# HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department Of Correction
Division Of Prisons

SECTION: Administrative – Performance Improvement and Risk Management

POLICY # AD II-1



SUBJECT: Performance Improvement Plan

EFFECTIVE DATE: July 2007
SUPERCEDES DATE: June 2004

## PURPOSE

The purpose of the Performance Improvement Plan is to insure that Health Services designs processes well, monitors, measures, analyzes and improves its performance to improve patient outcomes and improve organizational soundness and performance. The goals are to have an appropriate balance between good outcomes, excellent care / services, and costs; to understand the relationship between perception of care, outcomes, and costs, and how these three issues are affected by processes carried out by facilities within the Division of Prisons, and to recognize that the Division's performance of essential and important functions significantly affects the quality and value of its services.

## POLICY

The Division of Prisons Health Services Performance Improvement Plan plays an essential role in assisting all areas of Health Services in fulfilling its' mission to provide inmates the medical services that meet community standards. This constitutional obligation, grounded in the Eighth Amendment, and statutory requirement (GS 135-40.7(5) requires Health Services to provide inmates access to quality care provided by competent health care professionals. The Performance Improvement Plan will assist in the Divisions goals to:

- View correctional facilities as public health stations that significantly impact the health status of the larger community.
- Improve the health status of the inmate and non-inmate population in order to get the best value for the total tax dollar spent
- Meet the community standard of care
- Provide sound medical practices
- Provide appropriate care
- Provide care that will positively impact the public health sector
- Ensure consistency with the mission and goals of the Department of Correction
- Provide services based on customer needs.

**Authority**

The development and maintenance of the Health Services Performance Improvement Plan is delegated to the Division of Prisons Medical Director by the Secretary for the North Carolina Department of Correction. The Medical Director delegates authority for the oversight of the overall plan to the Quality Council. The Medical Director delegates the authority for the coordination of the overall plan to the Standards Director in conjunction with the Nurse Liaisons.

## PLAN

**I. Quality Council/Executive Roundtable**

A. The Quality Council/Executive Roundtable is composed of the Division of Prisons Health Services Core Group of Senior Management Team and the Performance Improvement Staff in accordance with the National Commission on Correctional Health Care, standard P-A-06 (an essential standard) and the National Institute of Justice standard 7. Regarding the Role of Central Office Staff, d. "Quality Assurance/Risk Management. Its functions and delegated subgroups such as Medical Peer Review Committee are protected by discovery laws as described in the statute GS 131-E-95 and GS90-21.22A. It is composed of the Medical Director for Health

Services; chairperson, Deputy Medical Director for Health Services, Mental Health Director, Dental Director, Director of Nursing, Director of Operations, Director of Pharmacy Services, Director of Medical Records Services, Human Services Coordinator, OPUS Coordinator, Quality Assurance Coordinator for Mental Health, and Standards Director for Health Services, or designee. The Council will meet a minimum of Quarterly in conjunction with Executive Roundtable and more often as needed.

B. Responsibilities of the Quality Council/Executive Roundtable:
   1. Developing and implementing the Performance Improvement (PI) Plan.
   2. Insuring all Health Services Staff receive education in Continuous Quality Improvement (CQI)
   3. Insuring that the PI activities promote survey readiness by various accrediting agencies
   4. Being a role model for PI principles for Division of Prisons' Staff.
   5. Setting priorities on monitoring activities, conducting CQI Projects and other PI efforts

C. In fulfilling the above duties, the Quality Council performs the following tasks:
   1. Reviews data on performance indicators and actions taken for improvement collected by Regional Nurse Liaisons and analyzed by Standards Director. Directs appropriate parties to implement additional corrective or improvement action if needed.
   2. Reviews and takes necessary action, if needed, to risk management issues identified by Nurse Liaisons and Standards Director, including Sentinel Event Reviews (suicide attempts, Medical Review Committee work, deaths, and any injuries or outcomes leaving a person permanently disabled or with permanent loss of function).
   3. Reviews data from customer satisfaction survey results and determines additional needed actions.
   4. Reviews and approves statewide CQI Projects; reviews the status of the projects and approves the improvement strategies. Also reviews regional and departmental CQI projects to insure they are in line with DOP Health Services Priorities.
   5. Determines resource needs and makes recommendations to the Director of Prisons.

## II. Performance Improvement Plan Overview

A. The PI Plan has four integral components:
   1. Monitoring and evaluation of performance and indicator data
      a. Peer Review
      b. Medical Records Audits
      c. Committees (such as Medical Records, Pharmacy and Therapeutics, etc.)
      d. Departmental (Nursing, Dental, Medical Records, Pharmacy, etc.) Example of reports – Nursing: Vacancy Data, Dental: Patients seen without charts, SW: MH and DD Aftercare Plans completed.
      e. Statewide (ex. – ER visits, Missing UR Data, etc.)
      f. Risk Management (Medication Error Reports, Medical Incidents, Implications of torte claims)
   2. Continuous Quality Improvement (CQI Efforts)
      a. CQI Projects (Quality Council based, Health Services departmental, regional, field unit, inpatient facilities etc.)
      b. Customer satisfaction surveys
      c. Clinical practice guidelines (Chronic Disease Clinical Guidelines)
      d. Policy improvement
      e. Survey readiness
      f. Committee activities
      g. Nursing Protocols

3. Risk Management
   a. Routine monitoring and tracking (med errors, pt. incidents)
   b. Sentinel event reviews
   c. Litigation
4. Competence in job performance
   a. Personnel file is one comprehensive package: job description, state TAP work plan, interim reviews and evaluations, competency assessments
   b. Core competencies (ex. Medication administration, nursing)(others being developed)
   c. Age specific, population specific (to be determined)
   d. Credentialing and privileging (tied to professional peer review data)

**III. Delegation of Responsibility for Implementation**

A. The Performance Improvement Plan is carried out collaboratively with an organization-wide approach. This means that Performance Improvement principles and techniques are utilized throughout the Division of Prisons facilities in departments, committees and work groups. While there are "division wide" CQI Projects, satisfaction surveys, risk management activities or competency determinations, the individual departments and committees implement departmental or committee PI measures. It is expected that each facility with an average daily inmate population of 500 or less, will develop a Basic CQI Program that includes at least annual monitoring of the fundamental aspects of the facility's health care system: intake/transfer process, access to care, continuity of care, emergency care, hospitalizations, and adverse patient events including deaths . The Basic CQI Program will include monthly physician clinical chart reviews of at least 5% (up to 25) of all patient health records. It is expected that facilities with average daily inmate population greater than 500 will develop a Comprehensive CQI Program by the establishment of a multidisciplinary quality improvement committee that meets quarterly, and reviews at least annually: intake/transfer/discharge process, access to care, continuity of care (including sick call, chronic disease management)infirmary care, nursing care, pharmacy services, diagnostic services, mental health care including substance abuse, as appropriate, dental care, diagnostic services, health assessments, emergency care hospitalizations, and adverse patient events including deaths . This multidisciplinary committee will also review critiques of disaster drills, environmental inspection reports, inmate medical grievances and infection control issues.

B. The Standards/Performance Improvement Section including Regional Nurse Liaisons, provides consultation and assistance to the Medical/Mental Health Staff, professional discipline heads, and managers of departments and services who are responsible for insuring that performance improvement, risk management activities, job competency assessments, CQI programs are implemented in their respective areas.

C. The Standards Director drafts the design of the annual PI plan based on the results of the previous plan's evaluation, current NCCHC Standards, and in accordance with administrative code. The Standards Director maintains documentation of the implementation of the PI Plan. This includes coordinating the development, monitoring and evaluation of division level performance indicators, and continuous quality improvement efforts such as projects, satisfaction surveys, etc. The Standards Director collects information regarding departmental PI plan Standards Director collects information regarding departmental PI plan implementation, IE: copies of PI plans, departmental indicator reports, status reports on CQI Projects, customer satisfaction surveys, etc. The Standards Director assists and monitors committee activities as it relates to collecting, evaluating, and taking action to PI data. The Standards Director collates, aggregates, analyzes and reports PI information to the Quality Council and the Medical-Mental Health QA Committee.

D. The Standards Director also drafts the design of the Division's Risk Management Program in accordance with the needs of the Division, NCCHC Standards and current risk management literature. The Standards Director in conjunction with Nurse Liaisons, collects, reviews, collates, analyzes and reports risk management information such as medication error reports, sentinel events and risk management data collected by Medical Review and Mental Health Committees, and other risk management issues. The Standards Director will also serve as the liaison between the Attorney General's office and the Health Services Director to coordinate chart review and tracking of Health Services related tortes and claims. The Standards Director insures the implementation of Serious Incident Investigation and Sentinel Event Review when applicable. The Standards Director is a standing member of the Medical Peer Review (Sentinel Event) Team. At this time, the Medical Peer Review Committee reviews Sentinel Events as a part of their regular meeting. The Standards Director manages the day to day follow-up of risk management issues, identified during NET meetings or those reported or brought to the attention of the Standards Office by Nurse Liaisons and others. Documenting such follow-up and needed actions .The Standards Director is responsible for presenting a verbal and written summary report to the Quality Council/Executive Roundtable quarterly, and a summary report to the Medical/Mental Health QA Committee monthly.

E. Division Committees and Medical/Mental Health Committees
The following committees are responsible for implementing various PI functions
Needlestick Committee
Medical Records
Pharmacy and Therapeutics
Protocol Committee
Medical Review (Sentinel Events)
Policy and Procedure
Nursing Protocols
Audit Team
Dental Steering Committee
Physicians Advisory Council
Mental Health Quality Assurance
Various CQI Committees

## IV. Monitoring And Evaluation Of Performance

All management staff are expected to monitor and evaluate the performance of pertinent patient care and facility functions. The mechanisms by which this is accomplished may be through manual or computerized methods. The two major parts of the Monitoring and Evaluation component are Quality Control and Performance Indicators.

A. **Quality Control**

Quality Control monitoring is performed to insure that the right things are done and that they are done right, and is a part of routine supervision and management. Health Services Department Heads shall identify tasks, duties and processes, which require monitoring for completion and quality, and develop the mechanisms and documentation for such monitoring. These may include tracking logs, flow sheets, check sheets, tickler systems, etc. Health Services will develop a Quality Control Program. This will be developed by each discipline establishing quality control monitors. Quality control monitors currently in place should continue to be monitored. Any concerns resulting from these monitors will be reported through the chain of command until a Quality Control Program can be established. These Monitors are not static, as performance of tasks, duties should improve through close monitoring, new ones will be added.

EXAMPLE: Spore testing will be conducted on the Dental Clinic sterilizer weekly by the dental assistant. Testing and results will be recorded on the Spore Testing Log. The Dental Director or Assistant Dental Director will review during annual site visits.
EXAMPLE: Nursing License Renewal will be verified by Nursing Managers and reported to their ADON or DON who will maintain a tracking system for Nurses in their area and report any discrepancies to the Director of Nursing for Health Services.

B. **Performance Indicators**

Performance indicators are measurement and assessment tools used to monitor and evaluate identified high risk, high volume or problem prone functions which affect, directly or indirectly, patient outcome. Data obtained through monitoring and evaluation of indicators raise important quality of care issues, which may lead to identifying opportunities for improvement and/or risk management issues, and assist in evaluating job performance and/or clinical competence.

1. Each indicator addresses at least one of the following functions:
   a. Care and Assessment of Patients
   b. Management of Information
   c. Infection Control
   d. Inmate's Rights and Ethics
   e. Human Resources
   f. Continuity of Care
   g. Patient Education,
   h. Environment of Care
2. Every indicator specifies the monitoring methods for determining compliance and evaluating for trends and patterns, and has a compliance standard (threshold, trigger or standard) for measurement.

Current Performance Indicators:

a. Vacancy and Turnover Rates –No more than 10% vacancy rate
b. Incomplete UR Information –No more than 2% incomplete URs
c. ER Visits – No unnecessary ER trips
d. Death Review – No preventable deaths
e. Medication Variance Report – No negative patient outcomes
f. Medical Incident Report –Access to care
g. Approved UR without a charge (Missing HS20)- Patient received requested service and a charge has been made therefore there is a charge posted on HS20 report

C. PERFORMANCE IMPROVEMENT MODEL

A Performance Improvement Model is really a way of management or philosophy. It should be used in staff meetings, committee meetings, CQI teams, etc.

**SUGGESTED MODEL: FOCUS-PDCA**

**F** - Find a Process to Improve
**O** - Organize a Group-Frontline People who do the process or work
**C** - Clarify Current Knowledge- "How is it done now"?
**U** - Understand Variation-identify what you want to achieve and compare with what is currently done. Identify the difference

**S** - Select Improvement/Change strategies
**P** - Plan how to implement the improvement or change -assign responsibilities and due dates
**D** - Do it - May do on trial or test basis
**C** - Check or study – Monitor, track, follow up and evaluate effectiveness - This is a very important step. It gives you data to validate that this is a needed change and if any additional revisions are needed.
**A** - Act - Based on evaluation, change if needed and repeat the PDCA Cycle

## V. Continuous Quality Improvement (CQI) Efforts

Improving patient care and Division functions throughout all departments and disciplines is essential. This may be accomplished through CQI projects, customer satisfaction surveys, clinical practice guidelines, clinical pathways and other initiatives.

### A. CQI Projects

1. A CQI project involves the design of a new process or the analysis of an existing process to improve the care, treatment and services to patients. CQI projects may also address services provided to internal and external customers (examples: Health Services Employees, Custody Staff, the taxpayer) who have an impact on patient care outcomes and/or organizational performance.
2. Continuous Quality Improvement Projects may be initiated and conducted by facilities, departments, disciplines, services, committees, or proposed to and approved by the Quality Council when the process studied affects multiple departments, services or disciplines. CQI project proposals may be submitted to the Quality Council by any employee or committee. The proposal should be in writing and sent to the Standards Director. The Quality Council may initiate a CQI project in response to performance indicator findings, customer satisfaction survey data or risk management monitoring.
3. Improvement projects are to possess the following characteristics:
   a. Based on the Health Services mission, goals and objectives;
   b. Based on the needs and expectations of patients, staff and others as identified through means such as customer satisfaction surveys, patient/employee suggestion system, etc.
   c. Based on NCCHC or NIC standards and regulations
   d. Involve collaboration with appropriate departments/services and disciplines. A quality team is organized. It is composed of those directly involved in the process to be improved; Measurable data/information (i.e. number of non-compliant medical records, number of trips to specialists, etc.)
   e. Performance expectation of the team is identified.
   f. Supports the need for the project (is the time/expense for the project justifiable based on expected impact?)
   g. Analyzes the process
   h. Evaluates the effectiveness of improvement strategies and actions
   i. All pertinent managers commit to the need to analyze and improve the process
   j. The designated process is not currently being changed in any way, nor scheduled to be overhauled in the near future;
   k. The process is not being studied by any other group;
   l. Improvement actions and implementation of new processes shall be implemented through proper channels of approval, such as, applicable committee or department, Medical, Mental Health Staff, Quality Council, etc.;
   m. Improvement actions may be tested rather than full-scale implementation
4. The role of the Quality Council/Executive Roundtable is to:
   a. Review and prioritize proposed division-wide CQI projects based on the Health Services mission and objectives;

b. Identify the goals of the project and prepare a written performance expectation, limitations and boundaries;
c. Determine and allocate resources;
d. Select or recommend the team leader, facilitator and team composition; and
e. Review status of current committee, department or service CQI projects and provide support and assistance when needed

5. Role of the Quality Team
The Quality Team is a group of individuals made up of employees most directly involved in the specified issue or process; therefore, has first hand knowledge of the process. The team may be made up of multiple disciplines and levels in the
hierarchy. The Quality Team is made up of a team leader, facilitator (optional) and team members. The team leader may serve as both the leader and facilitator. The team members are appointed by the team leader and/or Quality Council. The team's role is to implement the (proposed) FOCUS-PDCA model.

6. Role of Team Leader
The team leader may be selected by the quality team members or appointed by the Quality Council or Chair of the Quality Council. The role of the leader is to:
a. manage a quality team -to create and maintain channels that enable team members to do their work;
b. act as a full-fledge team member;
c. possibly serve as facilitator;
d. orchestrate all team activities;
e. serve as the official keeper of all paper work, minutes, data, etc.; and
f. maintain communication with the Quality Council through the Performance Improvement Coordinator and any other appropriate review body.

7. Role of the Facilitator
The Facilitator may be selected by the quality team. The role of the facilitator is to:
a. keep the discussion focused on the topic and moving along;
b. intervene if the discussion fragments into multiple conversations;
c. tactfully prevent anyone from dominating or being overlooked;
d. bring discussions to a close; and
e. serve as an advisor:
    1. assist in scientific approach -statistical and PI tools -teaches team how to gather data, use of analysis techniques and to use statistical and PI tools/ i.e. flowcharts, cause and effect diagrams, graphs
    2. assist leader in structuring tasks.

8. Role of the Standards Director:
a. Provide consultation to the Team Leaders, Facilitators and Quality Teams.
b. Collect CQI project proposals for projects, obtains necessary data and presents to Quality Council.
c. Obtain quarterly status reports on CQI projects and reports to the Quality Council.
d. Maintain files on CQI projects
e. Serve as a Team Leader, Facilitator or Team Member as appropriate.

9. The team leader of departmental level projects is responsible for informing the Standards Director of the project. The Quality Council shall be kept informed of these projects upon initiation of the project, and annually during the PI Plan evaluation. The Standards Director will maintain a selection grid on all

10. Mechanism for Implementing Improvement Strategies
    Certain improvement strategies may be implemented without prior approval from committees, department heads, etc. These may include doing an information article in the DOC Newsletter, sending a reminder flyer, etc. However, depending on what the strategy is, channels of approval may be required. Examples: where channels of approval are required include policies, medical record forms, anything that is an expenditure, etc. If the improvement strategies affect others outside the immediate department, then regular channels of approval must be gone through. Changes in clinical practices require review by the Medical Director and his/her designee. Strategies requiring resource allocation must go through the Quality Council.
11. Documentation of Continuous Quality Improvement Projects
    a. The Standards Director will maintain statewide records concerning CQI Projects approved by the Quality Council.
    b. The following are guidelines for documentation:
        1. Data justifying or substantiating the need to design a new process or improve existing Process
        2. Description of project in writing
        3. Quality Team identification
        4. Data obtained through statistical tools and improvement techniques
        5. Meeting minutes
        6. Comparative data from external databases if available
        7. Information and data on piloting or testing if applicable
        8. Written new process or flowchart or summary of improvement strategies including objectives, accomplishments; improvement strategies unable to implement and the reasons why, recommendations, any measurement data of new or revised process if available;
        9. Performance indicator(s) and compliance standard (threshold) for monitoring and evaluation; and
        10. Evaluation for effectiveness.

B. **Customer Satisfaction Surveys**

1. Patient Satisfaction Surveys:
   Patient Satisfaction Surveys are not routinely done at this time within the Division of Prisons Health Services; however, it is anticipated that this will be accomplished by the next PI Plan implementation. The Standards Director will be responsible for coordinating the Patient Satisfaction Survey Group. The work group should be multidisciplinary and will be responsible for designing the tool and submitting to the Quality Council. The Nursing Department would be responsible for administering the survey. The Standards Director will coordinate with the Survey Group and will be responsible for the collection of the tools, data entry, aggregating and summarizing statistical data and other survey results, report writing including graphics and improvement recommendations, report distribution and presentation.
   The Quality Council would be responsible for reviewing the survey report findings and taking additional action on the recommendations.
2. Other Customers:
   Health Services Department Heads are encouraged to conduct customer satisfaction surveys of non-patient customers such as custody, outside vendors, etc.

C. **Clinical Practice Standards**

The Quality Council delegates clinical practice guidelines development and implementation to the Deputy Medical Director and Director of Mental Health. They will keep the Quality Council informed of activities. The

Quality Council delegates Nursing Protocol Guidelines to the Director of Nursing. The Director of Nursing keeps the Quality Council informed of activities.

D. **Clincial Pathways**
Health Services is currently in the process of developing medication algorithms.

## VI. Risk Management

The North Carolina Division of Prisons Health Services is committed to providing the highest possible quality of care while minimizing risk to its patients, visitors and staff. This is accomplished by developing, implementing, and managing the Health Services Risk Management program. This program is responsible for risk identification, risk control, interfacing with the Attorney General's office for reviews of torte claims and those claims with implications from other disciplines that may prevent further negative outcomes, administering the program on a day-to-day basis by interfacing with field staff for risk management concerns; managing and analyzing data; conducting educational programs; and complying with NCCHC, state and federal standards.

Each member of the Medical and Mental Health Staff, professional discipline heads, and the Standards Director in conjunction with Regional Nurse Liaisons is responsible for identifying unanticipated problems or issues which may emerge, as well as routinely screening collected data, to determine which events have potential risk management implications for the Department and individual practitioners. All other health services staff are obligated to identify and report potential risk management issues. This may include (but is not limited to) patient incidents, requests for medical records from legal counsel, substantiation of abuse by Health Services, and/or unexpected deaths. Performance indicators are developed for monitoring and evaluating data that may have potential risk management implications (i.e. medication errors, patient incidents, deaths). [Refer to Monitoring and Evaluation of Performance].

At the direction of the Health Services Director, the Standards Director coordinates investigations into incidents that warrant such investigation, and report such information to the Medical Review Committee (Sentinel Events Committee). The committee will conduct a root cause analysis on all identified sentinel events. This information is deemed a peer review process and is protected under G.S. 90-22.21A

## VII. Competence In Job Performance

A. State Employee Performance System
   1. Job Description
      Each employee has a job description which identifies key responsibilities, their duties and responsibilities.
   2. The Appraisal Process (TAPS)
      Each employee is required by State policy to have a work plan which reflects their job description and competencies, an interim (mid-cycle) performance review and an annual performance evaluation. The evaluation incorporates applicable findings from objective data and as per the TAPS Manual.

B. Competencies
   1. Core Competencies
      The Clinical Department Heads shall identify competencies for each clinical discipline to determine level of competent and safe practice. They shall develop and implement a competency assessment program.
      EXAMPLE: Nursing has determined medication administration as a core Competency

2. Clinical Competency
   In addition, supervisors of professional disciplines are required to assess clinical competency of their staff. Performance improvement data collected may be a resource for the objective findings for clinical competencies.

   EXAMPLE: Staff working in Geriatric areas, Women's Health areas, or other specialty areas such as the OR

C. Credentialing and Privileging
   Each Clinical Department Head is responsible for establishing and implementing credentialing and privileging process for their professional clinical disciplines. Physician credentialing and privileging will be centralized out of Health Services utilizing contract services of a vendor service. No Physician shall be hired without being credentialed and privileged. Copies of credentialing and privileging files will be given to those facilities that the individual provider is assigned and practices.

**IX. Annual Evaluation**

Each December the Standards Director shall conduct an annual evaluation of the PI Plan and present to the Quality Council/Executive Roundtable in February. This evaluation shall encompass conducting a survey of the department heads, and committee chairpersons. It is an expectation that each recipient of the survey participate in the annual evaluation. The survey shall include questions pertaining to each of the four components of the PI plan and soliciting suggestions for improvement.

The evaluation shall include but is not limited to:

1) A summation of the survey
2) PI accomplishments such as CQI projects, satisfaction surveys, improvements in policy development/review process and survey readiness
3) Performance or compliance problems/issues such as those reflected in PI indicator reports and strategic plan progress report. The evaluation shall be instrumental in the review and revision of the PI Plan for the upcoming year.

7/30/07

Paula Y. Smith, MD, Director of Health Services Date

SOR: Standards Director