GILCHRIST HOSPICE

CONTINUOUS QUALITY IMPROVEMENT POLICY

HOSPICE PROGRAM EVALUATION
POLICY # 1-301

APPROVAL:

(Signature on file)
President

I. POLICY

The organization's performance in relation to its mission, purpose and objectives will be evaluated on an annual basis to assess the quality, safety and appropriateness of the services provided. The evaluation will be documented and reported to leadership and to the Quality Committee of the Board of Directors.

II. PROCEDURE

A. The annual evaluation will be based on the following:

1. Evaluation of effectiveness of administrative practices, policies and procedures focusing on high risk and problem prone areas identified during process improvement and metric selection. Regulatory requirements, survey results, Quantros trends and others are also considered when developing the plan. requirements.

2. Achievement of goals and objectives surrounding the CMS Hospice Quality Reporting Program (HQRP)

    a. Hospice CAHPS
    b. Hospice Item Set (HIS)
    c. Admission
    d. Discharge

3. Achievement of additional, internal goals and objectives as identified in the fiscal year Quality and Safety Plan as measured by internal data collection, analysis, and trending and guided by the organization's quadrupled Aim of Better Health, Better Care, Least Waste and More Joy.

    a. Infection control data and trends.
    b. Safety management data and trends

c. Risk management data and trends
d. Effectiveness of resource utilization/ management
e. Proposed goals/ priorities for the coming year.

4. Patient and family perceptions of care, treatment and services including:
    a. The number and content of patient/family complaints
    b. Patient and family feedback about how the complaint was resolved.

5. Staff contribution to the following:
    a. Expressed opinions, needs and expectations
    b. Perceptions of risks to individuals and suggestions for improving patient safety
    c. Willingness to report unanticipated adverse events
    d. Conditions in the organization or individual environment

6. The input of the following standing committees' area also considered when developing the plan:

    a. Pharmacy and Therapeutics
    b. Education/Staff Development
    c. Infection Control
    d. Utilization Review

7. The report will be approved by the Board of Directors in order to establish the organization's improvement priorities for the upcoming year and to allocate resources needed for performance improvement in the annual Quality Improvement Plan.

Date Posted on Web:	1/18/2018
Last Reviewed:	1/2018
Responsible for Review:	DIRECTOR OF QUALITY, SAFETY, AND STAFF DEVELOPMENT

HI.2e. The governing body carries out responsibilities as designated in CI.2f and in addition carries out the following responsibilities for hospice:

1. Assumes full legal authority and responsibility for:
   a) Determining, implementing and monitoring policies governing the hospice s total operations
   b) The management of hospice
   c) The provision of all hospice services
   d) Hospice fiscal operations
   e) Performance improvement
   (418.100 (b))
2. Appoints a qualified individual who is responsible for the day to day management of the hospice program. (418.100 (b))
3. Designates an interdisciplinary group or groups who provide the care and services offered by hospice to supervise the hospice care and services. (418.56 (a) (1))
4. Ensures that one Interdisciplinary Group is designated in advance to establish policies and procedures governing the day to day provision of hospice care and services if a hospice has more than one interdisciplinary group. (418.56 (a) (2))
5. Ensures that the interdisciplinary group maintains responsibility for directing, coordinating and supervising the care and services provided. (418.56 (e) (1))
6. Ensures that substantially all Hospice core services are provided directly by hospice employees or are supplemented only during extraordinary and non-routine times via a process and circumstance that is consistent with CFR 42 418.64 requirements. (418.64)
7. Ensures that all services provided are consistent with accepted standards of practice. (418.64, 418.70, 418.100(c))
8. Ensures that care and services are provided in accordance with plans of care and that plans of care are based on assessments of patient/family needs. (418.56 (e) (2), (3))
9. Ensures that information is shared among disciplines (direct or contractual) in all hospice care/service settings. (418.56 (e) (4))
10. Ensures that information is shared with non-hospice healthcare providers furnishing unrelated services. (418.56 (e) (5))
11. Ensures that the hospice-wide performance improvement program: 418.58
    a) Is defined, implemented, maintained and evaluated annually. (418.58 (e) (1))
    b) Addresses priorities and that all actions are evaluated for effectiveness. (418.58 (e) (2))
12. Designates at least one individual to be responsible for the performance improvement operations. (418.58 (e) (3))
13. Approves frequency and specific plan for performance improvement data collection. (418.58(b)(3))

HI.2f The Hospice IDT/IDG membership includes employees who are qualified and competent to practice in the following professional roles:

1. Doctor of Medicine or Osteopathy (may be by contract) (418.56 (a) (i))
2. Registered Nurse (418.56 (a) (ii))
3. Social Worker (418.56 (a) (iii))
4. Pastoral or other counselor (418.56 (a) (iv))
   (418.56 (a))

HI.2g Additional members of the IDT/IDG may include:

1. Physical Therapist
2. Occupational Therapist
3. Speech Language Therapist/Audiologist
4. Dietitian
5. Pharmacist
6. Home Health Aide/Homemaker
7. Volunteer

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HI.2 cont'd

D:	Policies or other official documents identify member composition and responsibilities of the IDT/IDG. (HI.2f, HI.2g, HI.2h)
I:	Team members verbalize their roles and contribution to team conferences. (HI.2f, HI.2g, HI.2h)
O:	IDT/IDG meetings have full participation of appropriate personnel. (HI.2g, HI.2h)
D:	Clinical records and IDT/IDG minutes document fulfillment of staff responsibilities. (HI.2h)
D:	Clinical records indicate the IDT/IDG care plans are developed, reviewed periodically and updated for each patient. (HI.2h)
D,I,O:	A process exists for the regular review and revision of policies and procedures that show evidence of incorporation of new information. (HI.2i)
D:	Staff meeting minutes (when available) include evidence of dissemination and updates of information. (HI.2i)
I:	Managers verbalize process for incorporating new knowledge into systems. (HI.2i)

HII.10 The adequacy, appropriateness, effectiveness and outcomes of care, services and supplies provided by hospice are routinely assessed.
42 CFR 418.58, 42 CFR 418.62

HII.10a The Hospice organization conducts an ongoing comprehensive, data-driven, integrated self-assessment of care provided including inpatient care, home care, and care provided under arrangements to ensure the provision of high quality care, services and products.
(418.58)

HII.10b The performance improvement program:

1. Reflects the complexity of its organization and services
2. Involves all hospice services, including those services furnished under contract or arrangement
3. Focuses on indicators related to improved palliative outcomes and is capable of showing measurable improvements in indicators (418.58 (a) (1))
4. Utilizes quality indicator data to monitor effectiveness and safety and to identify opportunities and priorities for improvement (418.58 (b) (1) - (2))
5. Measures, analyzes and tracks quality indicators, including adverse patient events (418.58 (a) (2), 418.58 (c)(2))
6. Takes action to demonstrate improvement in hospice performance (418.58 (c) (3))
7. Involves all licensed professional employees (418.62 (c))

(418.58, (a) (1), (2), 418.58 (b) (1), (2))

HII.10c Patient focused quality assessment and improvement activities include:

1. Comprehensive assessment and care planning
   a) Notification of significant changes to the agreed plan of care and scheduling of service
   b) Efforts are made to ensure the continuity of provision of care by designated staff
2. Patient teaching and levels of understanding
3. Determination of patient s discharge readiness
4. Use of findings from satisfaction surveys completed by the patient and/or family
5. Clinical record reviews are conducted on a routine basis from a random sample of 10% of unduplicated admissions with a maximum of 120 sample records per year. Record reviews include assessment of: (418.58 (d))
   a) compliance with plans of care
   b) appropriateness of care and services provided
   c) service duration
   d) high risk, high volume, or problem-prone areas incidence, prevalence, severity (418.58 (c) (1))
   e) adverse patient events (418.58 (c) (2))
6. Safety issues
7. Evaluation of systems designed to support clinical operations
8. Compliance with standards of clinical practice
9. Reprioritization of performance activities (418.58.(e) (2))
10. Integration of administrative, clinical and support functions

HII.10d The findings are tracked, trended, analyzed and used by the hospice organization to correct identified problems and to revise hospice policies if necessary. (418.58 (a) (2), 418.58 (c) (2),(3))

HII.10e Effective February 2, 2009, the hospice is required to implement performance improvement projects based upon patient and internal organizational needs and to document the projects conducted, the reasons for conducting the projects and the measurable progress achieved on the projects. (418.58 (d) (1), (2))

LEGEND:

D - DOCUMENTATION
I - INTERVIW
O - OBSERVATION
S - SURVEY

HII.11

D &O:	Documentation and observation validate compliance with policies and procedures for elements 1-5. (HII.1la)
D:	Schedules and logs are available and current. (HII.1la)
D:	A written safety program sets the parameters for monitoring environmental conditions and identifying potential hazards/risks in accordance with the 8 elements of HII.1lb.
D:	Disaster/fire drills as appropriate are conducted and documented. (HII.1lc)
I & O:	Staff describes and observation confirms the safety teaching provided to patients/families. (HII.11d)
I & O:	Staff demonstrates knowledge of the practice and procedure. (HII.1le)

HIV.2 Annual evaluation of the Hospice organization provides the basis for future planning.
42 CFR 418.58

HIV.2a The findings from the quality assessment are included as part of the Hospice annual evaluation. (418.58 (d) (1))

HIV.2b The hospice annual evaluation is consistent with and/or integrated into the overall organizational annual evaluation when the Hospice organization is part of a larger organization.

LEGEND:

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HIV.3

O:	Innovative strategies have been developed and implemented to meet the consumer and community needs and capitalize on consumer and community opportunities. (HIV.3a)
D:	Recognition of consumer and community needs and opportunities are evident as the basis for innovation. (HIV.3a-c)
I:	Strategies for recognizing and developing cutting-edge hospice-specific innovations are described. (HIV.3b)