.

STEP FOUR: IDENTIFY INDICATORS

Rate-Based Indicators

For each important aspect of care, between one and three rate-based indicators are developed. Indicators must be well-defined, comprehensive, objective and specific, clinically valid, relevant, and efficient. Depending on the important aspect of care, indicators may describe structure, process, or outcome variables. A mix of all three types of indicators is desirable. Refer to the appendix for a list of indicators.

Sentinel Event Indicators

Each and every serious patient care event will undergo intensive review and follow-up. Sentinel events may include, but are not limited to the following: serious suicide attempts or successful suicides, violent/assaultive episodes, serious self-injurious behavior, serious patient injury.

STEP FIVE: ESTABLISH THRESHOLDS FOR EVALUATION

Rate-Based Indicators

A threshold for evaluation is set for each rate-based indicator usually in the range of 80% to 100%. In general, a threshold of 100% is reserved for those indicators that if not met could result in an adverse patient outcome. Thresholds may be statistically determined or may be based on clinical and quality assurance literature and on the particular experience of the Nursing Department or individual unit/program. Refer to the appendix for a list of thresholds.

Sentinel Event Indicators

The threshold for sentinel events is always 100%. Each sentinel event will undergo intensive review and follow-up.

STEP SIX: COLLECTION AND ORGANIZE DATA

The specific indicator will help determine appropriate data sources. Data sources may include the following:

- direct observation of patients or staff
- patient records
- risk identification reports
- patient satisfaction questionnaires: monthly reports are utilized to identity opportunities to improve customer satisfaction

Data collection is done by unit staff members, as delegated by the unit Performance Improvement representative. Sample size is determined by the population being monitored. For sentinel event indicators that describe infrequent, but serious complications, each occurrence must be investigated.

For routine monitoring of rate-based indicators, the sample size is 5% or 30, whichever is greater. The unit quality representative will determine the appropriate sample size for each indicator in consultation with the Performance Improvement Specialist.

The frequency of data collection is determined by the number of patients affected by the care being monitored, the degree of risk involved, and the extent to which the aspect of care has proven to be problem free.

Data is collected on a data retrieval form which facilitates calculations and comparison of thresholds to actual compliance. Patient data is coded by admission number, not by name, to protect confidentiality.

The unit Performance Improvement representative or another staff member may do tabulation. The cumulative data for each indicator is compared to each threshold for evaluation.

STEP SEVEN: EVALUATE CARE

If the cumulative data reveals that the expected compliance to an indicator is being met and no opportunities to improve care are identified, then monitoring and evaluation will continue. (If expected compliance to an indicator is achieved for four sampling periods and no opportunities for improvement are identified, then the indicators will be discontinued and new indictors will be developed.)

If the cumulative data reveals that the expected compliance to an indicator is not met, then it is necessary to try to determine the cause of the deficiency. The unit Performance Improvement representative analyzes the data for trends and patterns. Patterns may relate to specific shifts, personnel and skills, or segments of the patient population. The elements of quality which may be selected for evaluation include the following:

- Accessibility of care
- Appropriateness of care
- Continuity of care

- Efficacy of care
- Efficiency of care
- Patient perspective issues
- Safety of the care environment
- Timeliness of care

The unit Performance Improvement representative, the manager, the clinical nurse specialist, or other staff may identify problems. Opportunities to improve care may be suggested by any member of the unit staff and validated by the unit Performance Improvement representative, manager, and CNS.

STEP EIGHT: TALE ACTIONS TO IMPROVE CARE

With the input of the unit Performance Improvement representative and the manager appropriate action plans are formulated and implemented.

Corrective actions may focus on deficiencies in staff knowledge, problems in behaviors, or deficiencies in systems.

- modified orientation activities
- in-service education
- continuing education
- circulating informational material

Corrective action of behavior problems may include:

- informal counseling
- formal counseling

Corrective action for systems problems may include:

- new or revised standards
- changes in communication channels
- changes in equipment or supplies

STEP NINE: ASSESS THE ACTIONS AND DOCUMENT IMPROVEMENT

Continued monitoring and evaluation is done to determine if the correct actions are successful. Even if a problem appears solved, monitoring and evaluation are continued to assure that care consistently remains at the expected level of quality.

STEP TEN: COMMUNICATE RELEVANT INFORMATION

The communication of Performance Improvement findings, recommendations for necessary actions, actions taken, and the results of those actions are essential steps in “closing the loop” in the monitoring and evaluation process. It assures that findings are integrated and are used to promote continuous quality improvement. Performance Improvement findings are communicated through the channels.

On a monthly basis:

Performance Improvement findings are discussed at staff meetings and documented in minutes.

An Interdisciplinary Performance Improvement meeting is held to discuss relevant Performance information. This meeting is chaired by the Performance Improvement chairperson for the Department of Psychiatry with several disciplines represented.

Completed monitors are documented on data retrieval forms. The monitor results, conclusions, recommendations and the unit Performance Improvement representative, and the PHP the Manager sign off follow-up actions. A copy of each completed monitor is forwarded to the Performance Improvement chairperson.

On a quarterly basis:

The unit Performance Improvement representative compiles a quarterly report consisting of a summary of monitoring activities, trends in safety indicators and extra quality activities which occurred on their units.

The Performance Improvement Representative maintains a Performance Improvement notebook.

On an annual basis:

The unit Performance Improvement chairperson reviews data annually at the end of the fiscal year.

REFERENCES:

Comprehensive Accreditation Manual for Behavioral Health Care 2006.

APPENDIX II
PHP/IOP Performance Improvement Indicators

Aspect of Care: Client Satisfaction:

Indicators	Threshold
1. Clients are satisfied with PHP/IOP services	90%
2. Clients report participating in their treatment planning	90%

Aspect of Care: Patient Symptom Changes/Treatment Effectiveness

Indicators	Threshold
1. Patients who complete PHP/IOP treatment (3 days or greater) experience improved symptoms according to the GAF scales.	80%
2. Patients who complete the PHP/IOP treatment (3 days or greater) experience a reduction in suicidal ideation as reflected on the PHQ-9 #9 indicator.	80%

3. Patients who complete the PHP/iop treatment (3 days or greater) experience a reduction in symptoms or depression as refelected by the total PHQ-9 indicator.

PHQ-9 is now being used in place of the Beck. The reason for this is two fold: the PHQ-9 is more concise and it targets neuron-vegetative signs of depression.

Aspect of Care: Documentation

1. Peer chart audits are completed quarterly on 12 open charts to ensure compliance with standards.	100%
2. Weekly peer chart audits for safety assessment for the next quarter.	100%

If compliance equals 100% this will be included in routine chart audits.

Performance Improvement Control Activities:

PI chart contents checklist
Patient Satisfaction Survey Audits
GAF Audits
PHQ-9 Audits
Safety Assessment Audits
Chart Audits

Revision Dates: 4/91, 6/93, 2/00, 5/03, 10/03, 7/06, 6/07, 6/08