SECTION - ADMINISTRATION
ADMINISTRATIVE DIRECTIVE NO. 138
(Replaces AD 138 dated 12/15/2005)

Effective Date: November 9, 2006

SUBJECT: PERFORMANCE IMPROVEMENT PROGRAM

I. PURPOSE

Coalinga State Hospital (CSH) requires a collaborative and systematic approach to improve services and Individual health outcomes through the proper design, measurement, analysis and continuous improvement of the following areas:

A. Assessment of Individuals
B. Care of Individuals
C. Continuum of Care
D. Forensic Services
E. Infection Control
F. Leadership
G. Management of Human Resources
H. Management of Information
I. Management of the Environment of Care
J. Medication Use
K. Individual and Family Education
L. Patient's Rights and Organizational Ethics
M. Performance Improvement
N. Safety and Security

II. AUTHORITY

The Hospital Executive Director authorizes the establishment of an effective performance improvement program in keeping with:

Special Order: 001.02: Governance of State Hospitals and Joint Commission on Accreditation of Healthcare Organizations.

III. POLICY

As a health care organization, CSH acknowledges its responsibility to the Individuals and community it serves, to conduct its business and Individual care operations within a consistent, ethical framework as defined by its Mission, Vision, Values and related policies. The Performance Improvement (PI) Program focuses on hospital-wide performance and is dependent on well-designed and well-executed systems that respond to Individual care needs and the skills of the entire work force.

IV. METHOD

The PI Program provides a mechanism for continuous evaluation and improvement of services and an objective basis for recommending changes in priorities. The organizational structure for performance improvement has been designed to manage, improve and facilitate communication about these areas throughout the hospital. It is also designed to promote the principles of PI and a team approach to enhancing these areas.

A. Executive Committee

1. The Executive Committee has overall responsibility and ultimate accountability for performance improvement.

2. Membership is determined by the Executive Director, and may include, but not be limited to:

a.) Clinical Administrator
b.) Coordinator of Nursing Services
c.) Director of Standards Compliance
d.) Executive Director
e.) Hospital Administrator
f.) Medical Director
g.) PI Manager

B. The planning process includes setting priorities for the PI of governance, management, clinical and administrative support activities that affect the quality of Individual care and services. The key is to bring quality to all areas at all levels of the hospital. Specific responsibilities include:

1. Ensuring that important processes and activities are measured, assessed and improved systematically throughout the hospital.

2. Prioritizing data collection based on the hospital's goals and objectives, scope of care and services provided.

3. Providing necessary consultation and resources.

4. Reviewing all proposals for PI projects.

5. Evaluating, reviewing and revising the PI program annually.

C. The PI Manager is responsible for collecting data, reviewing and working with Department Managers/Supervisors in developing ideas to facilitate change in areas that have been identified as requiring improvement.

Departments/Programs shall identify these areas by submitting a Process Improvement Opportunity System (PIOS) form (Attachment), describing the defect, error, or barrier on a monthly basis. The PICS shall be processed as follows:

1. Shall be sent to the PI Manager via fax, e-mail or inter-facility mail.

2. The PI Manager will log and send the PIOS to the Supervisor who oversees the area with the identified problem.

3. The Department Manager/Supervisor will address all applicable PIOS by initiating a Corrective Action Team (CAT).

4. The CAT is responsible for assessing identified issues, determining severity of impact to worksite, brainstorming a solution, relaying identified issues and recommended solutions to their Department Manager/Supervisor.

5. The Department Manager/Supervisor shall assess and consult with other department-heads who may be impacted by the recommended Plan of Correction (POC). If the POC impacts his/her department only, approval may be made at the department-head level for the assigned CAT to initiate the POC.

6. The effectiveness of all initiated POCs are monitored and assessed by the CAT. The CAT will be responsible for submitting periodic reports to the Department Manager/Supervisor. The department Manager/Supervisor shall provide a report to the Performance Improvement Manager on a monthly basis by means of a detailed report or minutes from the department Performance Improvement Meetings.

7. Identified areas requiring a POC that may impact more than one department or where the POC is determined to be non-effective or not possible at the department level, shall be forwarded by the Department Manager/Supervisor to the Performance Improvement Manager. The PI Manager is responsible for reporting these issues to the Executive Committee for review and recommendations.

8. Decisions by the Executive Committee shall be communicated by the PI Manager to the impacted Department Manager/Supervisor.

9. Upon resolution, the Department Manager/Supervisor shall send a copy of the PIOS to the initiating employee, with a copy to the PI Manager.

10. The PI Manager shall report outcomes, for PIOS received, to the Executive Committee and submit a Bi-annual performance improvement report to the Governing Body.

W.T. VOSS
Executive Director

Cross-Reference(s):
A.D. No. 126 Clinical Administrator
A.D. No. 130 Facility Declaration
A.D. No. 134 Facility Plan for Services
A.D. No. 166 Risk Management