COMPASS
CLINICAL CONSULTING℠

CENTERS FOR MEDICARE AND MEDICAID SERVICES
RESPONSE & ACTION PLAN

Presented to:

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Introduction

This document includes action plans that have been developed for all the recommendations (except as described below) included in Compass Clinical Consulting's September 20, 2011 assessment report. This document is segmented into three sections. In each section, the action plan format is tailored to the specific characteristics of each recommendation.

- Action plans for technical recommendations, such as those that address A-tag and B-tag deficiencies, are defined in key deliverables or milestones, with target dates and responsibility assignments until the corrective action is completed and monitoring demonstrates effective correction. Monitoring will continue beyond the completion of the action plan to ensure sustained correction. Some recommendations are listed together because they address common issues, and a single action plan addresses each recommendation.

- The K-tags action plans provide the same information but use a format that is similar to the K-tag format used in the original report.

- The format for recommendations that address cultural changes is less prescriptive; only initial actions steps are described and no specific measures of implementation or effectiveness are defined. This is because cultural changes are very different from technical changes. First, culture change takes years to implement, so action plans for culture change are emergent rather than defined at the outset of a change project. Action plans are developed as the change process acts within the organization. In addition, because culture influences a broad performance in a broad, contextual way, the effect of cultural change is best measured by overall organizational performance, rather than any specific set of measures. More information about culture change is described in the beginning of that section.

Three recommendations have not been included in the work plans.

Two of the recommendations have been completed and verified as completed.

Recommendation Patient Rights 1, "Post notice on patient rights", (which addresses A-0015, A-0116) has been verified as completed on October 25, 2011. Notices have been posted in admission office and at patient entrances.

Recommendation Governing Body 3, "The Governing Body or its executive committee should meet to monitor performance more frequently than quarterly, at least until stable acceptable results are achieved" has also been completed. At the October 25, 2011 meeting, the Governing Authority voted to conduct monthly meetings for the next 12 months.

Work on Leadership and Management Recommendation 13, "Begin a process for computerizing QAPI data (including infection control and prevention)" was initiated during the summer. The Department of Human Services hired a consultant to assess Arkansas State Hospital's (ASH) IT needs and resources relative to Quality Assurance. The consultant is expected to provide a report by November 30, 2011.

This report will outline steps for moving forward. Because of this prior action, a work plan development will be delayed until after the ASH IT System Assessment report has been reviewed.

It should also be noted that some of the target dates in the action plans have passed because ASH staff has stated these actions have been completed, especially relative to the K-tags. We have not verified these actions as completed so these items are listed in the work plans.

Section I: A- and B-Tag Related Recommendations

Recommendation: Ensure the Important Message (IM) from Medicare is delivered within two days of discharge. (PR 2)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise IM policy.	**Dec 1, 2011**	**CFO**	
Educate involved staff on changes.	**Dec 31, 2011**	**CFO**	
Implement.	**Jan 3, 2012**	**CFO**	
Report performance to PIC[1]	**Feb 28, 2012**	**CFO**	

Evidence of Completion/Monitoring

1. Revised policy.
2. Evidence of staff education.
3. Data shows that IM is delivered within two days of discharge.

Executive Responsible: CFO

[1] PIC refers to the Performance Improvement Committee

Recommendation: **Revise complaint and grievance policy and procedure. (PR 3)**

Monitor compliance with grievance policy, and report to Governing Body each quarter. (PR 4)

Integrate grievance policy monitors into QAPI program. (QAPI 5)

Implementation

Key Deliverables	**Target Date**	**Responsible**	**Verified Date of Completion**
Revise complaint and grievance policy and procedure with definitions and timeframes.	**Dec 15, 2011**	**CEO**	
Governing Body approval of revised policy.	**Dec 31, 2011**	**CEO**	
Staff education on complaint resolution, new expectations.	**Jan 31, 2012**	**Director, Human Resources**	
Revise monitoring process to align with new policy.	**Jan 31, 2012**	**Director, QAPI**	
Begin quarterly reporting on grievance data to PIC.	**Apr 30, 2012**	**Director, QAPI**	
Begin quarterly reporting on compliance and findings to Governing Body.	**May 31, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. Revised policy that complies with Conditions of Participation (CoP) requirements.
2. Evidence of approval by Governing Body in minutes.
3. Evidence of report of compliance with policy in Governing Body minutes.
4. Data shows that process operates in compliance with policy.

Executive Responsible: CEO

Recommendation: Include notice in admission package that physician may not be on-site 24/7. (PR 5)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise patient documents to include notice.	**Dec 1, 2011**	**Director, Admissions**	
Educate involved staff on changes.	**Dec 2, 2011**	**Director, Admissions**	
Implement.	**Dec 5, 2011**	**Director, Admissions**	
Monitor to assure implementation for 30 days, and report to PIC.	**Jan 31, 2011**	**Director, Admissions**	

Evidence of Completion/Monitoring

1. New patient documentation includes notice.
2. Documentation of staff training.
3. Report of successful implementation to PIC.

Executive Responsible: CFO

Recommendation: Develop policy on advance directives, and monitor compliance. (PR 6)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop policy on obtaining advance directive information.	**Dec 31, 2011**	**CEO**	
Governing Body approves policy.	**Jan 31, 2012**	**CEO**	
Educate involved staff on changes.	**Feb 28, 2012**	**Director, Human Resources**	
Implement.	**Mar 1, 2012**	**CEO**	
Monitor to assure implementation for 30 days and report to PIC.	**Apr 30, 2012**	**Director, QAPI**	

Evidence of Completion/Monitoring

1. New policy on Advance Directives.
2. Governing Body minutes document its approval.
3. PIC minutes demonstrate reporting and successful implementation of new policy.

Executive Responsible: CEO

Recommendation: Develop procedures to ensure compliance with patient's right to appeal premature discharge. (PR 7)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise policy to include required procedures when a patient appeals discharge decision.	**Dec 1, 2011**	**Director, Admissions**	
Educate involved staff on changes.	**Jan 15, 2012**	**Director, Admissions**	
Implement.	**Jan 31, 2012**	**Director, Admissions**	
If appeal occurs, report on event to UMC[2] (UMC reports to MEC, which reports to the Governing Body)	**At first UMC meeting after appeal**	**Director, Admissions**	

Evidence of Completion/Monitoring

1. Revised policy complies with CoPs.
2. Documentation of staff training.
3. If appeal occurs, UMC minutes show that policy was followed.

Executive Responsible: CFO

[2] UMC refers to Utilization Management Committee; MEC refers to the Medical Executive Committee

Recommendation: **Develop staff education material about protecting patient rights. Use numerous examples in training. (PR 8)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Organize interdisciplinary team to review all staff training/ education.	**Dec 1, 2011**	**Director, HR**	
Evaluate and redesign staff training about patient rights (include orientation, ongoing competency assurance, and other needs).	**Jan 31, 2012**	**Director, HR**	
Complete staff education	**Feb 28, 2012**	**Director, HR**	
Ensure that documentation of training is in personnel files and report to PIC.	**Mar 30, 2012**	**Director, HR**	

Evidence of Completion/Monitoring

1. Revised staff education about patient rights.
2. Documentation of staff training in personnel files.
3. PIC minutes demonstrate report that documentation of training is in personnel files.

Executive Responsible: CEO

Recommendations: **Engage leadership in QAPI process, and demonstrate leadership in addressing problems. The consultants will work with the interim CEO to provide training and coaching assistance to managers. (LM 1)**

Revise program documents to include more direction about setting priorities, methodology for fixing problems, reporting results, and accountability. (QAPI 1)

Provide education to hospital staff, not just QAPI staff, so they can implement the program effectively. (QAPI 2)

Implementation/Key Deliverables

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop QAPI policy.	**Dec 31, 2011**	**CEO**	
Obtain MEC and PIC approval.	**Jan 31, 2011**	**CMO**	
Obtain Governing Body approval.	**Feb 29, 2012**	**CEO**	
Training plan approved by PIC.	**Jan 31, 2012**	**CEO**	
Senior executives get training in PI and new leadership behaviors.	**Feb 29, 2012**	**CEO**	
Leaders demonstrate new behaviors in QAPI related meetings.	**Mar 1, 2012**	**CEO**	
Complete training for managers and staff.	**April 30, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. Governing Body approval of QAPI plan.
2. Personnel records reflect training of designated staff.

Executive Responsible: CEO

Recommendation: Teach management what to monitor, how to assess measures, and strategies for interventions and corrective action. (LM 2)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Define a management dashboard that describes key metrics to monitor the hospital operating environment.	**Dec 31, 2011**	**CEO/CNO**	
Report key metrics results to senior leadership, PIC, and MEC. Consultants to guide discussion to help management appreciate the implications	**Jan 31, 2012**	**CEO/CNO**	
Re-measure and report results.	**Mar 31, 2012**	**CEO/CNO**	
Re-measure and report results.	**Apr 30, 2012**	**CEO/CNO**	

NOTE: Training will be provided using Just-in-Time techniques, building knowledge and skills while doing.

Evidence of Completion/Monitoring

1. Key metrics dashboard.
2. PI, MEC minutes document conclusions, actions taken, and evaluation of actions taken.

Executive Responsible: CMO

Recommendation: **Design process to monitor personnel training. Ensure that "refresher" training is scheduled and occurs on the set schedule. Develop capability to prevent employees from working if their competency requirements lapse. (LM 3)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop plan to ensure that training documentation is in personnel files (includes contractor staff). Plan will compile a list of training deficiencies that need to be remedied.	**Nov 30, 2011**	**Director, HR**	
Implement plan.	**Dec 1, 2011**	**Director, HR**	
Conduct an audit of personnel files to assess compliance with requirements.	**Jan 13, 2012**	**Director, HR**	
Develop policy to prevent working with training deficiencies.	**Jan 31, 2012**	**Director, HR**	
Correct all training deficiencies.	**Feb 28, 2012**	**Director, HR**	
Report results to PIC and Governing Body.	**Mar 31, 2012**	**Director, HR**	

Evidence of Completion/Monitoring

1. Audit results showing personnel files are in compliance.
2. Evidence in PI Committee and Governing Body minutes demonstrate results reporting.

Executive Responsible: CEO

Recommendation: Implement reorganization plans for non-professional clinical staff, and monitor effect on staff retention. Efforts need to be undertaken to eliminate use of agency staff and entice BHTs to extend their service at ASH. (LM 4)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop reorganization plan for non-professional clinical staff.	**Dec 31, 2012**	**DON**	
Establish metrics to determine effect on staff retention.	**Dec 31, 2012**	**DON**	
Educate staff on plan.	**Jan 15, 2012**	**DON**	
Implement plan; begin to measure effectiveness.	**Feb 15, 2012**	**DON**	
Report results to PIC and continue measuring.	**Mar 15, 2012**	**DON**	
Report results to PIC and continue measuring.	**Apr 15, 2012**	**DON**	
Report BHT retention results to PIC each quarter.	**Apr 15, 2012**	**Director, Human Resources**	

Evidence of Completion/Monitoring

1. Copy of reorganization plan.
2. PIC minutes reflect effectiveness of reorganization plan on retention on non-professional clinical staff.

Executive Responsible: DON

Recommendation: **Develop an internal monitoring program to detect changes that affect the quality of care provided. (LM 6)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Define a management dashboard that describes key metrics to monitor factors impacting the ability to deliver quality of care.	**Dec 31, 2011**	**CEO**	
Report key metrics results to senior leadership, PIC, and MEC.	**Jan 31, 2012**	**CEO**	
Implement corrective action/process change as needed.	**Feb 29, 2012**	**CEO**	
Continue monthly monitoring and reporting.	**Mar 31, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. Copy of dashboard.
2. MEC and PIC minutes document review of key metrics dashboard.

Executive Responsible: CEO

Recommendation: **Develop a system for CMO oversight and evaluation of services (for privileged providers). (LM 7)**

Develop medical staff monitoring process to provide information that can be used for appraisal of privilege competence. (QAPI 7)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop list of key indicators and professional review activities to monitor performance of medical staff members. Develop data collection methods.	**Dec 31, 2011**	**CMO**	
Approval of list by Medical Executive Committee.	**Jan 13, 2012**	**CMO**	
Submit for Governing Body approval.	**Jan 27, 2012**	**CMO**	
Implement systematic review procedures.	**Feb 10, 2012**	**CMO**	
CMO reviews data.	**Apr 10, 2012**	**CMO**	
CMO present findings to MEC, which acts as appropriate.	**Apr 20, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. List of quality monitoring activities for medical staff.
2. Minutes demonstrate approval by MEC.
3. Documents demonstrating that data gathering and review system were implemented.
4. Minutes demonstrate that CMO reported findings to MEC.

Executive Responsible: CMO

Recommendation: Notify medical staff and clinical areas when medical staff privileges are granted or reapproved. (LM 8)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop a policy and procedure for sending notifications about privilege approvals and changes.	**Oct 30, 2011**	**CMO**	
MEC approves new policy and procedure.	**Nov 30, 2011**	**CMO**	
Implement.	**Next set of privilege changes**	**CMO**	
Notification of completion to Governing Body.	**Next board meeting**	**CMO**	

Evidence of Completion/Monitoring

1. New policy approved by MEC.
2. Copies of notification letters.
3. Evidence of notification in Governing Body minutes.

Executive Responsible: CMO

Recommendation: **Develop scope and complexity statement for radiology services, to be approved by medical staff and Governing Body. (LM 9)**

Develop contract for radiology services that includes credentials and quality monitoring requirements. (OC 13)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Prepare needs statement on radiology services, including credentials and quality requirements.	**10 days prior to Dec 2011 MEC meeting**	**CMO**	
Submit statement for MEC approval.	**Dec 31, 2011**	**CMO**	
Submit statement for Governing Body approval.	**Jan 31, 2012**	**CMO**	
Negotiate contract with vendor(s).	**Feb 28, 2012**	**CFO**	

Evidence of Completion/Monitoring

1. Evidence that needs statement was approved by MEC and Governing Body.
2. Contract with radiology provider that fulfills needs and requirements.

Executive Responsible: CMO

Recommendation: **Develop scope and complexity statement for rehabilitation services, to be approved by medical staff and Governing Body. (LM 10)**

Develop contract for adult rehabilitation services. (OC 14)

Integrate rehabilitation services into the QAPI program. (QAPI 8)

Implementation

Key Deliverables	**Target Date**	**Responsible**	**Verified Date of Completion**
Prepare needs statement for rehabilitation services, including credentials and quality requirements.	**10 days prior to Dec 2011 MEC meeting**	**CMO**	
MEC approves needs statement.	**Dec 31, 2011**	**CMO**	
Governing Body approves needs statement.	**Jan 31, 2012**	**CMO**	
Develop service and quality monitoring requirements for contract.	**Jan 31, 2012**	**CMO**	
Negotiate contract with vendor(s).	**Feb 28, 2012**	**CFO**	
Medical Staff reviews service and quality expectations data.	**3 months after contract initiation**	**CMO**	

Evidence of Completion/Monitoring

1. Evidence that needs statement was approved by MEC and Governing Body.
2. Contract with rehabilitation vendors that fulfills needs and requirements.
3. MEC minutes demonstrate review of QAPI data.

Executive Responsible: CMO

Recommendation: Revise UR policy to detail how to address determinations that services are not medically necessary. (LM 11)

Implementation/Key Deliverables

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise policy to include additional requirements for physician disagreement.	**Dec 1, 2011**	**CFO**	
Educate involved staff on changes.	**Dec 8, 2011**	**CFO**	
Implement.	**Dec 11, 2011**	**CFO**	
If physician disagreement occurs, report on event to UMC.	**At first UMC meeting after appeal**	**CFO**	

Evidence of Completion/Monitoring

1. Revised policy.
2. Documentation of staff training.
3. If appeal occurs, the report showing that policy was followed is included in UM Committee minutes.

Executive Responsible: CFO

Recommendation: Add system-level studies of utilization to UR program. (LM 12)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
UMC approves adding review of professional services to Utilization Management (UM) Plan.	**Dec 31, 2011**	**Director of Admissions**	
UMC to select topic for study.	**Dec 31, 2011**	**Physician advisor for UM**	
Conduct study and report to UMC.	**Jan 2012**	**Director of Admissions**	
UMC to evaluate study results and act if necessary.	**Mar 2012**	**CMO**	

Evidence of Completion/Monitoring

1. UM Plan includes review of professional services and has been approved by UMC, MEC, and Governing Body.
2. Minutes show that UMC approved study.
3. Minutes show that UMC reviewed a study.

Executive Responsible: CMO

Recommendation: **Contract with a nurse with a master's degree in psychiatric nursing to consult with Director of Nursing as required in CoPs. (LM 14)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Identified consultant with master's degree in psychiatric nursing to work with DON.	**Nov 1, 2011**	**DON**	
Create an agreement with consultant.	**Dec 1, 2011**	**DON**	
Institute monthly consultations.	**Jan 31, 2012**	**DON**	

Evidence of Completion/Monitoring

1. Agreement with consultant.
2. Monthly reports from consultant.

Executive Responsible: DON

Recommendation: **Integrate into QAPI program a review of medical emergencies to determine whether additional medical physicians are needed. (QAPI 3)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
MEC approves policy and procedure about reviewing medical emergencies.	**Jan 31, 2012**	**CMO**	
Implement new policy and procedure.	**Feb 14, 2012**	**CMO**	
Begin reporting findings monthly to MEC and PIC.	**Mar 31, 2012**	**CMO**	
Governing Body reviews MEC and PIC minutes.	**Apr 30, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. New policy and procedure on reviewing emergencies.
2. MEC minutes document policy approval.
3. Minutes demonstrate results reporting and review at MEC, PIC, and Governing Body

Executive Responsible: CMO

Recommendation: **Improve the comprehensiveness and goals for reviewing Restraint and Seclusion episodes within the QAPI program. In addition to ensuring compliance, look for opportunities to reduce the use of restraints and seclusion. (QAPI 4)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise restraint and seclusion policies and procedures, including staff training requirements.	**Dec 31, 2011**	**CMO**	
Define key performance metrics to assess compliance with revised policy and procedure.	**Dec 31, 2011**	**CMO**	
Obtain MEC and Governing Body approval for policies and metrics.	**Jan 31, 2012**	**CMO**	
Educate affected staff on revised policies and metrics.	**Feb 28, 2012**	**CMO**	
Begin to gather data for monthly analysis.	**Mar 1, 2012**	**CMO**	
Report finding to PIC and initiate corrective action as necessary.	**Mar 31, 2012**	**CMO**	
Report results to MEC and Governing Body each month in 2012.	**Apr 30, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. New policy and procedure on restraint and seclusion.
2. MEC and Governing Body minutes document policy approval.
3. Minutes demonstrate results reporting and review at MEC, PIC, and Governing Body.

Executive Responsible: CMO

Recommendation: Develop better measures of compliance with Restraint and Seclusion policy. (QAPI 5)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Review and revise restraint and seclusion policies and procedures, including staff training requirements.	**Jan 2, 2012**	**CMO**	
Define key performance metrics to assess compliance with revised policy and procedure.	**Jan 2, 2012**	**CMO**	
Obtain medical staff and Governing Body approval for policies and metrics.	**Jan 2, 2012**	**CMO**	
Educate affected staff on revised policies and metrics.	**Jan 31, 2012**	**CMO**	
Collect and analyze baseline metric data.	**Feb 29, 2012**	**CMO**	
Implement corrective action as necessary.	**Feb 29, 2012**	**CMO**	
Report results to MEC, PIC, and Governing Body.	**Feb 29, 2012**	**CMO**	
Collect and analyze metric data.	**Mar 28, 2012**		
Implement corrective action as necessary.	**Mar 28, 2012**	**CMO**	
Report results to MEC, PIC, and Governing Body.	**Mar 28, 2012**	**CMO**	
Collect and analyze metric data.	**Apr 25, 2012**	**CMO**	
Implement corrective action as necessary.	**Apr 25, 2012**	**CMO**	
Report results to MEC, PIC, and Governing Body	**Apr 25, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. MEC minutes document policy approval.
2. Personnel records reflect required training.
3. Minutes demonstrate results reporting and review at MEC, PIC, and Governing Body.

Executive Responsible: CMO

Recommendation: **Redesign and implement a new Infection Control program that complies with best practices. (QAPI 11)**

Update Infection Control policies and assure compliance with CoPs and best practices. Add policies such as exposure control, use of disposable equipment, cleaning patient care and non-patient care areas. (OM 30)

Implementation

Key Deliverables	**Target Date**	**Responsible**	**Verified Date of Completion**
Complete an infection control risk assessment.	**Dec 15, 2012**	**IC Practitioner**	
Develop a hospital-acquired infection surveillance plan.	**Dec 15, 2012**	**IC Practitioner**	
Develop an environmental surveillance plan.	**Dec 15, 2012**	**IC Practitioner**	
Develop an employee surveillance plan.	**Dec 15, 2012**	**IC Practitioner**	
Develop infection control performance metrics and data collection methodologies.	**Dec 15, 2012**	**IC Practitioner**	
Obtain MEC approval of risk assessment, surveillance plans, performance metrics, and data collection methodology.	**Dec 28, 2012**	**CMO**	
Implement surveillance and performance monitoring plans.	**Jan 31, 2012**	**IC Practitioner**	
Analyze data and report results to IC Committee, MEC and PIC.	**Feb 28, 2012**	**CMO**	
Review and revise infection control policies to bring into alignment with regulatory and accreditation requirements.	**Feb 29, 2012**	**IC Practitioner**	
Obtain MEC and Governing Body approval for plans and policy revisions.	Feb 29, 2012	CMO	
Educate affected staff on IC program, policies and procedures.	Apr 30, 2012	IC Practitioner	

Evidence of Completion/Monitoring

1. New Infection Control Risk Assessment and Surveillance Plans.
2. MEC minutes document Risk Assessment and Surveillance Plan approval.
3. Minutes demonstrate results reporting and review at MEC, IC Committee and Governing Body.

Executive Responsible: CMO

Recommendation: Integrate reconciliation into QAPI to achieve full 100% understanding of the reasons why medications were not used. (QAPI 11)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Implement measurement system to capture data related to un-used medications.	**Dec 31, 2011**	**CMO**	
Initiate monthly analysis of data.	**Jan 31, 2012**	**CMO**	
Begin monthly submission of findings to MEC, PIC and P&T[3]; identify opportunities for improvement.	**Feb 29, 2012**	**CMO**	
Collect and analyze data to assess effectiveness of actions taken; submit findings to MEC, PIC and P&T.	**Mar 31, 2012**	**CMO**	
Collect and analyze data to assess effectiveness of actions taken; submit findings to MEC, PIC and P&T.	**Apr 30, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. Minutes demonstrate results reporting and review at MEC, P&T, PIC, and Governing Body

Executive Responsible: CMO

[3] P&T refers to the Pharmacy and Therapeutics Committee

Recommendation: Integrate medication wastage documentation problems into QAPI process. (QAPI 12)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise medication administration policies to provide mechanisms for documenting medication wastage.	**Dec 31, 2011**	**Director, Pharmacy**	
Establish performance metrics to monitor compliance with policy.	**Dec 31, 2011**	**Director, Pharmacy**	
Obtain MEC approval of policy.	**Jan 31, 2012**	**CMO**	
Educate affected staff on revised policy.	**Jan 31, 2012**	**Director of Nursing**	
Implement new policy and begin data collection and analysis	**Feb 1, 2012**	**Director, Pharmacy**	
Report results to MEC, P&T, and PIC; take corrective action when necessary.	**Feb 29, 2012**	**CMO**	
Report results to MEC, P&T, and PIC; take corrective action as necessary.	**Mar 31, 2012**	**CMO**	
Report results to MEC, P&T, and PIC; take corrective action as necessary.	**Apr 30, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. New policy and procedure on medication administration.
2. MEC minutes document policy approval.
3. Minutes demonstrate results reporting and review at MEC, P&T, PIC, and Governing Body

Executive Responsible: CMO

Recommendation: **Integrate timeliness and lost specimens for lab services into QAPI program. Monitor compliance of lab vendor with CAP or TJC accreditation and proficiency testing. (QAPI 13)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Renegotiate QAPI requirements (as above) into contract.	**Jan 31, 2012**	**CFO**	
Vendor reports QAPI data as required.	**July 30, 2012**	**CFO**	
Report QAPI data to MEC, which reports to Governing Body.	**Aug 31, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. New contract contains QAPI requirements.
2. MEC minutes document review of laboratory QAPI requirements.
3. Governing Body minutes demonstrate review of laboratory QAPI data and MEC recommendation.

Executive Responsible: CFO

Recommendation: **Change the attitude that treatment planning is about documentation; it should be seen as organizing care to meet a patient's needs. Make treatment plans an integral part of treatment. (OC 1)**

Physicians need to show more consistent leadership in treatment planning. (OC 2)

Customize treatment plans to patient needs and update when the patient situation requires changes. Include family therapy when appropriate. (OC 3)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Establish a multidisciplinary team to explore current philosophy regarding treatment planning processes and barriers to change.	**Dec 31, 2011**	**CMO**	
Multidisciplinary team to develop and implement unit-specific plans to address and eliminate barriers to changing treatment planning processes.	**Jan 31,2012**	**CMO**	
Utilize findings to revise treatment planning processes and documentation tools.	**Feb 28, 2012**	**CMO**	
Unit attending psychiatrists to be designated as Treatment Team Leaders.	**Mar 20, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. MEC minutes document review of team findings and approve plan to address findings
2. Governing Body minutes demonstrate review of team findings and approve plan to address findings.
3. Treatment plan audits will reflect compliance with treatment planning processes, including individualization of plans and attending psychiatrist involvement.

Executive Responsible: CMO

Recommendation: Redesign treatment plan forms if the process is an impediment to optimizing treatment planning. (OC 4)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Establish a multidisciplinary team to revise current treatment planning processes and documentation tools.	**Dec 15, 2011**	**CMO**	
Complete revision of treatment planning processes and documentation tools.	**Feb 1, 2012**	**CMO**	
Revise treatment planning policies and procedures to reflect changes.	**Feb 15, 2012**	**CMO**	
Obtain Medical Staff approval for revised treatment planning processes and documentation tools and revised policy and procedures.	**Feb 15, 2012**	**CMO**	
Develop and implement education plan for all clinical staff involved in treatment planning on revised treatment planning processes and documentation tools.	**Mar 1, 2012**	**CMO**	
Implement new treatment planning processes and documentation tools.	**Mar 20, 2012**	**CMO**	
Develop and implement auditing system to monitor compliance with revised treatment planning processes and documentation requirements.	**Mar 20, 2012**	**CMO**	
Report findings to PIC and MEC	**May 31, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. Revised treatment planning processes, documentation tools, and related policies and procedures approved by MEC.
2. MEC minutes document review and acceptance of revised treatment planning processes.
3. Governing Body minutes demonstrate new process was reviewed and discussed upon reviewing MEC minutes.
4. Treatment plan audits demonstrate 95% compliance with documentation requirements within 60 days of implementation.

Executive Responsible: CMO

Recommendation: Nurses should be engaged in providing treatment. (OC 5)

Modify nursing practice to provide more therapy and monitor nursing therapy time. (OC 12)

Making the following changes is not just a matter of redirecting nurse time but also involves redefining the role of nurses, building skills, and overcoming any obstacles to nurses assuming these new responsibilities. While we have constructed an action plan to address this change, we acknowledge that this action plan might need to be altered as we encounter staff feedback regarding these changes.

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Establish Nurse Practice Committee (NPC) to include unit-based nurses from each service line; middle managers and nurse educator to identify barriers to practice change.	**Dec 31, 2011**	**DON**	
Nurse Practice Committee to develop and implement plan to address barriers including EOC, staffing, and education.	**Jan 31, 2012**	**DON**	
NPC to develop nursing group program schedule and documentation requirements that address the specific needs of each population.	**Feb 15, 2012**	**DON**	
NPC to develop educational plan/training program and group leader competency for nursing staff.	**Mar 15, 2012**	**DON**	
Nurse Group Leader competency to be incorporated into new orientation training.	**Mar 15, 2012**		
Inform MEC and Governing Board about nursing group program and related educational plan and competency	**April 1, 2012**	**DON**	
Implement group training program for nursing staff.	**Apr 15, 2012**	**DON**	
Implement group program on each unit.	**May 30, 2012**	**DON**	
Develop and implement auditing tool that monitors compliance with nursing lead groups and documentation requirements.	**Jun 1, 2012**	**DON**	

Evidence of Completion/Monitoring

1. MEC minutes document review of nursing group program schedule, training program, and competency.
2. Governing Body minutes demonstrate review of nursing group program schedule, training program, and competency.
3. Audits to reflect 95% compliance within 60 days of implementation.

Executive Responsible: DON

Recommendation: **Develop treatment guidelines and protocols to foster greater consistency and efficiencies that would lead to better patient care and shorter lengths of stay. (OC 7)**

Implementation

Key Deliverables/Milestones	Target Date	Responsible	Verified Date of Completion
Form work group on protocol development.	**Nov 30, 2011**	**CMO**	
Submit protocol and monitoring plan to MEC for approval.	**Jan 31, 2012**	**CMO**	
Medical staff education.	**Feb 28, 2012**	**CMO**	
Implement monitoring of protocol compliance and effectiveness	**March 1, 2012**	**CMO**	
Implement data evaluation and peer review of outlier cases.	**Apr 30, 2012**	**CMO**	
Feedback to MEC and medical staff.	**May 31, 2012**	**CMO**	
Integrate into periodic performance evaluation process.	**Jun 1, 2012**	**CMO**	
Governing Body reviews MEC report on guideline use.	**Jun 30, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. MEC minutes demonstrate approval of protocol.
2. Documentation of medical staff education about new protocol.
3. MEC minutes demonstrate data evaluation and feedback provided.
4. Protocol compliance is included in physician performance evaluation.
5. Evidence of Governing Body oversight in minutes.

Executive Responsible: CMO

NOTES:

1. Three guidelines will be developed during this timeframe, although the initiation of each will be staggered.
2. Monitoring will continue on a monthly basis until demonstration of consistent, appropriate use of guidelines is achieved for three months. After achieving stability, periodic sampling will occur to verify performance stability.

Recommendation: **Redesign medication administration process so patients get medications on time when the patient, not when the whole unit, is ready. (OC 8)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Convene workgroup to flowchart current medication administration process to identify delay and failure points.	**Dec 31, 2011**	**Pharmacy Director**	
Develop solutions to mitigate delay and failure points.	**Jan 31, 2012**	**Pharmacy Director**	
Implement solutions.	**Feb 29, 2012**	**Pharmacy Director**	
Monitor effectiveness of solutions and report to MEC and PIC.	**Mar 31, 2012**	**Pharmacy Director**	
Continue monthly measurement and report to MEC and PIC.	**Apr 30, 2012**	**Pharmacy Director**	

Evidence of Completion/Monitoring

1. Flowchart of redesigned medication administration process.
2. MEC and PIC minutes document review of monitoring results.

Executive Responsible: DON

Recommendation: **While pharmacy "owns" monitoring and compliance, nursing "owns" administration after medications are provided by the pharmacy. These groups need to collaborate to ensure safe medication practices. As such, nursing must assume greater responsibility for supervising and ensuring safe practices. (OC 9)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Establish a Nursing/Pharmacy Medication Safety Committee to analyze medication administration processes and oversee the implementation of process changes to improve safety.	**Nov 30, 2011**	**Director, Pharmacy and DON**	
Define process and performance metrics and document in policy and procedure.	**Jan 31, 2012**	**Medication Safety Committee**	
Pharmacy and Nursing education on policy and procedure.	**Feb 28, 2012**	**Director, Pharmacy and DON**	
Implement data collection and analysis methodology.	**Mar 1, 2012**	**Medication Safety Committee**	
Initiate monthly reporting to P&T, PIC, and MEC.	**Apr 31, 2012**	**Director, Pharmacy**	

Evidence of Completion/Monitoring

1. Establishment of a Nursing/Pharmacy Medication Safety Committee.
2. Minutes demonstrate results reporting and review at MEC, P&T, PIC, and Governing Body.

Executive Responsible: CMO

Recommendation: Install Pyxis, Omnicell, or comparable equipment to better control medication distribution and to implement an electronic Medication Administration Records (eMAR). (OC 10)

This recommendation is dependent on governmental elements outside the hospital's control, especially for funding and procurement. As a result, the timetable will need to be loosely defined until an RFP can be sent out.

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Submit RFP for automated medication dispensing equipment.	**Dec 31, 2011**	**CFO**	
Obtain approval for purchase and installation.	**TBD**	**CFO**	
Establish policies for use of automated medication dispensing system.	**Timeframe to be updated per RFP responses**	**Director, Pharmacy**	
Obtain MEC approval for policies.	**Timeframe to be updated per RFP responses**	**CMO**	
Educate affected staff.	**Timeframe to be updated per RFP responses**	**Director, Pharmacy**	
Monitor for compliance with policy.	**Timeframe to be updated per RFP responses**	**Director, Pharmacy**	
Collect and analyze data; report results to P&T, PIC, and MEC.	**Timeframe to be updated per RFP responses**	**Director, Pharmacy**	

Evidence of Completion/Monitoring

1. Installation of automated medication dispensing system.
2. Revised policies approved by the MEC.
3. Minutes demonstrate results reporting and review at P&T, PIC, and MEC.

Executive Responsible: CMO

Recommendation: **Adjust nursing staffing for acuity and census. Monitor to ensure that staffing model is used consistently. (OC 11)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Establish senior nursing management team to evaluate current acuity system for reliability and validity.	**Jan 31, 2012**	**DON**	
Established team to revise and or develop new acuity tool which measures nursing care hours needed to address patient needs of each service line.	**Mar 30, 2012**	**DON**	
Established team to identify two patient outcomes to measure effectiveness of acuity system (e.g., decreased safety incidents, decreased falls, increased patient satisfaction).	**Mar 30, 2012**	**DON**	
Develop training scheduled for all hospital RNs on use of acuity system.	**Apr 15, 2012**	**DON**	
Inform Governing Board on the acuity system.	**Apr 30, 2012**	**DON**	
Implement new acuity system.	**May 1, 2012**	**DON**	
Begin monitoring effectiveness of acuity system with two outcome measures.	**May 1, 2012**	**DON**	
Report results to PIC each month.	**Jun 30, 2012**	**DON**	

Evidence of Completion/Monitoring

1. Copy of acuity tool.
2. Copy of results of two outcome measures affected by acuity system.

Executive Responsible: DON

Recommendation: **Hire five additional FTEs in Plant Operations staff, based on space and patient population considerations. (OC 15)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Submit request to Department Director.	**Oct 31, 2011**	**CEO**	
Recruitment/posting.	**Dec 1, 2011**	**Director, Human Resources**	
Hiring complete.	**Jan 15, 2012**	**Director, Human Resources**	
Trained and ready to work.	**Feb 28, 2012**	**Director, Facilities**	

Evidence of Completion/Monitoring

1. New employees completed orientation.

Executive Responsible: CEO

Recommendation: Revise policy to ensure that medical records are returned within 24 hours of discharge. (OC 16)

Implementation/Key Deliverables

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Change policy regarding return of medical records after discharge.	**Oct 31, 2011**	**CEO**	
Implement new policy.	**Oct 31, 2011**	**CEO**	
Monitor timeliness of chart return and impact of timeliness of chart completion.	**Nov 30, 2011**	**Director of Medical Records**	
Report to PIC.	**Dec 31, 2011**	**Director of Medical Records**	

Evidence of Completion/Monitoring

1. Revised policy.
2. Timeliness data.
3. PIC minutes demonstrate reporting and compliance with new policy.

Executive Responsible: CEO

Recommendation: Update nursing policies, and maintain timeliness requirement for review. (OC 17)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Final 2011 policy drafts from compliance officer (Doug Strock).	**Dec 1, 2011**	**DON**	
Review and sign off by CNO & CMO.	**Dec 31, 2011**	**DON**	
Production and distribution (include J-drive changes).	**Jan 15, 2012**	**DON**	
Remove all old copies from units.	**Jan 15, 2012**	**ADON**	
Training for Nursing Managers on accessing/using new policy.	**Jan 31, 2012**	**ADON**	
Set schedule for policy review.	**Feb 15, 2012**	**ADON**	
Schedule responsible staff for education on policy and procedures after review, regardless of changes.	**Mar 15, 2012**	**ADON**	

Evidence of Completion/Monitoring

1. All nursing policies are current.
2. Evidence of nurse manager training.

Executive Responsible: DON

Recommendation: Revise policy to prevent accepting "po or IM" orders, and monitor compliance. (OC 18)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise medication order policy to prevent accepting "PO or IM" orders.	**Dec 31, 2011**	**Director, Pharmacy**	
Establish required clarification process for ambiguous medication orders.	**Dec 31, 2011**	**Director, Pharmacy**	
Obtain MEC approval of revised policy.	**Jan 31, 2012**	**CMO**	
Educate pharmacy staff on revised process.	**Feb 10, 2012**	**Director, Pharmacy**	
Implement monitoring process to assess compliance.	**Feb 15, 2012**	**Director, Pharmacy**	
Report monitoring results to P&T, PIC, and MEC.	**Apr 30, 2012**	**Director, Pharmacy**	

Evidence of Completion/Monitoring

1. New policy that complies with requirements.
2. MEC minutes document approval of policy.
3. P&T, PIC, and MEC minutes reflect results that demonstrate compliance with new policy.

Executive Responsible: CMO

Recommendation: **Revise policy on verbal orders to define when and how orders are used (e.g., limitations as to type of drug). (OC 19)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise medication order policy to define when and how verbal orders are permitted, including specific limitations as to type of drug.	**Dec 31, 2011**	**Director, Pharmacy**	
Obtain MEC approval of revised policy.	**Jan 31, 2012**	**CMO**	
Educate pharmacy staff on revised process.	**Feb 10, 2012**	**Director, Pharmacy**	
Implement monitoring process to assess compliance.	**Feb 15, 2012**	**Director, Pharmacy**	
Report monitoring results to P&T, PIC, and MEC.	**Apr 30, 2012**	**Director, Pharmacy**	

Evidence of Completion/Monitoring

1. New policy that complies with requirements.
2. MEC minutes document approval of policy.
3. P&T, PIC, and MEC minutes reflect results that demonstrate compliance with new policy.

Executive Responsible: CMO

Recommendation: **Implement monitoring of timeliness and content quality of history and physicals (psychiatric evaluations). (OC 20)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise policy to define timeliness and content expectations.	**Jan 4, 2012**	**CMO**	
Educate medical staff of changes.	**Jan 31, 2012**	**CMO**	
Implement monitoring process.	**Jan 31, 2012**	**Director, Medical Records**	
Submit data to Health Information Committee (HIM).	**Mar 31, 2012**	**Director, Medical Records**	
Feedback results to physicians.	**Mar 31, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. Revised policy.
2. Evidence of compliance with policy in HIM minutes.

Executive Responsible: CMO

Recommendation: Review practices to ensure records are completed within time frame. Develop tracking system. (OC 21)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop record-completion tracking system, including a mechanism for provider notification prior to 30-day completion timeframe.	**Dec 15, 2011**	**Medical Record Director**	
Report provider failures to CMO.	**Jan 1, 2012**	**Medical Records Director**	
Review completion failures with provider.	**Jan 31, 2012**	**CMO**	
Include completion rates in ongoing professional practice evaluations.	**Feb 29, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. Evidence of record completion tracking system and provider notification.
2. MEC minutes document review of record completion data.

Executive Responsible: CMO

Recommendation: Develop process to have new orders reviewed by a pharmacist at all times. (OC 22)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop after-hours pharmacy order-review policy.	**Dec 31, 2011**	**Director, Pharmacy**	
Establish metrics to monitor compliance with policy.	**Dec 31, 2011**	**Director, Pharmacy**	
Obtain MEC approval for revised policy.	**Dec 31, 2011**	**CMO**	
Educate affected staff.	**Jan 31, 2012**	**Director, Pharmacy**	
Collect and analyze data; report results to P&T, PIC, and MEC.	**Mar 31, 2012**	**Director, Pharmacy**	

Evidence of Completion/Monitoring

1. Revised pharmacy order review policy approved by the MEC.
2. Minutes demonstrate results reporting and review at P&T, PIC, and MEC.

Executive Responsible: CMO

Recommendation: Submit dietary manual to medical staff for approval. (OC 23)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Dietary manual prepared.	**Nov 30, 2011**	**Director, Dietary**	
MEC reviews and approves manual.	**Dec 31, 2011**	**CMO**	
Each year, MEC will review dietary manual.	**Dec 31, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. MEC minutes document review of dietary manual.

Executive Responsible: CMO

Recommendation: **Manage the environmental services vendor to improve the cleanliness of the facility. (OC 24)**

Implement monitoring process for Environmental Services. (QAPI 9)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Notify vendor to remedy deficiencies within 30 days; if vendor cannot remedy, cancel contract and rebid contract.	**Nov 30, 2011**	**CEO**	
Redefine requirements: written plan of cleanliness expectations; provide extra supervision; provide extra specialized staff for specific functions.	**Dec 31, 2011**	**CEO**	
Change contract to performance assessment done by facility.	**Mar 31, 2012**	**CFO**	
Conduct scheduled performance assessment.	**Apr 30, 2012**	**CEO**	
Report to PIC.	**May 31, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. Contract revisions consistent with above.
2. Evidence of performance assessments by ASH staff.
3. PIC minutes demonstrate reporting and compliance with new cleanliness expectations.

Executive Responsible: CEO

Recommendation: Prohibit patient and staff food items from being stored in the same refrigerator. (OC25)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Evaluate each unit for adequacy of staff refrigerator storage space.	**Nov 15, 2011**	**CNO**	
Requisition and install new refrigerators as indicated.	**Nov 30, 2011**	**CNO**	
Revise infection control policies as needed to establish standard for separate storage of patient and staff food.	**Dec 15, 2011**	**CNO**	
Obtain MEC approval for policy.	**Dec 31, 2011**	**CNO**	
Educate staff on proper separation of staff and patient food.	**Dec 31, 2011**	**CNO**	
Begin to monitor for compliance during infection control rounds.	**Dec 31, 2012**	**CNO**	
Report monitoring results to Infection Control, PIC, and MEC.	**Feb 28, 2012**	**CNO**	

Evidence of Completion/Monitoring

1. Policies approved by the MEC.
2. Minutes demonstrate results reporting and review at Infection Control, PIC, and MEC.

Executive Responsible: DON

Recommendation: **Because people are using their hands to put a scoop into the ice chest, establish a cleaning schedule, and monitor to ensure that schedule is followed. (OC 26)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Establish a standardized, evidence-based protocol for handling ice.	**Dec 15, 2011**	**DON**	
Identify performance metrics to evaluate compliance with protocol.	**Dec 15, 2011**	**DON**	
Obtain MEC approval for protocol.	**Dec 15, 2011**	**DON**	
Educate affected staff and implement.	**Jan 3, 2012**	**DON**	
Monitor compliance through Infection Control rounds.	**Jan 31, 2012**	**DON**	
Report results to Infection Control, PIC, and MEC.	**Mar 31, 2012**	**DON**	

Evidence of Completion/Monitoring

1. Protocols approved by the MEC.
2. Minutes demonstrate results reporting and review at Infection Control, PIC, and MEC.

Executive Responsible: DON

Recommendation: To avoid sharps injuries, the sharps containers must be secured wherever they are used in the hospital. (OC 27)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Submit purchase order for new mountable sharps containers.	**Oct 30, 2011**	**CFO**	
Receive new containers.	**Nov 30, 2011**	**CEO**	
Install new containers.	**Dec 31, 2011**	**Director of Facilities**	

Evidence of Completion/Monitoring

1. New sharps containers are secured in all unlocked patient care spaces.

Executive Responsible: CEO

Recommendation: Integrate lab reporting into infection identification process. (OC 28)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise surveillance plan to include lab reporting in the infection identification process.	**Dec, 15, 2011**	**CMO**	
Obtain MEC approval for revised surveillance plan.	**Dec 15, 2011**	**CMO**	
Develop standardized process for lab integration.	**Dec 15, 2011**	**CMO**	

Evidence of Completion/Monitoring

1. Revised policy approved by MEC.
2. Copies of surveillance reports.

Executive Responsible: CMO

Recommendation: Develop a log of infections. (OC 29)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise surveillance plan to include a requirement for log of hospital-acquired infections.	**Dec, 15, 2011**	**Infection Control Practitioner**	
Obtain MEC approval of revised policy.	**Dec 15, 2011**	**CMO**	
Develop an electronic log of hospital-acquired infections.	**Dec 15, 2011**	**CMO**	

Evidence of Completion/Monitoring

1. Revised policy approved by MEC.
2. Copies of electronic infection log.

Executive Responsible: CMO

Recommendation: Integrate review of video into staff self-evaluation of restraint and seclusion episodes. (OC 31)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Revise restraint and seclusion debriefing process to include review of video.	**Dec 9, 2011**	**CMO**	
Develop metrics to evaluate video review.	**Dec 9, 2011**	**CMO**	
Obtain MECapproval of revised process.	**Dec 31, 2011**	**CMO**	
Educate staff on revised process and implement.	**Jan 31, 2012**	**CMO**	
Report results to PIC and MEC.	**Mar 31, 2012**	**CMO**	

Evidence of Completion/Monitoring

1. New policy approved by MEC.
2. Minutes demonstrate results reporting and review at MEC, PIC, and Governing Body.

Executive Responsible: CMO

Recommendation: **Develop well-defined reporting requirements, including formats and key questions to be answered, an agenda for the important programs, and projects that should report to the Governing Body. These requirements will ensure that Governing Body oversees medical staff oversight, grievances, and contract services. (GB 1)**

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Develop plan for Governing Body oversight of key issues, including QAPI, medical staff, grievances and contract service.	**Jan 31, 2012**	**Consultants**	
Discuss with Governing Body.	**Feb 28, 2012**	**Consultants**	

Evidence of Completion/Monitoring

1. Document defining reporting requirements as described above.
2. Governing Body minutes reflect discussion of document and approval.
3. Governing Body minutes demonstrate reporting requirements are being met.

Executive Responsible: CEO

Recommendation: Coach the Governing Body to take an activist role in assessing CEO and organizational performance and intervening constructively to promote desired outcomes. (GB 2)

NOTE: This recommendation does not have specific definable deliverables but evidence of effectiveness should be reflected in Governing Body minutes.

Implementation

Key Actions	Target Date	Responsible	Verified Date of Completion
Consultant and CEO will collaborate to prepare items for board discussion.	**Jan 31, 2012**	**Consultants**	
Consultant and CEO will actively encourage broad discussions during board meetings	**Jan 31, 2012**	**Consultants**	

Evidence of Completion/Monitoring

1. Governing Body minutes demonstrate broader and constructive discussion of reporting and review of MEC and PIC minutes.

Executive Responsible: CEO

Recommendation: **Ensure that all contracts include quality performance measures and that these measures are monitored and reported to Governing Body. (GB 4)**

Develop a list of contractors, their quality requirements, and date quality reports are due. (GB 5)

Develop monitors for all clinical contractors. (QAPI 6)

Implementation

Key Deliverables	Target Date	Responsible	Verified Date of Completion
Renegotiate contract requirements with all vendors.	**Jan 31, 2012**	**CFO**	
Develop list of contractors, their quality requirements, and date quality reports are due.	**Jan 31, 2012**	**CFO**	
Begin reporting findings on schedule to MEC and PIC.	**Mar 31, 2012**	**CMO**	
Governing Body reviews MEC and PIC minutes.	**Apr 30, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. Contracted service contracts require quality monitoring and reporting.
2. List of contractors, their quality requirements, and date quality reports are due.
3. Minutes demonstrate quality reports and review at MEC, PIC, and Governing Body.

Executive Responsible: CEO

Section II: K-Tag Related Recommendations

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
K18 Corridor Walls and Doors	Roller latches were found on several doors in patient care areas. The Facilities Team has a listing of the locations in which these latches were found.	Perform an in-depth tour of all door latches, and remove **all** roller latches.	All removed.	**Oct 15, 2011**	
K22/K44/K47 Exit Signs	As a result of a patient-caused flood, the illuminated exit signs on Nursing Unit C are not functioning.	Repair the electrical circuit powering the lights.	Replaced sign.	**Oct 25, 2011**	
K21 Door Hold-Open Devices	Many doors throughout the facility are propped open by wedges, kick-down devices, boxes, chairs, and even a rock. These devices could potentially allow smoke and fire to spread in the event of an emergency. Locations include Ambulatory Area, Medical Records, Nursing Unit Medication Rooms, Pharmacy, Supply Building, Maintenance Building, and Dock Area.	1. Remove all door hold-open devices unless they are linked to the fire alarm system in order to allow closure. 2. Instruct staff that doors on required closures cannot be blocked open. 3. Make frequent rounds to reinforce this finding.	1. Done. 2. Managers directed to remind staff about door safety requirements. 3. Include in weekly safety rounds implemented by Safety and Facilities staff to ensure early detection and correction of any problems. 4. Include in weekly Environment of Care rounds by managers (to be implemented).	**1. Oct 15, 2011** **2. Oct 31, 2011** **3. Nov 1, 2011** **4. Dec 1, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
K44 Horizontal Exits	The main building service areas #851 and #852 do not have full two-hour protection or separation from the rest of the building or exit corridor. The wall is not fully built out with appropriate drywall. Sections of wall are not completed. In addition, there is no separation between a two-hour and one-hour rated area. This lack of separation reduces the level of protection to only one hour while the signage indicates a two-hour rated wall. Several electrical switch rooms are not protected from the exit corridors. Drywall is missing in several rooms. In Nursing Units B and C, penetrations exist in the Isolation Room ceilings.	Install rated drywall on the service- area side of the wall as needed to ensure that a two-hour wall is present. Install proper separation between the service area and electronic equipment room. Install rated drywall on the switch side of the walls as needed to ensure that a two-hour wall is present. Insure that walls are properly identified and marked.	All recommendations implemented.	**Oct 15, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
K104 Smoke Compartmentalization and Control	Duct penetrations through fire barriers are not clearly identified, and inspection documentation is not complete.	Improve the identification and documentation of duct penetration inspections.	Inspections scheduled every three months.	**Nov 1, 2011**	
K32 Remote Exits in Fire Section	In the activity center building, the far corner exit is locked. According to staff, the key is not readily available.	Understanding that this is a high-security area, either the key must be constantly available while the center is occupied, or the door and exit discharge area needs to be reworked to address the security concern as well as the fire-exit availability.	1. Lock box installed with key to enable unlocking back door. 2. Fence will be installed on southwest side of the building door to prevent elopement. Requisition has been completed. Ordering of materials and begin work when PO is completed.	**1. Oct 15, 2011** **2. Dec 31, 2011**	
K34 Stairway Usage	In Building 3, the fire exit stairway is being used as an equipment and supply storage area. Housekeeping is also storing an open trash container in the stairway.	Remove all equipment, supply storage, and lockers from this area.	1. Equipment removed. 2. Incorporated into weekly safety inspections.	**1. Oct 15, 2011** **2. Nov 1, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
K37/K47 Dead-End Corridor	In Building 3, at the top of the stairway, a conference room has been installed directly off the stairway. The doors are currently on an approved hold-open device, but were blocked from closing.	Investigate the practice of keeping the doors to this meeting room closed and labeled, "Not A Fire Exit."	New lock is being installed to lock the door.	**Nov 30, 2011**	
K35/K38/K72 Readily Accessible, Clear Exits	In office area 252-259, broken furniture is being stored that obstructs the exit path. The area was identified on 8-8-11, and the items were still present on 8-12-11.	Remove the furniture from the area.	1. Furniture removed. 2. Begin inspections every two weeks to assure that area remains clear.	**1. Oct 15, 2011** **2. Nov 1, 2011**	
K48 Fire Plan	Although a fire plan exists, there were three different areas in which staff could not implement the plan because they were unsure of the location of the pull-boxes, did not have keys to activate the alarm, or did not know the proper operation of fire extinguishers.	Investigate the Fire Drill method to involve all staff in the activation of the drill.	Modified documentation to show who participated in drills. Verify broad representation during drill evaluation.	**Nov 30, 2011**	
K50 Fire Drills	Although fire drills are being conducted and recorded, these drills can be	Instead of activating the alarm from the Security Office, go to the units	1. Employees will be presented with a verbal situation and actually	**1. Nov 15, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
	conducted in a more effective and efficient manner.	and present the employees with a verbal situation and have them actually activate the fire plan. Have the Security Department document the drill and alarm system operation on a formal Security Report. This documentation should include the notification of the Central Alarm Station of the drill, reception of the alarm, and a return to normal status. Consider having an evaluation team round during drills to document the drill activity, as the return of fire drill evaluation forms appears to be incomplete. Immediately after the drill, conduct a short meeting to discuss and document observations and findings.	activate the fire plan during drills. 2. The Public Safety Department will document their evaluation of each building drill, including notification of the Central Alarm Station and a time of return to normal status. 3. Working on implementation. It will include the Safety Manager, Public Safety Officer and Nurse/Department Manager.	**2. Nov 30, 2011** **3. Jan 31, 2012**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
K51/K52/K54 Fire Alarm System Records	The fire alarm system test and maintenance records do not meet the requirements of NFPA 72 and were not readily available during the survey. The fire alarm system inspection, testing, and maintenance documentation by the Triple S alarm company available at this survey consisted of a single-page item appearing to be more of a bill than report. There was no documentation of the required central station signal testing. There is a question of whether the Supply Building fire detection system is fully functional. The Simplex report indicates that the old kitchen area detection devices were not tested. It was reported that three smoke detectors were removed by patients in their rooms. This action should have signaled a fire alarm system trouble alarm.	Require that the reports submitted by the company meets the requirements of the NFPA 72. As a comparison, the Simplex maintenance report format performed on the outbuildings is more acceptable. Ensure that the devices function, and improve the documentation of the testing of these devices. Have the alarm system tested to ensure that removal of a device will produce a trouble alarm to the monitoring station. In addition, when a trouble alarm is received, have a procedure in place detailing what steps to take to correct the problem, and ensure that the trouble is cleared. Document this activity.	1. Informed vendor of expectation. 2. New quarterly report provides all required information. 3. Simplex tested kitchen area devices, which passed. 4. Devices in kitchen were added to the testing schedule. 5. Alarm system was tested to verify that trouble alarm was produced to monitoring station. 6. Steps to take for trouble alarm are written on panel and in safety management program document. 7. Per policy, documentation requirement established for when trouble alarm goes off.	**1. Oct 15, 2011** **2. Dec 31, 2011** **3. Oct 15, 2011** **4. Oct 15, 2011** **5. Oct 15, 2011** **6. Oct 15, 2011** **7. Oct 15, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
	According to the documentation, it was not clear whether the fire alarm system identified a problem and reported a trouble alarm to the monitoring station.				
K154/K155 Fire Alarm and Sprinkler System Repair	The fire alarm and sprinkler system was out of service for over four hours, and the fire department had not been notified nor had additional fire watch procedures been put in place or documented. Based on observation and documentation, it has been the practice when the fire system is out of service to call the central station monitoring company and give them a range of hours that the system has been down. However, if the system were back in service earlier, no notification took place. In addition, when the system was placed back in service, no follow-up call was made to notify the central station that the	1. Additional fire watch procedures should include placing additional firefighting equipment in the affected area, additional rounds in the work area, and advising affected staff of the temporary measure in place. 2. Any time the fire or sprinkler system is out of service longer than four hours, call the fire department's non-emergency line and advise them of the situation. When the system is back online, call again to notify the fire department of the online status. Document the calls.	1. Policy written to address all issues. 1a. Staff education to Public Safety and Maintenance departments. 2. A policy and procedure has been written and approved to meet the recommendation, including documentation on PSO Log. 3. Policy is already in place. Staff education to activate during times when facility's fire protection system is affected.	**1. Oct 30, 2011** **1a. Nov 30, 2011** **2. Oct 15, 2011** **3. Nov 30, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
	system was live; instead, the facility relied on the initial call and time frame reported.	3. Develop and implement what are commonly called "Interim Life Safety Measures," or ILSM procedures, any time the integrity of the facility's fire protection system is affected.			
K147 Electrical	In several electrical service switch-rooms throughout the buildings, electrical panel boxes and junction boxes are not covered—specifically in the outbuilding areas including the maintenance building, supply building, and basement maintenance areas. In many of the outbuildings, the boxes containing the circuit breakers are blocked. On the sidewalk areas outside of the building in between the main building and maintenance building, wire is exposed on the light pole.	1. Install the covers on all electrical panels and junction boxes. 2. Clear out the area of all unneeded items and ensure that the path is clear. 3. Properly insert the wires and cover the junction boxes on the light poles. 4. Remove or relocate the fans so that they are not located near a water source. 5. It is recommended that modifications be made to the testing	1. All covered. 2. Cleared. 2a. Implement regular inspections 3. Fixed 4. Fans have been removed or relocated. 5. E-mail of expectations sent to UAMS. Power plant operators have stated the changes will be in the next report. 5a. New report that meets expectations due.	**1. Oct 15, 2011** **2. Oct 31, 2011** **3. Oct 15, 2011** **4. Oct 15, 2011** **5. Oct 31, 2011** **5a. Dec 31, 2011**	

K-TAG	FINDINGS	RECOMMENDED ACTIONS	ACTION	DUE DATE	VERIFIED DATE OF COMPLETION
	In most of the main building medication rooms' sink areas, a small electrical fan is placed on the edge of the sink. In general, your generator system is unique and effective. The operating agreement with the University is a forward-thinking project and should serve you well. However, the testing records of the system do not meet the requirements of healthcare standards. Battery-powered lights are present in the new stairway elevator building, but no testing records were provided during the survey.	reports to indicate that the testing passed the goals. The reports should be signed by the person who conducted the test. In discussion with the Power Plant Operations Director he has agreed to make the changes to the generator report to reflect the needed areas. 6. Inventory all battery-powered lights. Perform and document testing as required by NFPA standards.	6. Inventory to be completed. 6a. Testing to be done.	**6. Nov 30, 2011** **6a. Dec 31, 2011**	
K211 Alcohol-Based Hand Rub Dispensers	While properly installed, several of the dispensing units have been broken off the wall, leaving a sharp, jagged edge.	Immediately replace or remove the units when they are damaged.	1. Replaced. 2. Implement "rounding" schedule to identify units needing replacement.	**1. Oct 15, 2011** **2. Nov 1, 2011**	

Section III: Cultural Recommendations

While cultural changes are not directly linked to specific Conditions of Participation requirements, culture has an impact on the organizational environment in which care is provided by influencing judgment and behaviors in ways that policies and procedures cannot address. Although as important as other corrective actions, cultural changes take five to seven years to implement and anchor. Furthermore, the process for changing organizational culture is very different from the process for implementing technical changes.

Our approach to changing culture relies on two related theories: Schein's work on organizational culture and Kotter's work on organizational change. Schein argued that culture change is manifest in three elements: rituals, enacted values, and norms. Changing cultures is extremely difficult but modifying cultures by redefining and adding new elements is more easily achieved. Kotter provides advice on how to make change happen and make it stick through eight separate elements. In both works, culture change is seen as an emerging and evolving process that cannot be defined at the beginning of the process, but is refined and augmented as the organization and its leaders work through the process of change. Unlike technical changes that have objective measures of completion, the effectiveness of culture change is ultimately determined through its facilitation of changes in metrics that are part of the QAPI program.

As a result, it is not possible or reasonable to define specific timetables for elements of a change plan at the outset of the engagement. Instead, leaders need to use the insights to define the desired change direction, initiate the process of organizational transformation, and manage the evolving change process. From an assessment of completion perspective, qualitative rather than quantitative evaluation is more common because the manifestations of cultural change appear in diverse measures and behaviors. For example, part of the culture change at ASH will be directed toward moving from a culture of caring to a culture of treatment, which means a greater focus on therapeutic interactions with patients. Besides typical treatment settings, this new value should result in viewing all activities as potential treatment opportunities. The ultimate measure of success is better rates and faster achievement of treatment goals, but the redefined value manifests itself in a range of behaviors that cannot be realistically measured reliably. Thus, reporting on plans and progress for culture change recommendations must be different from action plans to correct technical deficiencies.

For each of the three cultural recommendations in the report, we will present short-term (say three-month timetables) activities goals. Each month, we will review plan implementation and announce a new plan for extending culture-modification activities. The consultants will document this progress and send a report to CMS.

In the September 20, 2011 report, two recommendations address cultural change, rather than technical change, relative to performance improvement. These two cultural changes address performance improvement for at the management and governance levels.

Define and implement cultural changes that expand upon the existing expressed values of caring for patients and a sense of family. The new cultural elements will include actively seeking problems so they can be fixed, using performance measurement as a source of institutional pride, permitting task conflict without relationship conflict, and fostering shared and mutual accountability. (LM 5)

The purpose of this recommendation is to begin the process of changing how the organization views problems and addressing problems. Specifically, this recommendation addresses how managers identify and act upon problems that are identified, as well as how staff members collaborate to achieve performance improvement.

Key Actions	Target Date	Responsible
Identify and notify members of the steering committee.	**Dec 9, 2011**	**CEO**
Develop a document that defining the vision that guides the organizational culture change process, defines key messages, and identifies new rituals, values and norms and initial roll-out plan.	**Dec 31, 2011**	**Consultants/CEO**
Present document for discussion and approval by Governing Body.	**Jan 2012 Board meeting**	**Consultants/CEO**
Implement roll-out plan.	**Mar 1, 2012**	**Consultants**

The last step listed above is not the final step in this process. As mentioned, this will be an evolutionary process. The first four steps are the initial plans for initiating cultural change (developing a guiding coalition and developing a vision).

After the initial roll-out is completed, the steering committee will conduct monthly assessments of progress. Monthly assessments will address any problems during the roll-out as well as building additional cultural elements to remove barriers to adoption of new values and norms, and broaden the influence of the new culture throughout the organization.

Coach the Governing Body to take an activist role in assessing CEO and organizational performance and intervening constructively to promote desired outcomes. (GB 2)

The purpose of this recommendation is to engage the Board in discussions with the CEO about issues to illuminate the logic and assumptions used to address problems. To test the logic, conflict should arise in these discussions, but the conflict should be seen as illuminating rather than as evidence of disagreement between the Board and the CEO. By engaging in an analysis of managerial decisions, the Board is able to ensure that management has clearly selected the best alternative for addressing an issue.

Key Actions	Target Date	Responsible
Consultant will present training on board interactions and board self-assessment.	**Jan 2011 Board meeting**	**Consultant**
Initiate monthly meeting preparation, Consultant, CEO, and Board Chair will prepare the board package and agenda to facilitate board discussion of issues.	**Prior to Feb 2011 Board meeting**	**CEO**
Initiate monthly meeting debrief, Consultant, CEO, and Board Chair will debrief about board discussions and interaction.	**Following Feb 2011 Board meeting**	**CEO**

These actions are designed to introduce changes in the Board-CEO discussions during Board meetings. The result of greater analysis of management's decisions should be greater effectiveness in achieving the desired outcomes. This will be evident in the minutes of the Governing Body and progress on issues presented for Governing Body discussion.

One recommendation was related to culture that affect clinical care delivery. Operational Change recommendation 6 stated, "Define explicit expectations in terms of how staff work together and how staff treats patients. These expectations should be built into staff education and competencies."

The implications of this recommendation are to create an environment of teamwork among staff to provide safe care through anticipation (i.e., prevention of "crisis" events) and more effective treatment (i.e., care designed to achieve the goals in the treatment plan). Creating teamwork and defining care as safety and treatment goal fulfillment have cultural implications.

The following work plan defines initial actions that will be taken to begin the process of changing behaviors. However, we do not envision this work as being completed. Instead, we anticipate that the work group will need to continue to meet to expand the implications of teamwork and anticipatory safety. The consultants will collaborate with the work group as they execute the work and develop an implementation plan.

Implementation

Key Deliverables	**Target Date**	**Responsible**	**Verified Date of Completion**
Develop work group to define the issues of teamwork and safety as they relate to staff behaviors.	**Dec 31, 2011**	**CEO**	
Develop implications for clinical unit operations.	**Jan 31, 2012**	**Work group**	
Develop staff educational material.	**Feb 29, 2012**	**Work group**	
Revise performance appraisals to reflect evaluation relative to demonstration of newly identified behaviors.	**Feb 29, 2012**	**Work group**	
Initial staff education on new behavioral expectations.	**Mar 31, 2012**	**Work group**	
Implement revised performance appraisals.	**April 1, 2012**	**CEO**	

Evidence of Completion/Monitoring

1. Documents on teamwork and safety.
2. Personnel records contain confirmation of education.
3. Copies of revised performance appraisals.

Executive Responsible: CEO