



**Annual Patient Safety and Quality Plan
FY 2020**

INTRODUCTION

Hartford Hospital and The Institute of Living (IOL) are committed to providing clinical quality second to none. The IOL is also an entity of HHC's BHN, or Behavioral Health Network. Hartford Hospital's Annual Quality and Safety Plan provides a conceptual blueprint of how Hartford Hospital leadership, staff and physicians continuously assess and improve its performance and outlines the specific strategic initiatives for improvement for FY 2020. This document does not duplicate the information in that Plan, but provides the priorities for patient safety and quality at The Institute of Living. Along with the Quality and Safety Plan at Hartford Hospital, the IOL's quality initiatives are guided by the priorities of BHN Leadership.

1.0 STRATEGIC PRIORITIES FOR PATIENT SAFETY AND QUALITY

1.1 Priorities:

The Institute of Living's Collaborative Management Team (CMT), under the framework of the BHN safety and quality priorities agrees on priority areas of focus for safety and quality and associated measures to be reported quarterly via the Annual Improvement Priorities (AIPs). Targets and strategies to achieve these goals have been established. In addition, the Hartford Hospital QAPIC and BHN Quality Council regularly reviews these measures as well as a broader set of high level quality and safety performance metrics described below:

1.1.1 Mortality

The ultimate measure of success in any patient safety and quality program is to eliminate needless deaths. Assessing and mitigating the risk of suicide are two of the most important indications for contemporary inpatient psychiatric treatment. The IOL reports suicides in all registered patients, monitors patterns of self-injurious behaviors and reports potentially lethal suicide attempts in inpatients.

1.1.2 30 Day Readmission Rate

A measure of high quality care is the successful transition of patients from the acute care setting following the episode of care. The IOL reports 30 day inpatient readmission rates, excluding those patients transferred for a medical-surgical admission.

1.1.3 Count of Sentinel Events

Unexpected adverse events occur in all health care settings and result in significant morbidity and mortality. In support of its mission to continuously improve the safety and quality of health care provided to the public, The Joint Commission reviews organizations' activities in response to "sentinel events" in its accreditation process. Such events are called "sentinel" because they signal the need for immediate investigation and response including a root cause analysis and development of a formal corrective action plan which is presented to the Hospital's Board Quality Committee.

A sentinel event is defined as the unexpected occurrence involving death or serious physical (loss of limb or function) or psychological injury, or risk thereof, to a patient. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

Some examples of sentinel events are as follows, but are not limited to:

- ◆The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, or
- ◆The event is one of the following (even if the outcome was not death or major permanent loss of function):
 - Suicide of any individual receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge
 - Abduction of any individual receiving care, treatment or services
 - Rape

The Count (number) of Sentinel Events that occurred at The Institute is reported on the Dashboard.

1.1.4 Patient Experience

The IOL continues to measure and monitor patient and family satisfaction for inpatients. Press Ganey is the vendor used for patient satisfaction surveys in the BHN, or Behavioral Health Network, HHC. The measure on our 2020 Balanced Score Card reported is the “overall rating of care”.

1.1.5 Other High Level Quality and Safety Performance Metrics routinely reported to the Executive Quality Management Committee and/or the IOL Board include:

1.1.5.1 Restraint and Seclusion events and hours

The use of restraint and seclusion presents one of the more complex issues in clinical care, requiring a balance of safety and patient rights. Reduction or elimination of use, and ensuring its safe use when necessary, is crucial to avoid death or serious injury, complications related to immobility, and violations of individual rights.

Seclusion and restraint utilization is reported via multiple indicators including the number of events and hours for both seclusion and restraint, and the number of patients involved.

1.1.5.2 Events Reported

Events (incidents) may or may not reach the patient and may or may not lead to harm (near misses). Reviewing events that are reported into the Event Reporting System can identify opportunities to improve. Events are reviewed by Institute management staff and Risk Management and action plans are developed as appropriate.

Total Events and Type of Events (e.g., falls, ECT anesthesia events, elopements) are reported on a monthly basis (in the aggregate and at the unit level).

1.1.5.3 Count of Inpatient Falls (Total number of falls and with: no injury, minor injury, moderate injury, and major injury)

Patient falls in hospitals are a significant cause of morbidity and mortality. The root causes for patient falls are multiple and include, among others, medication side effects; patient frailty, confusion, and disorientation; and failure to institute preventative measures.

Hartford Hospital monitors and evaluates all patient falls on a daily basis and, through root cause analysis, identifies new strategies to prevent additional falls, with a particular emphasis on avoiding all falls with injury.

1.1.5.4 DMHAS Performance Outcome Measures

The Department of Mental Health and Addiction Services (DMHAS) has established client outcome indicators for each service level (group home, outpatient) provided under its Human Services Contract. Performance measures include:

- Utilization rates
- Client ability to manage their lives
- Client ability to live independently
- Client satisfaction
- Client abstinence
- Client ability to remain free of arrest
- Client compliance with service plan
- Avoidance of readmission

1.2 Initiatives

Annual Improvement Priorities for the Hartford Hospital and Institute of Living initiatives are approved by the Hospital Board of Directors, and for the Institute of Living, the Behavioral Health Network (BHN) Executive Leadership Group for FY 2020 (See Attachment: Annual Improvement Priorities). While each of these initiatives is designed to enhance organizational performance, one initiative is the centerpiece and addresses transforming the organization (i.e., Daily Lean Management reflecting the framework of H3W, or *How Hartford Hospital Works*). The Institute has cascaded this to IOL AIPs for 2020. A summary of the initiatives associated with enhancing patient experience, quality and safety is listed below.

- Improve staff responsiveness to patient concerns
- Improve communication in coordination of care
- Achieve best practice in reducing inpatient seclusion and restraint utilization
- Achieve best practice in fall prevention in a psychiatric setting
- Implementation of IOL best practices on inpatient services
- Reorganize multidisciplinary treatment team planning to enhance patient involvement
- Create a high performance organization (H3W Lean Model)
- Implement IOL best practices model in all services and programs

2.0 ROLE OF LEADERSHIP

Responsibility for patient safety and performance improvement is the role of every individual at Hartford Hospital. At Hartford Hospital, leaders are defined as the Board of Directors of Hartford Hospital, Board Quality Committee, elected officers and chairs of the medical staff, the Chief Executive Officer, HH Vice Presidents, Department Directors and Managers. The BHN has a similar leadership structure to support patient safety and quality improvement.

Leaders at Hartford Hospital play an active role in promoting and supporting patient safety and performance improvement and in role modeling behavior. Leaders initiate, give direction, and monitor the identification, measurement, assessment and improvement of important processes and outcomes. They promote communication and collaboration across departmental lines and provide training to staff involved in performance improvement activities.

2.1 Hartford Hospital Boards of Directors

The Hospital Board of Directors maintains the ultimate responsibility for assuring optimal quality of all care delivered by the medical, professional,

technical and ancillary staff within the institution. The Board of Directors has the final authority and overall responsibility for a flexible, comprehensive and integrated performance improvement program. The Board reviews IOL performance improvement initiatives quarterly. The Hospital Board of Directors delegates the authority and accountability for the implementation of the performance improvement program to the hospital administration and medical staff. The Board of Directors delegates review functions to the Hartford Hospital and BHN Quality Councils.

3.2 IOL Quality and Safety Council

The IOL Safety and Quality Committee membership includes the Chief of the Department of Psychiatry and Medical Director, the Director of Nursing, Program Directors for Child and Adolescent Psychiatry, Geriatric Psychiatry, Adult Psychiatry, Ambulatory and Residential Programs, and Directors of Environmental Services and Engineering. The committee meets monthly and reviews performance reports for each of the clinical areas, quality indicator results, critical incidents and generally coordinates and monitors all quality and data-related initiatives for the IOL. Reports from this committee cascade to the BHN Quality Council and the Hartford Hospital Quality Assessment and Performance Improvement Council (QAPIC).

3.3 Medical Staff Leadership

The Executive Committee of the IOL works collaboratively with IOL Leadership to ensure the overall quality of the medical care and the treatment of patients. This is accomplished through a process-improvement focus as well as by ensuring individual provider competency.

3.4 IOL Leadership

Leadership is provided through the Collaborative Management Team (CMT) and the Administrative Council. The Collaborative Management Team is comprised of four members: the Chief of the Department of Psychiatry/Medical Director, Senior Associate Medical Director, Vice President, Clinical Operations, and the Director of Nursing. The IOL Leadership Forum is held monthly, and is comprised of the CMT, the Director of Clinical Research, the Director of Development, Human Resources Consultant and Director, Director of Compliance and Privacy, the Hartford Hospital Director of Public Relations, the Director of Assessment Services, the Director of Psychology, Program Directors for Child and Adolescent, Adult and Geriatric Psychiatry, Residential

Services, and the IOL Patient Family Resource Center. These two teams work closely to ensure overall quality of patient care, monitor day to day operations, plan programmatic developments manage contracts and evaluate new contracting opportunities, and maintain excellent education and training programs.

IOL leadership provides resources to ensure competent staff and an effective infrastructure. Each director/manager is responsible for measuring, assessing and improving patient care, service, and satisfaction. These leaders are charged with the following:

- Oversee the hospital process improvement priorities
- Ensure competency of staff
- Measure outcomes of key systems and processes and provide information which demonstrates the quality of care and services provided at Hartford Hospital
- Provide leadership on process improvement opportunities of hospital processes and multi-disciplinary problem solving
- Collaborate with Medical Staff Leadership to establish common goals and address quality issues
- Communicate information to Medical Staff Leadership and the Board of Directors related to quality
- Allocate resources for performance improvement including staff time, needed information, and financial resources
- Communicate and involve all members of the organization in performance improvement
- Role Model and educate others on the principles of Patient Safety and Performance Improvement

3.0 DESIGN OF OVERALL PERFORMANCE IMPROVEMENT EFFORT

Hartford Hospital recognizes that Performance Improvement must be an organization wide effort if it is to be successful. This includes a balanced integration with the Hospital staff and the Medical Staff. Hartford Hospital's Quality Assessment and Performance Improvement Council (QAPIC) is the working body that oversees organization-wide performance improvement, safety and risk management. As the model for How Hartford Hospital Works (H3W) is designed and deployed during 2020 at HH, the performance improvement structures and processes described herein will both lead and adapt, as necessary.

4.1 Performance Improvement Committee Structure

4.1.1 HH Quality Assessment and Performance Improvement Council (QAPIC)

This Quality Council meets monthly and is chaired by the Vice President of Quality. Membership of QAPIC is composed of representatives from Administration, the Medical Staff, the Nursing Executive Council, Quality Management Department, Risk Management, Chair of the Environment of Care Committee, Information Systems, Health Information Management, Education, IOL Director of Nursing, and the IOL Medical Executive Committee, as appropriate.

4.1.2 Patient Safety Action Group (PSAG)

The PSAG is a multidisciplinary team that huddles each morning to identify opportunities to enhance patient safety and quality at Hartford Hospital. The IOL Director of Nursing regularly attends the daily meetings; inpatient IOL managers and directors rotate attendance at PSAG with other nurse managers on a regular basis.

4.1.3 Environment of Care Committee (EOC)

The EOC meets monthly and is responsible for overseeing Hartford Hospital's environmental safety initiatives. The EOC monitors trends related to safety, provides accountability for implementing safety improvement initiatives and provides periodic updates and reports to the Quality Assessment and Performance Improvement Council.

4.1.4 BHN Quality Council

The Behavioral Health Network Quality Council ("Council") meets monthly and is an inter-disciplinary council with representation from both inpatient and outpatient behavioral health settings. The council is responsible for the overview of quality outcomes for the behavioral health settings, improving the quality of care for those patients and driving optimal outcomes.

4.2 Management of Events (Incidents)

Event Management includes the process of reviewing events (incidents) with a focus on systems and not on individual performance. An "event" encompasses any incident defined as a Sentinel Event (per the Joint Commission), adverse events (per State of Connecticut), near-misses, or other process variances. Event Management consists of a process for:

- identifying, reporting, prioritizing, reviewing, analyzing root causes, and creating action plans for "events",
- disclosing to patients and/or families, and
- educating and training staff.

4.3 Organization-wide Performance Improvement

4.3.1 Models for Improvement

Hartford Hospital has adopted the H3W Lean Operating Model. The H3W Lean Operating Model is a foundation anchored in our

values and built on leadership behaviors and Lean principles with tenants that encompass respect for people and continuous improvement. The use of the model drives the continually improvement of outcomes, customer experience, and engagement to ensure a high reliability organization. The journey is initiated with Daily Management and matures through milestones of Bronze, Silver and Gold unit status.

Harford Hospital also utilizes the Plan-Do-Study-Act model for improvement. It is a simple yet powerful tool for accelerating improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes.

The model has two parts:

1. The first part is to answer three fundamental questions;
 - What is the aim?
 - What measures should be established?
 - What changes need to be made?
2. The second part is to follow the Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.

4.3.2 Steps in the PDSA Cycle

Step 1: Plan

Plan the test or observation, including a plan for collecting data.
State the objective of the test.
Make predictions about what will happen and why.
Develop a plan to test the change. (Who? What? When? Where?
What data need to be collected?)

Step 2: Do

Try out, or do the test on a small scale.
Document problems and unexpected observations.
Begin an analysis of the data.

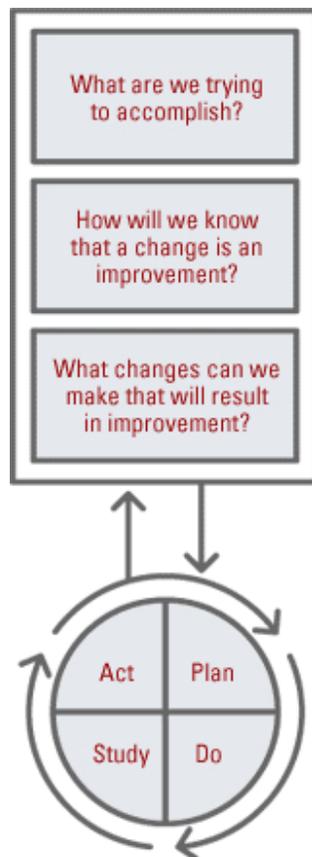
Step 3: Study

Study the results, and complete the analysis of the data.
Compare the data to your predictions.
Summarize and reflect on what was learned.

Step 4: Act

Refine the change, based on what was learned from the test.
Determine what modifications should be made.
Prepare a plan for the next test.

Model for Improvement



5.0 CONFIDENTIALITY

Hartford Hospital makes every effort to respect the privacy of patients, employees and the medical staff at all times including confidential performance improvement and peer review activities. In accordance with federal Healthcare Quality Improvement Act of 2005 and Connecticut State Statute 19a - 17b Section (4) activities are protected as utilized for evaluation and improving the quality of health care rendered and considered non-discoverable by courts/legal processes.

6.0 ANNUAL PATIENT SAFETY & QUALITY PLAN EVALUATION

The Patient Safety & Quality Plan is evaluated annually and revised and updated as necessary. The Plan is presented to Hospital Administration, Medical Staff Leaders and the HH Quality Assessment and Performance Improvement Council (QAPIC).

