

WHITING FORENSIC HOSPITAL

BY-LAWS

of the

GOVERNING BODY

Approved: December 13, 2021

**Jose Crego LCSW, LADC
Chief Executive Officer (CEO)
Chair, Governing Body**

WHITING FORENSIC HOSPITAL BY-LAWS OF THE GOVERNING BODY

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WHITING FORENSIC HOSPITAL BY-LAWS OF THE GOVERNING BODY

Article I Name and Principal Office

A. Name:

The name of this organization is the Governing Body of Whiting Forensic Hospital (WFH). WFH is located at 70 O'Brien Drive in Middletown, Connecticut.

B. Principal Office:

The principal office for the transaction of business by the Governing Body of WFH is located on the hospital campus at 70 O'Brien Drive in Middletown, Connecticut, 06457.

Article II Introduction

A. Role and Scope

WFH is a 229-bed state-operated inpatient psychiatric hospital, which provides services to adults (persons 18 years and over). The hospital consists of two major services:

- 1. Whiting Maximum Security Service**
- 2. Dutcher Enhanced Security Service**

WFH is a secure forensic inpatient facility for the treatment of patients with psychiatric disabilities who are involved in the criminal justice system and/or who exhibit aggressive behavior that cannot be managed safely in other psychiatric settings. The WFH is established under the auspices of the Connecticut Department of Mental Health and Addiction Services (DMHAS). The hospital shall provide resources, support, and treatment services in the least restrictive environment possible. Admissions may be on a voluntary or involuntary basis, under civil or criminal statutes. No one is denied admission or treatment on the basis of race, color, religion, age, national origin, gender, gender identity, sexual orientation, physical disability, or inability to pay.

The Governing Body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and values. The mission vision and values of the hospital are communicated to patients and staff through posters throughout both buildings of the Hospital and in patient handbooks.

B. Vision of WFH

Whiting Forensic Hospital will provide exceptional care and support for all, where patients' health and wellbeing will be enhanced to their fullest potential.

C. Mission of WFH

Whiting Forensic Hospital provides high-quality, comprehensive, and individualized treatment and evaluation services for patients with mental health conditions who are involved in the criminal justice system or are not yet ready to be safely treated in less restrictive settings. This is accomplished with full respect for each patient's civil and human rights. Our goal is to assist individuals to manage their illnesses and achieve personal recovery goals through developing the skills necessary to live safely in the community.

Goals:

- **Providing Recovery oriented treatment and care.**
- **The ongoing positive engagement of patients in their care.**
- **Providing a safe environment physically and culturally to staff and patients.**
- **Maintaining the highest level of Professionalism.**
- **Consistently striving for excellence.**
- **Acknowledging and embracing our cultural diversity.**

Article III Establishment an Organization of the Department of Mental Health and Addiction Services (DMHAS)

A. Statutory Authority

Pursuant to Connecticut General Statutes (CGS) Sec. 17a-450 authority is given for the creation and establishment of the DMHAS.

B. Governing Authority

In accordance with CGS Section 17a-451, the DMHAS Commissioner is appointed by the Governor with the advice of the State Board of Mental Health and the approval of the General Assembly. The Department is operated with oversight by the Governor and the General Assembly and with the advice of the State Board of Mental Health and the

regional and facility advisory boards, including the advisory board for the Whiting Forensic Hospital established under CGS Sec. 17a-565. The Commissioner is the executive head of the department and is a qualified person with experience in hospital, health and mental health administration. The Commissioner functions as the Governing Authority of all offices, divisions, regions, facilities, and programs of the DMHAS. The Commissioner appoints facility directors.

Article IV Establishment and Organization of the Governing Body

The Governing Body of WFH shall have By-Laws which specify the following: the role and purpose of the hospital; the duties and responsibilities of the Governing Body; the process and criteria for the selection of the Governing Body; the Governing Body's organizational structure; the requirement for the establishment of a medical staff; the mechanism for adopting the Governing Body By-Laws; and the mechanism of review and revision of the By-Laws.

A. Responsibilities of the Governing Body

The Governing Body of WFH shall address issues of importance to the hospital and to the Department of Mental Health and Addiction Services. Responsibilities include:

1. communicating between the Governing Body of WFH and the Office of the Commissioner;
2. communicating among members of the Governing Body of WFH's administration, Medical Staff and Disciplines;
3. strategic planning which incorporates the view of staff and service recipients;
4. ensuring that patients receive care that is appropriate and medically necessary;
5. ensuring sound fiscal management of resources;
6. reviewing and approving clinical and performance standards relating to quality of care which ensures that one level of care is provided throughout the hospital;
7. reviewing/approving all Operational Policies;
8. developing a mechanism to review credentials and delineate individual clinical privilege;

9. developing a mechanism to ensure the competence of all staff providing patient care services, including cultural competence;
10. taking action on the recommendations of the Medical Staff of WFH, including access to care, quality of care and treatment outcomes;
11. taking action on the recommendations of other components of hospital leadership;
12. reviewing and taking action on the procedures and results of the hospital's performance improvement activities;
13. ensuring that WFH complies with State of Connecticut Ethics Guidelines and Policies for conducting fiscal operations;
14. participating in due process procedures as specified in the Governing Body By-Laws and the By-Laws of the Medical Staff;
15. developing and implementing mechanisms to evaluate its own performance;
16. providing for organizational management and planning;
17. approving the hospital's written scope of services; and
18. advising the Commissioner on the appointment of the CEO of the hospital.

B. Membership

In order to provide for the proper discharge of the duties and responsibilities of the Governing Body, the membership shall consist of the staff members holding the following offices: the Chief Executive Officer (CEO); the Chief Medical Officer (CMO); the Chief Operating Officer (COO); the Chief Financial Officer (CFO); the Chief Nursing Officer (CNO); the Director of Forensic Services, DMHAS; the Chief Quality and Compliance Officer (CQCO); the Director of Social Work; the Director of Recovery Services; the Program Managers of the Whiting and Dutcher Services; the Service Medical Directors of the Whiting, Dutcher, and Ambulatory Care Services; the Chief of Forensic Services; the Plant Facilities Engineer 2; the President and President-elect of the Medical Staff.

C. Officers of the Governing Body

1. Mechanism for selecting Officers of the Governing Body

The CEO shall function as Chairperson of the Governing Body. When absent, the CEO designates the Chief Medical Officer to function as Chairperson.

The CEO designates each member of the Governing Body as an officer thereof with duties and responsibilities as described in Article V, B.2. The CEO may delegate other duties within the Governing Body at any time as deemed necessary.

2. Responsibilities of Officers of the Governing Body

The officers of the Governing Body shall discharge the duties and responsibilities specified in Article IV-A.

D. Meetings of the Governing Body

1. Meetings of the Governing Body shall be held at least quarterly, All members shall attend or be represented by a designee, as appropriate, unless excused by the Chair.
2. Meetings of the Governing Body shall have an agenda prepared in advance and proper notice shall be provided to the members.
3. Minutes shall be recorded and kept in a permanent file. A quorum is defined as 60% of the committee's membership (excepting positions not yet established or not filled, for which no designee is available), including available designees, being present to conduct the business at hand.
4. The agenda of the Governing Body shall, with the guidance and consent of the CEO, include any pertinent issues brought before it including, but not limited to, the making of policy, the planning, implementation and coordination of services, the standards of quality of care, administrative and personnel issues, budget matters, and consideration of reports received.

E. Committees of the Governing Body

Standing Committees will exist to perform special functions of the Governing Body.

Other committees of the Governing Body may also be established by the CEO when necessary or appropriate to discharge specialized duties of the Governing Body.

Otherwise, the business of the Governing Body shall be accomplished by the Governing Body as a whole. If the CEO creates Committees of the Governing Body, the CEO shall appoint the chairs of such committees. The CEO shall be an ex-officio member of all committees of the Governing Body. Whenever committees of the Governing Body deliberate matters affecting the discharge of medical staff responsibilities, such

committees shall include members of the Medical Staff with voice. Each committee meeting shall have an agenda, proper notice shall be provided to the members, and minutes of its meeting shall be submitted to the CEO for review and for the permanent file, including a listing of those present. To constitute a quorum for a committee of the Governing Body, 60% of the membership must be present to conduct the business at hand. Each committee, through its chair or co-chairs, distributes minutes of committee meetings to Governing Body members.

1. Standing Committees

a. Investigation Review Committee (IRC)

This committee is chaired by the CQCO. Membership shall consist of: the COO, CMO (or designee), CNO, Facility Human Resources Representative, Facility Labor Relations Representative, Performance Improvement Manager, the Program Managers, the Service Medical Directors, the Director of Advocacy, and the appropriate supervisor/manager for the alleged perpetrator(s) of abuse, neglect or exploitation under investigation. At least one clinical staff (e.g. CMO), one representative from Performance Improvement, and two additional members of the IRC will be present for all IRC meetings. Responsibilities shall include:

1. review all investigations concerning abuse, neglect, or exploitation to determine if they were conducted according to the relevant policies on patient abuse or neglect and if appropriate corrective actions were taken in response to investigation findings;
2. identify and track disciplinary and programmatic corrective actions to ensure effective and timely implementation;
3. track the timeliness of reports in the IRC minutes.
4. maintain minutes, including conclusions and recommendations, following each meeting, and forward to the Governing Body.

b. Ethics Committee

The committee is chaired by the CMO, or designee. Membership shall consist of: representatives from the professional disciplines, the maximum

security and enhanced security services, medical staff, and the Director of Advocacy, and a Chaplain. Meetings are held quarterly; ad hoc meetings may be held at the call of the chair. Responsibilities include:

1. provide a forum and a process in which treatment teams and individuals (patients, families, clinicians, community members, and others) can explore ethics concerns;
2. provide case consultations to help focus ethics questions and formulate strategies for consideration;
3. assist clinical teams with questions and concerns regarding such patient's rights issues as conservatorship, capacity to give informed consent, and emergency and involuntary medication;
4. develop in-service modules and learning experiences that inform the hospital staff about the ethics aspects of patient care;
5. review hospital policies and procedures relating to the ethics of patient care including, but not limited to, end of life issues, advance directives, withdrawal of life-sustaining treatments, pain management and organ donation; and
6. advise the hospital leaders on issues involving organizational ethics, such as conflict of interest. The committee may initiate suggestions for policy additions or changes, related to patient advocacy, improving organizational performance, or any ethics matters.

Article V Organized Medical Staff

A. Authority

WFH shall have an organized medical staff in accordance with the Medical Staff standards set forth in the most current Joint Commission (TJC) Manual for hospitals.

The Medical Staff of WFH shall have overall responsibility for the total clinical care of patients at WFH and shall account for the Governing Body. There shall be

a mechanism to assure that all individuals with clinical privileges or credentials provide their services within the scope of their clinical practice.

B. By-Laws

The Chair of the Governing Body of WFH shall assure that the Medical Staff develop and adopt By-Laws and rules and regulations that are consistent with the Governing Body By-Laws; Department of Mental Health and Addiction Services policies; federal and state statutory and regulatory requirements; and the current Joint Commission standards.

The Medical Staff By-Laws shall provide for procedures by which the Medical Staff is organized, including the selection of officers, in order to establish leadership and a functional structure to accomplish its tasks. Such by-laws and rules and regulations shall be reviewed at least every two years by the Medical Staff, and revisions and/or amendments adopted as appropriate. By-Laws revisions, or amendments adopted by the Medical Staff shall be subjected to, and effective upon, approval of the Governing Body. Approval shall be promptly provided unless specific reason is given for withholding approval.

Article VI Quality of Patient Care

The CEO of WFH shall require the Medical Staff and the CQCO to implement mechanisms for monitoring and evaluating the quality of patient care and services, for identifying and resolving problems in patient care and services, and for identifying opportunities to improve patient care and organizational performance. The CEO shall require each discipline to implement mechanisms to monitor the performance of persons providing care. The results of these activities shall be reported, as appropriate, to the Office of the Commissioner. Review and action on these items shall ordinarily be accomplished through oversight by the Governing Body of WFH. Items appropriate for action at a higher level may be forwarded to the DMHAS Medical Director.

A. Performance Improvement and Uniformity of Care

As guided by TJC standards for improving organizational performance, the Governing Body of WFH shall establish, implement and maintain systems

designed to assess and improve the quality of patient care and organizational performance, integrating services across programs and over time. Furthermore, mechanisms shall be established to assure that each person served by WFH will receive, as appropriate for the individual, the same quality of care without regard to race, color, religion, age, national origin, gender, gender identity, sexual orientation, physical disability or inability to pay/social status.

B. Use of Information Systems and Performance Indicators

Quality improvement activities throughout WFH shall be integrated using information management systems that permit comparison and analysis of empirical data and performance indicators across programs and divisions.

C. Performance Improvement Plans and Periodic Reports

As directed by the CEO, each clinical service shall comply with the hospital Performance Improvement (PI) plans and produce periodic reports regarding performance improvement activities. These reports shall be submitted to the CQCO and reviewed by the Governing Body quarterly. The Governing Body shall provide comment to the clinical services as appropriate and, through the CEO, bring such matters to the Office of the Commissioner as deemed appropriate or as directed by the Commissioner or designees.

D. Competence to Provide Quality Patient Care

Each professional discipline of WFH shall develop, implement and maintain systems designed to assure that each individual who provides patient care services is competent and/or credentialed to provide such services and has current licensure and/or certification, if applicable. Such systems shall include, but not be limited to, establishment and adherence to standards of care and performance assessment processes; supervision and evaluation of staff; and use of continuing education to provide ongoing training.

Article VII Patient Rights and Patient Education

WFH shall maintain a patients' rights program consistent with the Patients' Rights Standards as set forth in the Department of Mental Health and Addiction Services

Patients' Rights Manual and the Commissioner's Policy Statements. The Director of Advocacy shall be responsible for the Patient's Rights Program at WFH. The Patients' Rights program shall recognize and identify the rights of patients as an integral part of the treatment process. Every patient is entitled to receive humane and compassionate treatment at all times, with full respect for his/her personal dignity and privacy.

The Governing Body shall foster a patient environment of humane and compassionate treatment at all times that respects the rights of patients and recognizes that each patient is an individual with a unique history and health care needs who must be treated with a specialized treatment plan suited to those needs. The Governing Body will promote principles of recovery, including patient empowerment and self-determination. Consumer organizations are encouraged and permitted to provide education and advocacy to patients.

Article VIII Conflicts of Interest

- A.** WFH is fully owned and controlled by the State of Connecticut, except where programs and/or services are contracted from individuals, private organizations, private non-profit organizations, municipalities, or other entities of state government. Such DMHAS contracts with individuals or organizations are a matter of public record.
- B.** All members of the Governing Body shall adhere to guidelines established by the State of Connecticut Ethics Commission.
- C.** The authority or position of the Governing Body or confidential information about WFH or its patients may not be used for private purposes except as provided by law.
- D.** The CEO shall require prompt investigation of apparent conflict of interest within WFH and shall refer pertinent cases to the Office of the Commissioner for possible evaluation by the State of Connecticut Ethics Commission and/or the Attorney General.

Article IX Mechanisms for Resolving Conflicts

There are mechanisms designed for resolving conflicts among leaders and individuals under their leadership. The Medical Staff has a mechanism to resolve conflicts within the Medical Staff By-Laws. Conflicts between the Medical Staff and Governing Body may be resolved through referral and/or appeal to the DMHAS Medical Director. Administrative and Managerial Staff resolve conflict in accordance with grievance procedures outlined in the State of Connecticut Personnel Regulations. Clinical and other staff conflict resolution procedures are outlined in their respective Collective Bargaining Agreements. All issues related to patient care are arbitrated by the CEO and CMO. The effectiveness of these mechanisms are periodically reviewed and modified to improve their effectiveness as needed.

Article X Performance of the Governing Body

- A. The Governing Body will meet annually for the specific purpose of considering its own performance in one or more respects, and any educational needs arising out of this performance evaluation.
- B. The Governing Body may request an independent outside consultant or group to evaluate its performance in one or more respects.
- C. The Commissioner of Mental Health and Addiction Services regularly reviews aspects of the performance of the Governing Body. The Commissioner may reach conclusions, make recommendations or take appropriate actions.

Article XI Orientation and Education of the Governing Body

New members of the Governing Body shall have a thorough orientation to the Connecticut Department of Mental Health and Addiction Services, to WFH, and to the rights and duties of a member. The Chairperson of the Governing Body or

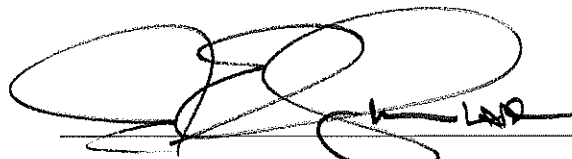
designee shall provide an overview of the functioning of the Governing Body. The new member shall be provided with a copy of these By-Laws, and access to all laws pertaining to mental health and the Department of Mental Health and Addiction Services, as well as all pertinent policies, procedures, rules, and regulations approved by the Governing Body of WFH. The new member shall also have a copy of the most recent annual report and any other information deemed appropriate by the Chairperson. Key staff members shall meet with the new member to describe current operations and future plans and goals.

An orientation to the responsibility of the Governing Body for quality of care and to the hospital's performance improvement programs shall be provided. Each member of the Governing Body shall participate in ongoing education programs appropriate to the member's duties, training, and professional identity.

The Chairperson shall be responsible for assessing the educational needs of the Governing Body as a whole and for making recommendations or taking steps to meet those needs.

Article XII Adoption and Amendment of the Governing Body By-Laws

The Governing Body shall, after consideration and review, adopt these By-Laws by an affirmative vote of at least two-thirds of the members of the Governing Body, subject to approval by the Commissioner of DMHAS. Thereafter, these By-Laws may be amended, repealed or altered in whole or in part, by an affirmative vote of at least two-thirds of the members of the Governing Body subject to approval by the Commissioner of DMHAS. Any such action concerning the Governing Body By-Laws may take place at any meeting where such action has been announced.

A handwritten signature in black ink, appearing to read 'Jose Crego', is written over a horizontal line. The signature is stylized and somewhat cursive.

*Jose Crego, LCSW, LADC, Chief Executive Officer (CEO)
Chair, Governing Body*

Approved at Governing Body: January 25, 2018
Rev. March 26, 2018
Rev. September 24, 2018
Rev. November 7, 2018
Rev. December 16, 2019
Rev. January 11, 2021
Rev. December 13, 2021

Whiting Forensic Hospital Committees September 2023

Committee Name	Purpose of Committee	Chair(s)	Attendees	Frequency of Meeting	Data Reported/Reviewed	Frequency Report up to GB
Executive Committee Medical Staff	<p>1. Responsible for making recommendations to the Chief Executive Officer and to the Governing Body. Such recommendations and actions shall include, but are not limited to, the following:</p> <p>A. The structure of the Medical Staff;</p> <p>B. The mechanism used to review credentials and to delineate individual clinical privileges;</p> <p>C. Recommendation for individual Medical Staff appointment, reappointment, and termination;</p> <p>D. The granting, renewal, and revision of specific clinical privileges for each eligible individual;</p> <p>E. The mechanism by which membership on the Medical Staff may be terminated;</p> <p>F. The mechanism for fair hearing procedures;</p> <p>G. Questions pertaining to clinical practice;</p> <p>H. Reasonable steps to insure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of, and/or participation in Medical Staff corrective or review measures when warranted;</p> <p>I. The Executive Committee receives and acts on reports and recommendations from Medical</p>	President of the Medical Staff	<p>President and President-Elect of the Medical Staff, one elected delegate each from the Whiting Service, Dutcher Service, and Medical Services, and the Service Medical Directors from the Whiting and Dutcher Services (seven voting members in total). The Chief Medical Officer will also serve as an ex-officio (non-voting) member.</p> <p>The Executive Committee of the Medical Staff may invite other individuals necessary to conduct its business to attend its meetings. Such individuals shall not have voting privileges.</p>	Monthly	<p>Hospital Infection Prevention Plan</p> <p>Medical staff audits from corrective action plans</p> <p>Bi-annual reports from the following medical staff committees:</p> <ol style="list-style-type: none"> 1) PNT 2) Infection Prevention 3) Medical Records 4) Credentialing and Privileging 5) Peer Review 	Annually

	<p>Staff committees;</p> <p>J. When appropriate, the Executive Committee shall recommend educational activities for each individual with delineated clinical privileges that:</p> <ol style="list-style-type: none"> 1. relate in part to the privileges granted; 2. are related to the type and nature of care offered by the Hospital; 3. are related to the findings of improvement of performance activities; 4. consider the expressed educational needs of individual members of the Medical Staff; 5. are documented and considered at time of reappraisal and in the renewal or revision of individual clinical privileges; <p>K. Recommending amendments to the By-Laws, and revisions to the Rules and Regulations, as changes in Medical Staff structure, policies and procedures and Hospital structure occur;</p> <p>L. Reviewing the By-Laws and the Rules and Regulations, making appropriate changes at least every two years;</p> <p>M. Reviewing the credentialing process of each of the professional disciplines (Nursing, Social Work, Psychology and Rehabilitation) which permits clinical services staff to provide specified patient care services within their scope of practice; and</p> <p>N. Reporting on its activities and the activities of the various Medical Staff committees to the Governing Body on a quarterly basis.</p> <p>O. The Executive Committee has the primary</p>					
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	oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members. P. In the event the Executive Committee cannot perform its duties, the Medical Staff will assume authority with a majority vote of a quorum.					
Quality, Risk and Safety (QAPI)	Analyze data, establish/monitor PI Projects/CAP, conduct root cause analysis, Conduct Critical Incident and Administrative reviews	Co- Chair CQCO Co-Chair- QA/PI Manager	Dutcher/Whiting UDs CMO MR Supervisor Director of Recovery Services Director of Social Work Maintenance Supervisor Director of EOC CNO Director of Staff Development Supervising Psychologist Program Managers Director of Advocacy	Monthly	ANE, R/S, audits, medical emergencies, dept/disciplines quality indicators	Quarterly
Pharmacy, Nutrition & Therapeutics	Review drug utilization practice, develop guidelines, policies and procedures for the use of drugs serve as an advisory group to the Medical Staff and the pharmacy on matters pertaining to the choice of available drugs; develop, maintain, and review periodically a formulary or drug list for use, evaluate clinical data concerning new drugs or preparations requested for use, review all significant adverse drug reactions and recommend necessary actions.	Chair – Elected Member of Medical Staff	CNO ACS Service Medical Director Supervising Pharmacist Pharmacy Consultant Psychiatrist Provider Medical Services Dietitian	Quarterly	Drug utilization, adverse drug events, med errors, non-formulary requests and utilization	Quarterly

Infection Prevention	Ensure implementation of hospital-wide Infection Prevention program and maintain surveillance over the program; develop a system for identifying, reporting and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities, develop and implement a preventive and corrective program designed to minimize infection hazards including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques, develop written policies defining special indications for isolation requirements.	Infection Preventionist and Manager	CNO ACS Service Medical Director Director of EOC Supervising Pharmacist Pharmacy Consultant Psychiatrist Provider of General Medical Services HN Dietitian PT Housekeeping/Maintenance IP Consultant	Monthly	Reporting and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities.	Quarterly and annual reports to Medical Staff and Governing Body
Staff Development	Ensure quality new hire and ongoing training; establish and monitor Annual Training Plan	Director of Staff Development	Rep from: Social Work, Psychology, MHA/FTS, Nursing, Medical CQCO DNs Clinical Nurse Instructors Trainer	Monthly	Workforce Dev Compliance Reports Training Evaluations Staff Satisfaction Surveys	Quarterly
EOC	Ensure safe and healthy environment for patients/staff	Director of EOC	Maintenance Supervisor, CQCO Whiting Program Manager Dutcher Program Manager UD from Whiting/Dutcher, CNO DN MHA/FTS Dietary Director of Recovery Services	Monthly	EOC Rounds, Hot Spot Logs, Infection Prevention, Spill, Falls, Workman's Comp, Annual Ligature Risk Assessment	Quarterly

Policy and Procedure	Identify need for and develop new/revise policy and procedure, ensure meet licensing, regulatory and JC standards	CQCO	MHA/FTS Representatives Dutcher Program Manager Whiting Program Manager Discipline Representatives Content Matter Experts Director of Recovery Services Director of Social Work CNO CEO COO Patient Representative	Monthly	N/A	Quarterly
TJC Accreditation Oversight Committee	Ensure practice compliance with JC standards, prepare for JC site visit	CQCO	CNO Whiting Program Manager Dutcher Program Manager Director of Recovery Services Director of Social Work CEO CMO Supervising Pharmacist Service Medical Directors Supervising Psychologist Infection Preventionist	Monthly	N/A	Quarterly following accreditation
Medical Records	Evaluate and improve the quality of the medical record, develop and implement changes to the medical record, assure compliance with hospital requirements including timeliness, accuracy, and legibility of the medical record.	Co-Chair- Psychiatrist Co-Chair – HIM Supervisor	CQCO QAPI Manager CNO Dept Heads	Quarterly	Timeliness of monthly treatment plans and annual/admission documentation for all disciplines, admission documentation audits, quarterly chart audits	Quarterly

Nurse Executive Committee	Ensure the design, coordination and implementation of patient safety principles and nursing best practices	CNO	DNs Director of Staff Development Nursing Supervisors ACS Service Medical Director	Monthly	Weekly/Monthly audits, QI Indicators	Quarterly
Governing Body	Strategic planning, ensuring patients receive care that is appropriate and medically necessary; e. ensuring sound fiscal management, reviewing and approving clinical and performance standards, approving all policies; taking action on the recommendations of the hospital leadership; reviewing and taking action on the procedures and results of the hospital's performance improvement activities; providing for organizational management and planning; approving the hospital's written scope of services	CEO	CMO COO CNO CQCO Service Medical Directors Chief of Forensic Services President /President-elect of the Medical Staff Chief of Fiscal Services Program Managers Director of Recovery Services Director of Social Work QAPI Manager Director of Advocacy Director of Staff Development	Monthly	Quarterly review of R/S, ANE, IP, Special Observations	N/A
Ethics	Review ethical concerns raised by staff of the hospital, provide a forum in which treatment teams and individuals (patients, families, clinicians, community members and others) can explore ethics concerns; provide case consultations; develop in-service modules and learning experiences; review hospital policies relating to the ethics of patient care; advise the hospital leaders on issues involving organizational ethics	CMO (or designee)	Chair CMO Whiting SMD CEO COO Psychology Chair Director of Advocacy Chaplain	Quarterly (or when called upon to address specific question)	Provide written opinions of committee findings	Quarterly

Medical Staff	Review all medical staff related issues, receive reports from medical staff committees (PNT, Medical records, Peer Review, C&P)	President of the Medical Staff	All members of the medical staff	Monthly	Provide reports of PNT, Medical Records, Peer Review, and C&P Committees	Quarterly
Peer Review	Oversee, coordinate, and evaluate peer review activities of the Medical Staff including but not limited to death reviews, peer reviews, Focused Professional Performance Evaluations, and critical incident reviews, take responsibility for performing case reviews	Chair – Elected Member of Medical Staff	Chair CMO Psychiatrist General Medical Provider	Quarterly	Recommend corrective action for identified problems regarding clinical competence, make recommendations for further activities by departments and services designed to promote quality and maintain the highest caliber of clinical care and professional conduct.	Quarterly
Credentialing/ Privileging	Gather, authenticate and evaluate all necessary information to assure that an applicant possesses the necessary qualifications for an appointment and reappointment to the Medical Staff and is appropriately trained, maintaining competence and capable of carrying out any privileges granted to him/her, provide the Medical Staff with recommendations regarding the credentials and privileges of any	Chair- Attending Psychiatrist	CMO General Medical Provider Psychiatrist	Monthly	Recommend their findings regarding C&P applications to Medical Staff on at least a quarterly basis, which Medical Staff then reports to Governing Body	Quarterly

	application, or Medical Staff member, applying for or reapplying for Medical Staff membership, privileges, or delineated clinical activities					
IRC	Review all ANE allegations, determine course of action, close cases based on investigation findings	CQCO	QAPI Manager CNO COO Labor Relations Program Managers Whiting and Dutcher Medical Service Directors Director of Advocacy	Weekly	ANE	Quarterly
I Dream Team (Diversity)	Identify and address racial disproportionalities within hospital practices, ensure that patients experience equitable outcomes, provide learning opportunities for staff in conjunction with Staff Development	Co-Chair-COO Co-Chair - Unit Director	Representatives from each discipline MHA/FTS APO Director of Advocacy QAPI Manager Trainer	Monthly	Patient Satisfaction Surveys Other data points to be identified by the committee	Quarterly
Forensic Review	Risk assessment and management of patients under the PSRB/high-risk civil and competency restoration cases; compliance with MODs, transfers from maximum to enhanced security; significant incident review; reviews significant changes in patient clinical status that may have risk management implications; Roe v. Hogan; levels, TLs, discharge planning challenges, patients meeting risk thresholds, Behavioral Intervention Service updates	CEO	CMO COO Chief of Forensic Services Service Medical Directors Supervising Forensic Psychologist Forensic Coordinator Chair of Psychology QAPI Manager Consulting Forensic Psychiatrists Program Managers Service Medical Directors Director of Social Work	Weekly	Incident Report cases exceeding risk thresholds, BIS updates, clinical progress reports for patients presented, status of civil patients in maximum security	Quarterly

Programming Committee	To ensure programing that meets the needs of our patients, through quality and availability	COO	Program Manager DN Director of Recovery Services Director of Social Work Patient Representative	Monthly	Attendance of groups Cancelations Alternatives Clinician work loads	Quarterly
Falls Committee	To identify falls risk within environment, identify strategies to prevent falls, analyze falls data for trends	ACS Manager DN	DN QAPI Manager OT PT SMD	Quarterly	Number of occurrences; location of occurrence; cause of falls	Quarterly
Antibiotic Stewardship Committee (sub-committee of Infection Prevention)	Prevention of increased antibiotic resistance through auditing, staff education, and monitoring of local resistance patterns	ACS Service Medical Director	Infection Preventionist Pharmacy Supervisor Pharmacy Consultant, Infection Prevention Consultant	Quarterly	Antibiotic Orders and associated risk factors for antibiotic resistance	N/A Reports to Infection Prevention Committee
Patient Steering Committees (Dutcher and Whiting)	Provide patients will opportunity to share feedback, address concerns, build community and increase patient sense of empowerment to effect change within the hospital	Chair- Patient Representative	Program Manager Director of Advocacy CEO/COO	Weekly	N/A	Minutes reviewed in weekly leadership meeting
Technology Initiative Steering Committee	Identify and implement opportunities for patients to learn and use technology to enhance their recovery	COO/CEO	Director of Advocacy Service Medical Directors Director of EOC Program Managers IT Representative	Monthly	N/A	Updates Governing Body as needed
Recovering Citizenship Learning Committee/ Change Team	Identify and implement opportunities to embed the principals of Recovering Citizenship throughout the hospital	Co-Chair Director of Advocacy Director of Recovery Services	Director of Advocacy Whiting Service Medical Director QAPI Manager Director of Recovery Services Patient Representative RSS	Monthly	N/A	Updates Governing Body as needed

Workplace Violence Prevention Committee	Assess hospital needs around workplace violence prevention and staff safety. Monitor data and make recommendations for strategies/interventions to prevent/reduce workplace violence and mitigate risks toward staff	Supervising Psychologist QA/PI Manager	Whiting Program Manager DN Whiting SMD QA Manager Director of Social Work Representatives from Rehab and Nursing	Monthly	Incidents of workplace violence, staff injuries, culture of safety survey results	2x annually
Pain Committee	At least annual review and, if indicated, update of pain management policies, related protocols, and forms Review and make recommendations to the Staff Development Department regarding the development and, if indicated, updating of staff education materials Creation of staff education tools Data collection, audits, and monitoring for the purpose of making recommendations related to policy change and to ensure appropriate / safe use of opioids	ACS Manager	ACS SMD CNO Pharmacy Supervisor ACS Principal Physician Representative from nursing	Quarterly and at the Chair's discretion	Opiate use and orders; Nursing assessment and documentation of current pain management plan efficacy; Use and documentation of non-pharmacologic methods	Quarterly

Whiting Forensic Hospital Committees December 2022

Committee Name	Purpose of Committee	Chair(s)	Attendees	Frequency of Meeting	Data Reported/Reviewed	Frequency Report up to GB
Executive Committee Medical Staff	<p>1. Responsible for making recommendations to the Chief Executive Officer and to the Governing Body. Such recommendations and actions shall include, but are not limited to, the following:</p> <p>A. The structure of the Medical Staff;</p> <p>B. The mechanism used to review credentials and to delineate individual clinical privileges;</p> <p>C. Recommendation for individual Medical Staff appointment, reappointment, and termination;</p> <p>D. The granting, renewal, and revision of specific clinical privileges for each eligible individual;</p> <p>E. The mechanism by which membership on the Medical Staff may be terminated;</p> <p>F. The mechanism for fair hearing procedures;</p> <p>G. Questions pertaining to clinical practice;</p> <p>H. Reasonable steps to insure professional ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of, and/or participation in Medical Staff corrective or review measures when warranted;</p> <p>I. The Executive Committee receives and acts on reports and recommendations from Medical</p>	President of the Medical Staff	<p>President and President-Elect of the Medical Staff, one elected delegate each from the Whiting Service, Dutcher Service, and Medical Services, and the Service Medical Directors from the Whiting and Dutcher Services (seven voting members in total). The Chief Medical Officer will also serve as an ex-officio (non-voting) member.</p> <p>The Executive Committee of the Medical Staff may invite other individuals necessary to conduct its business to attend its meetings. Such individuals shall not have voting privileges.</p>	Monthly	<p>Hospital Infection Prevention Plan</p> <p>Medical staff audits from corrective action plans</p> <p>Bi-annual reports from the following medical staff committees:</p> <ol style="list-style-type: none"> 1) PNT 2) Infection Prevention 3) Medical Records 4) Credentialing and Privileging 5) Peer Review 	Annually

	<p>Staff committees;</p> <p>J. When appropriate, the Executive Committee shall recommend educational activities for each individual with delineated clinical privileges that:</p> <ol style="list-style-type: none">1. relate in part to the privileges granted;2. are related to the type and nature of care offered by the Hospital;3. are related to the findings of improvement of performance activities;4. consider the expressed educational needs of individual members of the Medical Staff;5. are documented and considered at time of reappraisal and in the renewal or revision of individual clinical privileges; <p>K. Recommending amendments to the By-Laws, and revisions to the Rules and Regulations, as changes in Medical Staff structure, policies and procedures and Hospital structure occur;</p> <p>L. Reviewing the By-Laws and the Rules and Regulations, making appropriate changes at least every two years;</p> <p>M. Reviewing the credentialing process of each of the professional disciplines (Nursing, Social Work, Psychology and Rehabilitation) which permits clinical services staff to provide specified patient care services within their scope of practice; and</p> <p>N. Reporting on its activities and the activities of the various Medical Staff committees to the Governing Body on a quarterly basis.</p> <p>O. The Executive Committee has the primary</p>					
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	oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff members. P. In the event the Executive Committee cannot perform its duties, the Medical Staff will assume authority with a majority vote of a quorum.					
Quality, Risk and Safety (QAPI)	Analyze data, establish/monitor PI Projects/CAP, conduct root cause analysis, Conduct Critical Incident and Administrative reviews	Co- Chair CQCO Co-Chair- QA/PI Manager	Dutcher/Whiting UDs CMO MR Supervisor Director of Recovery Services Director of Social Work Maintenance Supervisor EOC Coordinator CNO Director of Staff Development Supervising Psychologist Program Managers Director of Advocacy	Monthly	ANE, R/S, audits, medical emergencies, dept/disciplines quality indicators	Quarterly
Pharmacy, Nutrition & Therapeutics	Review drug utilization practice, develop guidelines, policies and procedures for the use of drugs serve as an advisory group to the Medical Staff and the pharmacy on matters pertaining to the choice of available drugs; develop, maintain, and review periodically a formulary or drug list for use, evaluate clinical data concerning new drugs or preparations requested for use, review all significant adverse drug reactions and recommend necessary actions.	Chair – Elected Member of Medical Staff	CMO Supervising Pharmacist Dietician CNO Consulting Pharmacist ACS Service Medical Director	Quarterly	Drug utilization, adverse drug events, med errors, non-formulary requests and utilization	Quarterly

Infection Prevention	Ensure implementation of hospital-wide Infection Prevention program and maintain surveillance over the program; develop a system for identifying, reporting and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities, develop and implement a preventive and corrective program designed to minimize infection hazards including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques, develop written policies defining special indications for isolation requirements.	Infection Preventionist DN	CNO ACS Service Medical Director EOC Coordinator Supervising Pharmacist HN – Dutcher Dietitian PT Rep from Housekeeping, maintenance	Monthly	Reporting and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data and follow-up activities.	Quarterly and annual reports to Medical Staff and Governing Body
Staff Development	Ensure quality new hire and ongoing training; establish and monitor Annual Training Plan	Director of Staff Development	Rep from: Social Work, Psychology, MHA/FTS, Nursing, Medical CQCO DNs Clinical Nurse Instructors Trainer	Monthly	Workforce Dev Compliance Reports Training Evaluations Staff Satisfaction Surveys	Quarterly
MEC	Ensure safe and healthy environment for patients/staff	EOC Coordinator	Maintenance Supervisor, CQCO Whiting Program Manager Dutcher Program Manager UD from Whiting/Dutcher, CNO DN MHA/FTS Dietary Director of Recovery Services	Monthly	EC Rounds, Hot Spot Logs, Infection Prevention, Spill, Falls, Workman's Comp	Quarterly

Policy and Procedure	Identify need for and develop new/revise policy and procedure, ensure meet licensing, regulatory and JC standards	CQCO	MHA/FTS Representatives Dutcher Program Manager Whiting Program Manager Discipline Representatives Content Matter Experts Director of Recovery Services Director of Social Work CNO CEO COO Patient Representative	Monthly	N/A	Quarterly
TJC Accreditation Oversight Committee	Ensure practice compliance with JC standards, prepare for JC site visit	CQCO	CNO Whiting Program Manager Dutcher Program Manager Director of Recovery Services Director of Social Work CEO CMO Supervising Pharmacist Service Medical Directors Supervising Psychologist Infection Preventionist	Monthly	N/A	Quarterly
Medical Records	Evaluate and improve the quality of the medical record, develop and implement changes to the medical record, assure compliance with hospital requirements including timeliness, accuracy, and legibility of the medical record.	Co-Chair Co-Chair – MR Supervisor	CMO CQCO DN Discipline representatives	Quarterly	Timeliness of monthly treatment plans and annual/admission documentation for all disciplines, admission documentation audits, quarterly chart audits	Quarterly

Nurse Executive Committee	Ensure the design, coordination and implementation of patient safety principles and nursing best practices	CNO	DNs Director of Staff Development Nursing Supervisors ACS Service Medical Director	Monthly	Weekly/Monthly audits, QI Indicators	Quarterly
Governing Body	Strategic planning, ensuring patients receive care that is appropriate and medically necessary; e. ensuring sound fiscal management, reviewing and approving clinical and performance standards, approving all policies; taking action on the recommendations of the hospital leadership; reviewing and taking action on the procedures and results of the hospital's performance improvement activities; providing for organizational management and planning; approving the hospital's written scope of services	CEO	CMO COO CNO CQCO Service Medical Directors Chief of Forensic Services President /President-elect of the Medical Staff Chief of Fiscal Services Program Managers Director of Recovery Services Director of Social Work QAPI Manager Director of Advocacy Director of Staff Development	Monthly	Quarterly review of R/S, ANE, IP, Special Observations	N/A
Ethics	Review ethical concerns raised by staff of the hospital, provide a forum in which treatment teams and individuals (patients, families, clinicians, community members and others) can explore ethics concerns; provide case consultations; develop in-service modules and learning experiences; review hospital policies relating to the ethics of patient care; advise the hospital leaders on issues involving organizational ethics	CMO (or designee)	Representatives from the professional disciplines, the maximum security and enhanced security services, medical staff, Director of Advocacy, Chaplain	Quarterly (or when called upon to address specific question)	Provide written opinions of committee findings	Quarterly

Medical Staff	Review all medical staff related issues, receive reports from medical staff committees (PNT, Medical records, Peer Review, C&P)	President of the Medical Staff	All members of the medical staff	Monthly	Provide reports of PNT, Medical Records, Peer Review, and C&P Committees	Quarterly
Peer Review	Oversee, coordinate, and evaluate peer review activities of the Medical Staff including but not limited to death reviews, peer reviews, Focused Professional Performance Evaluations, and critical incident reviews, take responsibility for performing case reviews	Chair – Elected Member of Medical Staff		Quarterly	Recommend corrective action for identified problems regarding clinical competence, make recommendations for further activities by departments and services designed to promote quality and maintain the highest caliber of clinical care and professional conduct.	Quarterly
Credentialing/ Privileging	Gather, authenticate and evaluate all necessary information to assure that an applicant possesses the necessary qualifications for an appointment and reappointment to the Medical Staff and is appropriately trained, maintaining	Chair- Attending Psychiatrist	CMO Service Medical Directors	Monthly	Recommend their findings regarding C&P applications to Medical Staff on at least a quarterly	Quarterly

	competence and capable of carrying out any privileges granted to him/her, provide the Medical Staff with recommendations regarding the credentials and privileges of any application, or Medical Staff member, applying for or reapplying for Medical Staff membership, privileges, or delineated clinical activities				basis, which Medical Staff then reports to Governing Body	
IRC	Review all ANE allegations, determine course of action, close cases based on investigation findings	CQCO	QAPI Manager CNO COO Labor Relations Program Managers Whiting and Dutcher Medical Service Directors Director of Advocacy	Weekly	ANE	Quarterly
Diversity	Identify and address racial disproportionalities within hospital practices, ensure that patients experience equitable outcomes, provide learning opportunities for staff in conjunction with Staff Development	Co-Chair-COO Co-Chair - Unit Director	Representatives from each discipline MHA/FTS APO Director of Advocacy QAPI Manager Trainer	Monthly	Patient Satisfaction Surveys Other data points to be identified by the committee	Quarterly
Forensic Review	Risk assessment and management of patients under the PSRB/high-risk civil and competency restoration cases; compliance with MODs, transfers from maximum to enhanced security; significant incident review; reviews significant changes in patient clinical status that may have	CEO	CMO COO Chief of Forensic Services Service Medical Directors Supervising Forensic Psychologist	Weekly	Incident Report cases exceeding risk thresholds, BIS updates, clinical progress reports for patients presented,	Quarterly

	risk management implications; Roe v. Hogan; levels, TLs, discharge planning challenges, patients meeting risk thresholds, Behavioral Intervention Service updates		Forensic Coordinator Chair of Psychology QAPI Manager Consulting Forensic Psychiatrists Program Managers Service Medical Directors Director of Social Work		status of civil patients in maximum security	
Programming Committee	To ensure programing that meets the needs of our patients, through quality and availability	COO	Program Manager DN Director of Recovery Services Director of Social Work Patient Representative	Monthly	Attendance of groups Cancelations Alternatives Clinician work loads	Quarterly
Falls Committee	To identify falls risk within environment, identify strategies to prevent falls, analyze falls data for trends	Dr. Tillman	CNO DN QAPI Manager OT PT SMD	Quarterly	Quarterly to QRS	Quarterly
Antibiotic Stewardship Committee (sub-committee of Infection Prevention)	Prevention of increased antibiotic resistance through auditing, staff education, and monitoring of local resistance patterns	ACS Service Medical Director	Infection Preventionist Pharmacy Supervisor Pharmacy Consultant, Infection Prevention Consultant	Quarterly	Antibiotic Orders and associated risk factors for antibiotic resistance	N/A Reports to Infection Prevention Committee
Patient Steering Committees (Dutcher and Whiting)	Provide patients will opportunity to share feedback, address concerns, build community and increase patient sense of empowerment to effect change within the hospital	Chair- Patient Representative	Program Manager Director of Advocacy CEO/COO	Weekly	N/A	Minutes reviewed in weekly leadership meeting

Technology Initiative Steering Committee	Identify and implement opportunities for patients to learn and use technology to enhance their recovery	COO/CEO	Director of Advocacy Service Medical Directors EOC Coordinator Program Managers IT Representative	Monthly	N/A	Updates Governing Body as needed
Recovering Citizenship Learning Committee/Change Team	Identify and implement opportunities to embed the principals of Recovering Citizenship throughout the hospital	Co-Chair Director of Advocacy Director of Recovery Services	Director of Advocacy Whiting Service Medical Director QAPI Manager Director of Recovery Services Patient Representative RSS	Monthly	N/A	Updates Governing Body as needed
Workplace Violence Prevention Committee	Assess hospital needs around workplace violence prevention and staff safety. Monitor data and make recommendations for strategies/interventions to prevent/reduce workplace violence and mitigate risks toward staff	Supervising Psychologist QA/PI Manager	Whiting Program Manager DN Whiting SMD QA Manager Director of Social Work Representatives from Rehab and Nursing	Monthly	Incidents of workplace violence, staff injuries, culture of safety survey	2x annually

WHITING FORENSIC HOSPITAL

PERFORMANCE IMPROVEMENT (PI) PLAN 2023

Governing Body Approval: August 14, 2023

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WHITING FORENSIC HOSPITAL PERFORMANCE IMPROVEMENT PLAN

I. Introduction

As a facility of the Department of Mental Health and Addiction Services (DMHAS), Whiting Forensic Hospital (WFH) has implemented the requirements established by the Commissioner who, as the Governing Authority of the Department, has issued Policy Statement No. 72 wherein each hospital is to improve its performance in a systemic, cooperative and continuous manner; is to establish a facility-specific Governing Body; and is to assure a hospital-wide collaborative approach in pursuing quality in its patient care responsibilities.

II. Statement of Purpose

To establish organizational responsibilities and processes by which the Governing Body, Medical Staff, Disciplines and Departments achieve and maintain high quality care, support services and patient safety at WFH.

The Performance Improvement Plan sets forth the functional framework for monitoring and improving processes, outcomes and safety in a planned and systematic manner that supports the mission of the hospital. The plan targets the improvement of key governance, managerial, clinical and support processes that contribute to improved patient outcomes and the safety and satisfaction of both patients and staff. It is designed to integrate the pursuit of WFH's mission with the understanding that excellence in clinical outcomes must be achieved with the appropriate allocation of resources.

Improvement in performance is geared toward reducing the risk of adverse event occurrence and ensuring the best use of hospital resources in the delivery of services. Consequently, the hospital's primary objective is to ensure quality patient care through supporting staff in improving processes for which they are accountable and to assure that staff have adequate knowledge, skills, training, and resources to address problems that may arise, in order to ensure the ongoing, sustainable provision of high quality patient care.

III. Goals

The goals of the Performance Improvement Plan include the following:

- Ensure a planned, systematic and hospital-wide approach to performance improvement and patient safety, focusing on outcomes of treatment, care and services;

- Ensure that individuals, disciplines and departments representing the scope of care and services across the hospital work collaboratively to plan and implement improvement activities;
- Incorporate feedback and findings from root cause analyses, administrative reviews and culture of safety surveys into performance improvement activities to effectively reduce factors that contribute to unanticipated adverse events and/or outcomes;
- Evaluate performance improvement, patient safety, risk management and incident data and analysis to identify changes that will improve patient safety and quality of care, treatment and services;
- Ensure changes made to improve processes or outcomes are evaluated and appropriate actions are taken when planned improvements are not achieved or sustained;
- Identify policy and procedure, staff education and other system vulnerabilities impacting safety and quality of care and recommend corrective actions;
- Address internal and external customers' needs and expectations;
- Promote open communication among disciplines within a culture that encourages transparency, innovation, creativity and change;
- Identify priorities for performance improvement activities annually

IV. Authority and Accountability

The Governing Body of WFH has the final authority and responsibility for the assurance of a flexible, comprehensive and integrated performance improvement program. In meeting this responsibility, the Governing Body ensures the provision of appropriate resources to assist in review functions, mechanisms for systematically collecting and analyzing data, and monitoring and evaluating the quality, safety, and appropriateness of patient care and information management processes that support performance improvement and safety improvement activities.

The Governing Body has authority and accountability for the operation of the Performance Improvement Program as it relates to the hospital's culture of safety, risk management processes and various safety issues, including, but not limited to, the use of high risk interventions and environmental risks brought forth from the Environment of Care Committee. The Governing Body delegates authority and accountability for oversight of investigations of incidents of abuse, neglect and exploitation of patients that allegedly involve hospital staff misconduct to the Investigation Review Committee under the direction of the Chief Quality and Compliance Officer. The Governing Body also has authority and accountability for oversight of the quality, appropriateness and integration of services in providing patient care.

The Governing Body shall be provided information on the hospital's Performance Improvement Program through periodic performance improvement reports from the Environment of Care Committee, the Investigation Review Committee, the Medical Staff, the Quality, Risk & Safety Committee, other committees and disciplines/departments.

V. Scope of Activities

Performance improvement priorities are established by identifying important aspects of care which affect a large percentage of patients, which are likely to be problem prone and/or which are likely to place patients at risk if not performed well, not performed when indicated or performed when not indicated. The analysis of process and outcome data forms the basis for objectively evaluating the hospital's priorities. Additional factors that affect prioritized initiatives include accreditation and/or regulatory requirements (The Department of Public Health, The Joint Commission, State Statutes, and Federal Regulations) best practices (use of practice guidelines, evidence based medicine and clinical standards), DMHAS mandates, changing needs of the community, patients and staff, and changes in the environment of care. The CEO, the Governing Body and the Medical Staff actively seek feedback from patients and stakeholders (including families, hospital staff and supporting agencies) as performance improvement priorities are set.

Performance indicators relate to standards of care in important functions of treatment delivery and include quality indicators for all departments/disciplines (see appendix A). These indicators reflect the following areas as delineated by The Joint Commission:

Patient Focused Functions

- 1) Rights and Responsibilities (RI)
- 2) Provision of Care, Treatment & Services (PC)
- 3) Record of Care, Treatment & Services (RC)
- 4) Medication Management (MM)
- 5) Infection Prevention & Control (IC)
- 6) National Patient Safety Goals (NPSG)

Organization Focused Functions

- 7) Performance Improvement (PI)
- 8) Leadership (LD)
- 9) Environment of Care (EC)
- 10) Emergency Management (EM)
- 11) Life Safety (LS)
- 12) Human Resources (HR)
- 13) Information Management (IM)

Structures with Functions

- 14) Medical Staff (MS)
- 15) Nursing (NR)

Performance indicators are objective and measurable. Baseline measures and/or thresholds are identified, as is the sample size, frequency of review and data collection methodology.

Performance indicators are reviewed within the hospital, disciplines or department, with summary analysis provided to the Governing Body, QRS and any other committee(s) as appropriate or required. This summary analysis identifies any variances in performance, corrective action plans developed, including the necessary corrective action step(s); anticipated outcome(s); person(s) responsible and the time frame in which each action step must occur, the effectiveness of corrective actions and any modifications made as warranted to ensure the effectiveness of interventions on improving and sustaining the quality and safety of care and services.

The hospital, disciplines and departments monitor processes and practices by utilizing data and information from various sources, including the hospital databases. Such data sets include, but are not limited to, restraint and seclusion use; incident reporting, medication events and adverse drug reactions. Disciplines examine the timeliness and completeness of medical records, as well as, treatment planning processes, discharge planning processes, and overall patient involvement in the treatment process from admission to discharge. Clinically related information is also reviewed, including admissions and discharges, length of stay, and readmission rates.

Once accredited, the hospital will utilize NASMHPD Research Institute (NRI) for benchmarking specific ORYX comparative data as well as benchmarking and reporting the required Hospital-Based Inpatient Psychiatric Services (HBIPS) Core Measure Set indicators to The Joint Commission. The HBIPS Core Measure Set data is reviewed quarterly by the Governing Body.

Fiscal Year 2023-2024 Focused Performance Improvement Priorities

1. Suicide Prevention Program:

Goal: To establish a hospital wide Suicide Prevention Program to reduce the risk of patient suicide

Objectives: review and update policy as needed, provide training, identify/implement additional mitigation strategies (patient related and environmental), establish Quality Indicators, collect and analyze data, and identify corrective action as indicated

2. Workplace Violence:

Goal: To establish a defined and functioning multi-disciplinary committee to reduce risk of workplace violence

Objectives: review and suggest policy revisions, resume Peer Incident Response Team activities, provide feedback for training curriculum; identify Quality Indicators, collect and analyze data; Facilitate Culture of Safety Survey and put forth recommendations to Governing Body

3. Medication Administration

Goal: Reduce risks associated with medication administration; reduce medication administration errors

Objectives: Complete the Medication Administration Performance Improvement Project, utilizing the Failure Mode and Effects Analysis process; analyze MERF data, and identify additional corrective action as indicated

VI. Description of the Plan

WFH's Performance Improvement Plan details the hospital-wide, multidisciplinary monitoring of important functions and processes. This includes a model for improvement that will be followed by all departments and disciplines in the organization.

Department/Discipline Plans

Each department/discipline reviews and tracks key indicators as approved by the WFH Governing Body and identified in collaboration with the Quality Assurance department. The Investigation Review Committee (IRC), the Environment of Care Committee (EOC), and the Executive Committee of the Medical Staff (ECMS) advise the Governing Body in determining hospital priorities and provide oversight in monitoring various processes.

The ongoing monitoring and evaluation activities of the Medical Staff are reviewed monthly at meetings of the Executive Committee of the Medical Staff (ECMS) through reports on various functions including Infection Prevention (IP), Health Information Management (HIM), Pharmacy, Nutrition and Therapeutics (PNT), Research, and Credentialing and Privileging.

Data on identified indicators is collected and analyzed. In order to most effectively interpret results, data will be evaluated utilizing statistical process control techniques whenever appropriate and possible. The results will be compared internally over time and may also be compared to external benchmarking data as available or appropriate.

A schedule is identified by the Quality Assurance Department for all department and discipline Performance Improvement activities to report to QRS and Governing Body.

Evaluation of monitoring activities occurs within each department, discipline or committee. The department heads, discipline directors and/or committee chairs are responsible for addressing identified problems, developing corrective action plans, including the necessary corrective action step(s) identified to address factors contributing to the problem; anticipated outcome(s); person(s) responsible and the time frame in which each action step must occur, disseminating action plans to all parties responsible for their implementation, monitoring the implementation and effectiveness of corrective actions and modifying corrective action plans as warranted. The Whiting Forensic Hospital – Corrective Action Plan template (Appendix C) is the standardized format used for corrective action plans.

Findings from performance improvement processes are communicated to staff in each department and discipline for their respective responsibilities and duties.

Summary analysis of each discipline's key quality indicators is presented to and reviewed by the Governing Body, Quality, Risk & Safety (QRS) Committee and any other applicable committees on a quarterly basis, unless otherwise specified

Governing Body

The hospital has an Governing Body comprised of the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Medical Officer (CMO), Service Medical Director(s) for each service (Whiting and Dutcher), Chief Quality and Compliance Officer, Chief Nursing Officer, Program Managers for each service (Whiting and Dutcher), the Quality Assurance/Performance Improvement (QAPI) Manager, Director of Staff Development, Director of Advocacy, Service Medical Director of Ambulatory Care, Director of Social Services, Director of Recovery Services, Director of EOC, and others involved in the monitoring of patient care and performance improvement activities. Representatives from the departments of Human Resources, Fiscal Services and Plant Operations participate in the Hospital Executive Committee as needed to enhance communication and problem solving. In addition, the Health Information Management supervisor and Infection Prevention Practitioner attend and report on issues relevant to the hospital's operation.

The Hospital's Chief Executive Officer shall assure that the Governing Body:

- a) evaluates the quality, appropriateness and safety of patient care;
- b) identifies and investigates problems that interfere with or prevent the delivery of high quality patient care as brought forth through QRS, Incident Management/Critical Incident Reviews and other operational processes; and
- c) coordinates efforts for necessary improvement.

The Chief Quality and Compliance Officer ensures ongoing documentation of performance improvement processes.

Critical to achieving positive patient outcomes and safe, quality patient care, is the communication to hospital staff of performance improvement outcomes and identified opportunities for improvement. To accomplish this task, the hospital utilizes its Quality, Risk and Safety (QRS) Committee as a performance improvement council. It is expected that all members of the QRS Committee will ensure that feedback is elicited from, and provided to, their respective departments/disciplines, including all of the patient care units.

Resources from the Quality Assurance/Performance Improvement Department are available to facilitate the coordination of performance improvement activities and to serve as a resource in identifying and defining indicators, establishing baselines and thresholds, performing data analysis, identifying patterns and trends and integrating improvement methodology in addressing issues that impact the quality, risk and safety of care to patients.

The Quality Assurance/Performance Improvement Manager works collaboratively with the hospital staff to identify performance improvement findings that reflect a need for continuing education, training, or change in operations, and evaluates patient satisfaction data making recommendations related to improving patient perception of care and safety.

The Quality Assurance/Performance Improvement Manager assists programs/units in identifying performance improvement objectives, developing methods to monitor and evaluate important aspects of patient care and evaluating the results of monitoring activities.

VII. Role of the Hospital Committees

As part of the strategic planning process, the Performance Improvement Plan at WFH is a collaborative effort of the Medical Staff and the Governing Body performed through their respective committees. Each committee has specific responsibility relating to the Standards of Practice of the various disciplines and standards relative to hospital operations adopted by the Governing Body. Standards of Practice are outlined in the Medical Staff Bylaws as well as in the credentialing plan of the Medical Staff. The hospital, through its participation in certification and accreditation programs, adopts those aspects of the life-safety codes, public health codes, statutory responsibilities of professional disciplines and their specific codes of ethics which impact both its clinical and administrative operations.

The role of the Governing Body committee and Medical Staff committees is to monitor and evaluate *Standards of Practice and Clinical Effectiveness* as they impact performance improvement functions. Key to these committees is the use of aggregate data to inform decision-making processes, which supports and enhances the Governing Body's role in communicating issues and addressing opportunities for improvement throughout the hospital.

VIII. Performance Improvement Methodology

To effectively monitor and evaluate the quality, appropriateness and safety of patient care in a planned and systematic manner, "Plan, Design, Measure, Assess and Improve" (PDMAI) has been selected for the hospital's methodology for conducting performance improvement projects. This methodology is used for monitoring and evaluating initiatives undertaken by the Medical Staff, disciplines, departments and committees. Discipline directors, department heads and committee chairs are responsible for ensuring that this process is implemented. Performance Improvement Projects (PIPs) are specific in scope and purpose and are time limited.

The principles of performance improvement methodology described below pertain to all performance improvement activities, although the application of these principles will vary depending on the particular type of activity. Activities may be directed at quality control, performance monitoring and/or performance improvement, and include The Joint Commission required performance measures, priority issues identified by the hospital and performance improvement projects (PIPs). (See Appendix B)

The PDMAI (plan, design, measure, assess and improve) approach utilized in improving organizational performance is as follows:

A. Planning

- 1) Hospital leadership establishes a planned, systematic and hospital-wide approach to performance improvement, focusing on outcomes of treatment, care and services.
- 2) Hospital leaders set priorities for performance improvement and ensure that the disciplines representing the scope of care and services across the hospital work collaboratively to plan and implement improvement activities.
- 3) Performance improvement activities are planned to effectively reduce factors that contribute to unanticipated adverse events and/ or outcomes.

B. Designing

- 1) PI activities identify data sources, including frequency and duration of data collection.
- 2) PI activities identify the persons responsible for data collection and persons responsible for summary analysis.
- 3) PI activities identify where summarized data analysis will be reported to

C. Measuring Performance

- 1) The hospital collects data to monitor its performance.
- 2) Data are collected on selected key indicators, including:
 - Restraint and Seclusion Use;
 - Medical Emergencies;
 - Utilization;
 - Patient Satisfaction;
 - Patient Allegations;
 - Culture of Safety;
 - Medication Management;
 - Medical Records;
 - Environment of Care;
 - Staff Training and Competence;
 - Infection Prevention;
 - Behavioral Management;
 - Treatment Planning;
 - Special Observations;
 - Risk Management including near misses, elopement, suicide, falls and pain management

- 3) Indicators are measured by focusing on nine important dimensions of performance that strongly affect patient outcomes and resource use:
- Efficacy or accomplishment of the described outcome.
 - Appropriateness or relevance to the patient's clinical needs.
 - Availability – Appropriate care is available to meet the patient's needs.
 - Timeliness – Care is provided to the patient at the most beneficial or necessary time.
 - Effectiveness – Care is provided in a correct manner, given the current state of knowledge.
 - Continuity – Coordination of services provided with respect to other services and providers, and other organization outcomes.
 - Safety – Risk of an intervention and risk in the care environment are reduced for the patient and others.
 - Efficiency – Relationships between outcomes (results of care) and resources used to deliver care.
 - Respect and Caring – Degree to which the patient is involved in his/her own care decisions and to which staff provides care with sensitivity and respect for the patient's needs, expectations, and individual differences, including multicultural issues.

Depending on the specific performance improvement initiative, WFH will utilize the Failure Mode and Effects Analysis (FMEA) as a proactive method of uncovering potential failures in high-risk processes in order to prevent them from happening or to mitigate their effect. This is accomplished by identifying where they might occur and determining severity of impact, probability and detectability. FMEA's systematic approach to identifying and addressing causes of failures can help prevent untoward effects to patients, staff and the hospital.

D. Assessing Current Performance

- 1) The hospital uses a systematic process to aggregate and analyze data in order to provide information on the following:
- Current level of performance;
 - Stability of processes; and
 - Emerging patterns or trends
- 2) Data are aggregated at the frequency specified in the Quality Indicators description.
- 3) Various quality and/or statistical tools and techniques may be used to analyze and display data, including:
- Line Charts
 - Pie Charts

- Bar Charts
 - Pareto Charts;
 - Flow Charts;
 - Cause and Effect Diagrams;
 - Histograms;
 - Scatter Diagrams;
 - Run Charts; and
 - Control Charts
- 4) Data are analyzed and compared internally over time and externally (upon accreditation) through NRI HBIPS Core Measure data.
 - 5) Comparative data are used to determine if there is excessive variability or unacceptable levels of performance.
 - 6) Analysis is performed when data comparisons indicate that levels of performance, patterns or trends vary substantially from those expected.
 - 7) Data are tracked with sufficient particularity to identify trends by building, units, work shifts, individual staff and/or patients (when indicated), in regard to protection from harm, provision of treatment, care and services and outcomes being achieved.
 - 8) Analysis is performed for all of the following:
 - Serious adverse drug events;
 - Significant medication errors; and
 - Patient Safety and Adverse Events, Critical Incidents and Sentinel Events via the CIR process

E. Improving Performance

- 1) The hospital uses the information from data analysis to identify and implement changes that will improve the quality of care, treatment and services.
- 2) The hospital identifies and implements changes that will reduce the risk of Patient Safety Events/Critical Incidents and Sentinel Events.
- 3) The hospital uses the information from data analysis to identify changes that will improve patient safety.
- 4) The hospital ensures that corrective action plans are developed, disseminated to all parties responsible for implementation, monitored for appropriate implementation and effectiveness and modified as warranted.

- 5) The hospital ensures that all corrective action plans include:
 - a.) contributing factors to the identified problem;
 - b.) anticipated outcomes/measures of effectiveness
 - c.) action steps/risk reduction strategies
 - d.) person(s) responsible; and
 - e.) completion date for each action step
- 6) Changes made to improve processes or outcomes are evaluated to ensure they achieve the expected results.
- 7) Appropriate actions are taken when planned improvements are not achieved or sustained.
- 8) The hospital selects one high-risk process at a minimum of every 18 months, and conducts a Failure Mode and Effects Analysis to identify and reduce risks to patients. This analysis includes:
 - a) Describing the chosen process using a flowchart;
 - b) Identifying potential failure modes of the process;
 - c) Identifying possible effects that identified failure modes could have on patients and the seriousness of the possible effects.
 - d) Prioritizing the failure modes for corrective actions;
 - e) Determining causes of the prioritized failure modes;
 - f) Redesigning the process and/or underlying systems to minimize the risk of the effects on patients;
 - g) Testing and implementing the redesigned process; and
 - h) Monitoring the effectiveness of the redesigned process.

Recommendations for improvement can be made as a result of the assessment of department, or discipline specific data, as a result of aggregate data review, including NRI HBIPS core measure set indicators, or based on feedback from patients, employees, committees, or other stakeholders. Actions to resolve problems or improve processes may be initiated by a department or discipline leadership, or physicians responsible for specific processes and systems in the hospital.

Another approach to process improvement may be through the initiation of a Performance Improvement Team. Performance Improvement Teams will be established by the Quality Assurance & Performance Improvement Manager as directed by the Governing Body and/or at the recommendation of a hospital committee, or based on requests from staff and/or patients when they have identified a significant issue in need of correction. Performance Improvement Teams will follow standardized models for facilitation of process redesign with the assistance of the Quality Assurance & Performance Improvement Manager as facilitator.

Performance Improvement priorities may include:

- Risk reduction associated with Aggressive Acts
- Individual and Group Programming
- Milieu management
- Risk reduction associated with Falls
- Engagement of individuals in treatment to enhance treatment outcomes
- Implementation of preventative actions, with feedback and learning throughout the hospital, based on tracking and analysis of causes for medical errors and adverse patient events.
- Ensure the safety of medication practices through tracking and analysis of medication events and adverse drug reactions, analysis of causes and timely implementation of corrective measures.
- Ensure adequate staffing levels through tracking and analysis of historical staffing patterns and trends
- Increase patient satisfaction as reflected in patient satisfaction surveys
- Reduction in use of restraint and seclusion

IX. Communication of the Plan

Performance improvement necessitates an interactive, open communication process, which is continuously utilized. In order to achieve the exchange of ideas and information required for a continuously improving organization, communication between all committees and groups responsible for performance improvement is expected.

Communication includes reports of activity, change in direction or philosophy, assessment activities, and guidance for performance activity and improvement. Other information is communicated as necessary.

X. Education and Training

WFH recognizes the important role that training and education plays in performance improvement efforts. The Governing Body, Medical Staff, Staff Development, Department Heads and the Quality Assurance & Performance Improvement Manager will work together to identify competency-based learning needs and develop training and education programs that will facilitate implementation of the Performance Improvement Plan.

XI. Confidentiality

Data and information collected through the performance improvement process concerning patients and providers can be of a sensitive nature. Much of this information is protected under state laws regarding peer review. While WFH is committed to protecting and preserving the confidentiality due our patients, our employees, and our Medical Staff, this must be balanced with the goal of transparency in the fulfillment of

our mission and interactions with various stakeholders in terms of sharing aggregate, de-identified data and information.

XII. Adoption

Adoption of the plan follows approval by a majority vote of the Governing Body.

XIII. Annual Evaluation

Each department and discipline evaluates their quality indicators and performance improvement activities on an annual basis. Elements of this review include:

- a) The outcomes of performance improvement activities and the ongoing appropriateness of current performance indicators.
- b) The identification of the need for any educational events that may be conducted as a result of the analysis of the outcomes of performance improvement activities.
- c) The identification of the need for any proposed changes to the department or discipline

The objectives, scope, organization and effectiveness of the hospital's Performance Improvement Plan is evaluated annually by Governing Body, revised as necessary, and will include identification of priority areas for improvement.

Appendix A: Quality Indicators

**WHITING FORENSIC HOSPITAL
QUALITY INDICATORS AND BENCHMARKS
(Approved by Governing Body 11/13/23)**

Quality Assurance & Performance Improvement Manager:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Restraint and Seclusion	SSRS Reports	Below NRI benchmark 90% of the time	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Allegations of Abuse/Neglect	Excel Spreadsheet	90% Phase 1 and Phase 1A closed w/in specified timeframes 10% annual decrease in allegations	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Aggressive Acts to Self/Others	RMANS	10% annual decrease in the number of aggressive acts to self/others	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Codes	Excel Spreadsheet	10% decrease in # of codes annually	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Incident Reports (WFH-494)	SSRS Reports	100% of incident reports will be closed within 10 business days	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
DPH Adverse Events	DPH FLIS	Trend baseline in order to identify a meaningful benchmark for reason, number and timeliness requirements ¹	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly

Director of Recovery Services:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Admissions, Annuals & Progress Notes	Chart Audit	90% completed as required	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Rehabilitation Services)	RMS	Rehab Therapists will each have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Vocational Services)	RMS	Vocational Counselors will each have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Occupational Therapy)	RMS	OTRs will each have at least 8 patient contact hours weekly COTA will have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly

¹ DPH timeliness requirements - report submitted within seven calendar days; Corrective Action Plan (CAP) submitted within thirty calendar days

Number of Contact Hours (Addiction Services)	RMS	Substance Abuse Counselor will have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Education Services)	RMS	State School Teacher will have at least 20 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly

Director of Social Services:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Social Work Treatment Notes	RMS	90% of treatment notes are completed as required ²	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Number of Contact Hours (Social Work)	RMS	At least two groups per week	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Treatment Plan	RMS	90% of treatment plans include discharge related interventions	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Psychosocial Assessment	Social Work Audit	90% of admission/annual assessments are timely per policy	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Psychosocial Assessment	Social Work Audit	90% of assessments are thoroughly completed	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Psychosocial Assessment	Social Work Audit	90% of assessments include required elements regarding discharge	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Social Work Progress Notes	Social Work Audit	90% of progress notes are timely per policy	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Social Work Progress Notes	Social Work Audit	90% of progress notes include required elements	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

Health Information Management (HIM) Supervisor:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee Reported To</u>	<u>Frequency of Reporting</u>
Admission/Annual Assessments	HIM Audit	90% of Discipline Assessments (Psychiatry Nursing, Psychology, Social Work, Rehab) completed	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Admission/Annual Assessments	HIM Audit	90% of Discipline Assessments (Nursing, Psychology, Social Work, Rehab, Psychiatry) are timely	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Discharge Summaries	HIM Audit	90% within 30 days of discharge	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Concurrent Chart Quality Audit (treatment plans, progress notes, etc.)	HIM Audit of 4 charts on every unit	90% compliance with each element	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

² At least 2 social work groups per week (minimum required patient contact)

Conservator Notification	Excel Spreadsheet	90% of all medical interventions will have documentation of conservator notification in the progress notes	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
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Supervising Pharmacist:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Adverse Drug Reaction	Pharmacy access database	Increase reporting of ADRs to baseline 4 individuals per month	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Medication Events	MERFs/RMANS	Increase reporting of events to baseline 15 per month	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Opioid Prescribing	Pyxis	100% will be reviewed by pharmacy for appropriateness	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Pyxis Overrides	Pyxis	Overrides will remain within 10% of baseline monthly average	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Pyxis Overrides	Pyxis	80% of overrides will be appropriate and include a valid reason entered by the RN	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly

Director of Staff Development:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Annual Trainings (LMS)	Monthly Workforce Development Compliance Report	85% training compliance within 30 days of expiration	<ul style="list-style-type: none"> • Staff Development • Governing Body • QRS 	Quarterly
Annual CSS, CPR & Safewards (Live)	Monthly Workforce Development Compliance Report	85% compliance within 30 days of assignment	<ul style="list-style-type: none"> • Staff Development • Governing Body • QRS 	Quarterly
CAPS/retraining (LMS)	Monthly Workforce Development Compliance Report	85% training compliance within 30 days of assignment	<ul style="list-style-type: none"> • QRS 	Monthly
CAPS/retraining (Live)	Monthly Workforce Development Compliance Report	85% training compliance within 30 days of assignment	<ul style="list-style-type: none"> • Staff Development • QRS 	Monthly
New Hire Survey	Survey Monkey	85% of respondents indicate “good” or “excellent” in response to Q2, Q3, Q4, Q5, Q6 & Q7	<ul style="list-style-type: none"> • Staff Development • Governing Body • QRS 	Quarterly

Chief Medical Officer:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Suicide Prevention	Audit	100% of admission suicide screenings are completed on the Admission Psych Evaluation (WFH-314) and those with low/mod/high risk resulted in full assessment (WFH-632)	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly
Suicide Prevention	Audit	90% of Admission Psych Evals have interventions which correspond to assessed level of risk	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly
Suicide Prevention	Audit	100% of episodic screeners are completed (WFH-106) per policy and those with low/mod/high risk resulted in full assessment (WFH-632)	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly
Suicide Prevention	Audit	90% of episodic Suicide Assessments (WFH-632) have interventions which correspond to assessed level of risk	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly
Special Observation Orders	Audit	90% of orders are clearly written, contain no cross outs and reflect appropriate level of observation	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly
Treatment Plans (weekly, monthly, annuals & FTPs)	Audit	100% of treatment plans audited will include required elements in the present status	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly
Monthly Notes	Audit	100% of psychiatry monthly notes audited will include required elements	<ul style="list-style-type: none"> • ECMS • Governing Body • QRS 	Quarterly

Chief Nursing Officer:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Patient Engagement	Audits/Excel Spreadsheet	100% engagement when patient does not attend group	<ul style="list-style-type: none"> • Programming Committee • QRS • Governing Body 	Quarterly
Pain Management	Audit/Excel Spreadsheet	100% of pain assessments will be completed per policy at admission and upon return from hospital	<ul style="list-style-type: none"> • Nurse Executive Committee • P&T • QRS • Governing Body 	Quarterly

		100% assessed will include interventions in treatment plan as indicated		
Milieu Management	Audit	90% compliance with policy	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Group Activities	Audit	MHA/FTSs will conduct 3 activities 1 st and 2 nd shift, 7 days a week, 100% of the time	<ul style="list-style-type: none"> • Programming Committee • QRS • Governing Body 	Quarterly
Restraint/Seclusion	MAD Audit	90% of required elements will be in compliance	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Critical Test Results	Excel Spreadsheet	100% timeliness of reporting from lab to MD, per policy	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Staff	Nurse Supervisor Staffing Reports	Trend data to establish benchmarks: Call Out Rates, Overtime Rates (mandatory), Overtime Rates (voluntary)	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

Director of Advocacy:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Grievances	Advocacy Report	90% met w/ client within 3 days of receipt	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Grievances	Advocacy Report	90% closed with resolution within 21 days	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Grievances	Advocacy Report	Decrease number of grievances by 10% annually	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Complaints	Advocacy Report	90% met w/ client within 7 days of receipt	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Complaints	Advocacy Report	90% closed with resolution within 21 days	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Complaints	Advocacy Report	Decrease number of complaints by 10% annually	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Patient Satisfaction Surveys	QA Spreadsheet	50% patient participation by each unit, each service and the hospital	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body • 	Quarterly

Patient Satisfaction Surveys	QA Spreadsheet	Hospital average score of 3.5 or higher	<ul style="list-style-type: none"> Steering Committee QRS Governing Body 	Quarterly
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Psychology Chair:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Group Notes	Psychology Audit Tool	90% of group progress notes are present and include required elements	<ul style="list-style-type: none"> QRS 	Quarterly
Individual Notes	Psychology Audit Tool	90% of individual progress notes are present and include required elements	<ul style="list-style-type: none"> QRS 	Quarterly
Orientation Checklist & Competencies	Psychology Audit Tool	100% of all new psychologists receive training and orientation as required	<ul style="list-style-type: none"> QRS 	Quarterly
Admission IIPE	HIM Audit	90% of admission evaluations completed per policy timeframe	<ul style="list-style-type: none"> QRS 	Quarterly
Monthly Notes	HIM Audit	90% of monthly notes are completed per policy timeline and are labeled appropriately	<ul style="list-style-type: none"> QRS 	Quarterly
Contact Hours (Psychology)	RMS	W1, W2, W3 & D2S - 60 hours per month W4 & W6 ³ – 60 hours per month D1N ⁴ , D2N, D3N, D1S, D3S – 90 hours per month Psychotherapy Service Psychologist – trending to identify a meaningful benchmark ⁵	<ul style="list-style-type: none"> QRS 	Quarterly
Outside Consultants	Contract Review	90% of reports will be completed per timeliness guidelines	<ul style="list-style-type: none"> Governing Body 	Annually

³ W6 supervising psychologist is expected to provide 48 hours of service per month given supervisory responsibilities beyond those of a non-supervisory clinician.

⁴ D1N supervising psychologist is expected to provide 48 hours of service per month given supervisory responsibilities beyond those of a non-supervisory clinician.

⁵ Given that the Psychotherapy Service Psychologist is a newly filled position, at this point the Psychology department is still collecting data toward this purpose.

Ambulatory Care Services (ACS) Service Medical Director:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee Reported To</u>	<u>Frequency of Reporting</u>
ED Visits/Admissions	Excel Spreadsheet	100% of patients who require medical intervention or hospitalization 3 or more times in 90 days will undergo a case review process	<ul style="list-style-type: none"> • Advisory Board • Governing Body • QRS 	Quarterly
Falls	Excel Spreadsheet	<p>Decrease number of falls by 10% annually</p> <p>100% of patients who experience 3 or more falls within a 30-day period will undergo a case review process</p> <p>100% of patients who experience a serious fall will undergo a case review process</p>	<ul style="list-style-type: none"> • Governing Body • QRS • Falls Committee 	Quarterly
Community Medical Appts	Excel Spreadsheet	90% scheduled within 2 business days from referral date	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
WFH Consultant Appointments (Podiatry, Optometry & Neurology)	Excel Spreadsheet	90% of appts will occur within 30 days from referral date	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Dental Appointments	Excel Spreadsheet	90% of scheduled dental appointments will be kept	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Dietary Appointments	Excel Spreadsheet	90% of patients will be seen within 2 business days of referral	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Physical Therapy Referrals	Excel Spreadsheet	90% of patients will be seen within 2 business days of referral	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Speech Language Pathology Referrals	Excel Spreadsheet	90% of patients will be seen within 2 business days of referral	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Documentation	Excel Spreadsheet	90% of all medical interventions will be documented in the patient chart.	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

Infection Preventionist (IP):

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Hand Hygiene	Observation audits/excel spreadsheet	Following revised auditing process, 90% compliance with 5% annual improvement	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly
Flu Vaccine Program (either vaccination or signed declination)	IT Database	100% program participation –employees (students, contractors, volunteers) 20% annual improvement per unit in patient participation	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly
Hospital Acquired Infections (HAI)	MAR, rounds, order sheets	Not to exceed 0.75% baseline threshold	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly

Antibiotic Stewardship

Antibiotic Stewardship (Infection Preventionist)	Chart audit	100% of patients prescribed antibiotics will include proper chart documentation by prescriber, including valid reason for use, time out 48-72hrs if applicable, resolution of infection, and inclusion of diagnosis in Treatment Plan	<ul style="list-style-type: none"> • ABS Committee • QRS • Governing Body 	Monthly Quarterly Quarterly
Antibiotic Stewardship (Infection Preventionist)	Chart audit	100% of patient prescribed antibiotics will include proper chart documentation by nurse including signs/symptoms, effect of antibiotic after 72 hours, interventions in Treatment Plan	<ul style="list-style-type: none"> • ABS Committee • QRS • Governing Body 	Monthly Quarterly Quarterly

Chief Operating Officer:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Treatment Hours	RMS	80% of patients will receive 20 hours or more per week of treatment hours	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
MHAS-20 (non-ANE)	Labor Relations	Decrease the number of documented work rule violations by 10% annually	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Treatment Plan Timeliness	RMS	90% timely completion	<ul style="list-style-type: none"> • ECMS • Nurse Exec • Unit Directors Meeting • Governing Body 	Quarterly
Treatment Plan Quality	Unit Director Audit	80% of treatment plans audited include required elements ⁶	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Focused Treatment Plans	Audit	90% completed within one business day of being opened	<ul style="list-style-type: none"> • ECMS • Nurse Exec • Unit Directors Meeting • Governing Body 	Quarterly

Chief of Forensic Services:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Time from TL to CR	Excel Spreadsheet	Decrease time from TL to CR by 10% annually	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
Active TL Patients	Excel Spreadsheet	Increase total number of patients in active TL process by 10% annually	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
PSRB Reports	Excel Spreadsheet	80% of reports will be completed per required timeframe	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
Competency Reports	Excel Spreadsheet	80% of reports will be submitted for review 7 days prior to court	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
Competency Notes	HIM Audit	90% compliance with session/documentation every 10 days	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually

⁶ Required elements include: 12. Do all disciplines have services listed in the plan? 14. Does the treatment plan reflect patient specific active treatment services that are consistent with the current clinical presentation of the patient? and 23. Are there staff and/or patient signatures indicating that the patient received a copy of their treatment plan, or that they refused?

Director of Environment of Care (EOC):

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
EOC Rounds	Worxhub	Decrease in the number of findings by 10% annually	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Work Orders	Worxhub	Decrease completion time by 10% annually	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Work Orders	Worxhub	80% completed within 30 days of submission	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Hot Spots	Excel Database	80% completion rate of rounds	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Hot Spots	Excel Database	80% accuracy of rounds data	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Workman's Comp	HR	Trend baseline in order to identify benchmark	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly

Appendix B: Quality Indicator Data Reporting Template

WHITING FORENSIC HOSPITAL
Quality Indicator Data Reporting Template
DISCIPLINE/DEPARTMENT

Date Presenting	DATE PRESENTING	Committee Reporting To	COMMITTEE PRESENTING TO (i.e. QRS, Governing Body, etc.)
Fiscal Year Presenting	Fiscal Year runs July 1 st – June 30 th ; year is determined by the calendar year in June (i.e. 07/01/22 – 06/30/ 23 = FY 23)	Fiscal Quarter Presenting	Select One: <ul style="list-style-type: none"> • Q1 (July – Sep) • Q2 (Oct – Dec) • Q3 (Jan – Mar) • Q4 (Apr – Jun) + Year to Year
<u>Indicators/Outcome Measures:</u> what measures does the data reflect? <ul style="list-style-type: none"> • List quality indicators 			
<u>Goals/Benchmarks:</u> what was the baseline you were comparing your data set against and/or goals identified for program improvement? <ul style="list-style-type: none"> • List benchmarks 			
<u>Methods and Data Source:</u> by what process was the data you are presenting collected? <ul style="list-style-type: none"> • List data source/tracking method for each quality indicator 			
<u>Analysis and Trends:</u> Was the goal/benchmark met for the reporting period; were there any trends in the data you examined compared to last quarter/fiscal year; what significant positive /negative outcomes did data reveal compared to last quarter/fiscal year? <ul style="list-style-type: none"> • For each quality indicator, indicate whether or not the benchmark was met (Y/N/NA) • For each quality indicator, compare this quarter’s data to previous quarter’s data • For Q4/YTY report, compare this year’s data to previous year’s data 			
<u>Story behind the data:</u> what accounts for meeting/missing the benchmark/goal and trends identified? <ul style="list-style-type: none"> • If a benchmark was met for a quality indicator, explain what attributed to • If a benchmark wasn’t met for a quality indicator, explain what attributed to 			
<u>Strengths:</u> did data indicate any noteworthy positive outcomes that we want to ensure continue? <ul style="list-style-type: none"> • If data reveals positive performance, give credit and highlight the positive work the discipline/department is doing 			
<u>Corrective Actions:</u> what corrective actions need to be taken in an attempt to resolve any identified issues? <ul style="list-style-type: none"> • If data reveals poor performance (anything below the benchmark), indicate what corrective action(s) will be taken to address the performance issue 			
<u>Goals:</u> what would you like to achieve or see improve by your next report? <ul style="list-style-type: none"> • Separate from missed benchmarks (which require corrective actions), indicate if are any other specific areas where improvement is wanted (if applicable) 			
<u>Follow up from previous quarter:</u> corrective action steps taken from previous quarter and impact on current quarter data; were the interventions successful and if not, what are the next steps? <ul style="list-style-type: none"> • Indicate the outcome of any corrective actions implemented since last report, specifically whether or not the corrective action resulted in improved performance; if performance did not improve, indicate revised corrective action plan 			

Appendix C: Improving Organization Performance Planning Document

Whiting Forensic Hospital Performance Improvement Plan Proposal

Date		Service	Whiting <input type="checkbox"/>	Dutcher <input type="checkbox"/>	Unit/Department	
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A. DESIGN

1. Rationale for Project:
2. Objective:
3. List of interdisciplinary staff participants and titles
4. Identify data to be collected
5. Identify the databases(s) used for benchmarking

B. MEASUREMENT

1. Data Sources (include frequency and duration of data collection)
2. Person(s) responsible for data collection
3. Persons responsible for summary data analysis
4. Summarized data analysis reported to:

C. ASSESSMENT

1. List the QI tools used to focus the data review
2. Conclusions of summarized data analysis (which may include current level of performance stability of current process, areas needing improvement)
3. Recommendations

D. IMPROVEMENT

1. Describe the actions to be taken (include whether hospital-wide action of pilot project is to be implemented)
2. Persons responsible for implementation of actions
3. Planned performance measures (indicators)
4. Results (actual performance compared to desired performance)
5. If improvements are effective, identify plan to conduct ongoing measurement and assessment to verify that improvements are maintained (include timeframes).
6. If improvements are ineffective, identify the plan to redesign, plan, test and implement new actions.

Reviewed /Approved By:

Name/Title:

Approved: Yes No

If no, reason:

Date:

Appendix D: Root Cause Analysis and Corrective Action Plan Template

ROOT CAUSE ANALYSIS IN RESPONSE TO CRITICAL INCIDENT REVIEW
WHITING FORENSIC HOSPITAL, UNIT
INCIDENT OF – PT. MPI #
DATE OF CRITICAL INCIDENT REVIEW:

LEVEL OF ANALYSIS	QUESTIONS	ANALYSIS	FINDINGS
What happened Why did it happen What was the proximate cause What processes were involved	Critical Incident Review	See also Clinical Summary and medical record.	FINDINGS: See
	Were risk factors identified, includes the process for assessing patient's risk to self and others, including 3 P's identified	Behavioral assessment:	
		Physical assessment:	
		Patient identification:	
	Was incident directly observed by staff? What was the proximity of staff to the patient? Where was staff assigned at the time of incident?	Patient observation:	
	Were risk factors or clinical changes addressed in patient's treatment plan?	Care planning:	
	Were there any issues in transitioning levels of care, pt. hand-off?	Continuum of care:	
	Was staffing adequate, regular vs. float staff on duty. Include ideal vs. actual staffing, and unit census at the time of event	Staffing level:	
	Review of shift staffing, voluntary vs. mandatory OT. review of hours worked in the prior week	Healthcare worker fatigue and patient safety:	

	Can orientation and in-service training be improved? Were float staff oriented to the unit?	Orientation and training:	
	Is staff properly qualified and currently competent for their responsibilities? Scope of practice issues, credentialing policy	Competency assessment/credentialing:	
		Supervision:	
	Involvement of patient, family, conservator, language/culture barriers	Communication with patient/family:	
	Proper completion of internal and external hand-off communication. Evaluate timing of communication, verbal/written/electronic processes	Communication among staff members:	
	Is all necessary information available when needed?	Availability of information:	
	Was available technology used as intended? RMS, Pyxis, WITS	Adequacy of technological support:	
	How did the equipment performance affect the outcome?	Equipment maintenance/management:	
	Was the physical environment appropriate? Includes furnishings, hardware, lighting, distractions, overhead paging issues, spacing	Physical environment:	
	Are systems in place to identify risk and act to reduce risk	Security systems and processes:	
		Medication Management:	
	Does the p & p reflect current practice; does p & p need to be revised to reflect best practice	Policy and Procedure	

Signatures:

Medical Director

Date

QA/PI Manager

Date

WHITING FORENSIC HOSPITAL - CORRECTIVE ACTION PLAN (CAP)

Date of Event/Problem: _____ Date of Plan: _____

Person/Entity responsible for CAP, including dissemination and tracking implementation/effectiveness (Owner): _____

Plan disseminated: yes no

<u>Problem Description</u>	<u>Contributing Factors/Root Causes</u>	<u>Anticipated Outcomes/Measures of Effectiveness</u> (these should be aligned with action steps and clearly remedy original problems)	<u>Action Step/Risk Reduction Strategy</u> (these should be aligned with outcomes; <i>only put one action per row in this table</i>)	<u>Person(s) Responsible</u>	<u>Completion Date</u> (for each action step)	<u>Actions Implemented Fully?</u>	<u>Timely Implementation?</u> (actions occurred according to completion date)	<u>Status of Outcomes</u> (Actions resulted in desired outcomes)
						<input type="checkbox"/> yes <input type="checkbox"/> no If "no," explain, modifying plan as necessary with new or revised action steps	<input type="checkbox"/> yes <input type="checkbox"/> no If "no," explain, modifying plan as necessary with revised completion dates:	<input type="checkbox"/> yes CLOSED <input type="checkbox"/> no OPEN If "no," explain, modifying plan as necessary with new or revised outcomes and/or action steps
						<input type="checkbox"/> yes <input type="checkbox"/> no If "no," explain, modifying plan as necessary with new or revised action steps	<input type="checkbox"/> yes <input type="checkbox"/> no If "no," explain, modifying plan as necessary with revised completion dates:	<input type="checkbox"/> yes CLOSED <input type="checkbox"/> no OPEN If "no," explain, modifying plan as necessary with new or revised outcomes and/or action steps

CAP modified on (include all dates): _____

CAP completed on: _____

Owner Signature/Date: _____

**WHITING FORENSIC HOSPITAL
QUALITY INDICATORS AND BENCHMARKS
(Approved by Governing Body 8/14/23)**

Quality Assurance & Performance Improvement Manager:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Restraint and Seclusion	SSRS Reports	Below NRI benchmark 90% of the time	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Allegations of Abuse/Neglect	Excel Spreadsheet	90% Phase 1 and Phase 1A closed w/in specified timeframes 10% annual decrease in allegations	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Aggressive Acts to Self/Others	RMANS	10% annual decrease in the number of aggressive acts to self/others	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Codes	Excel Spreadsheet	10% decrease in # of codes annually	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Incident Reports (WFH-494)	SSRS Reports	100% of incident reports will be closed within 10 business days	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
DPH Adverse Events	DPH FLIS	Trend baseline in order to identify a meaningful benchmark for reason, number and timeliness requirements ¹	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly

Director of Recovery Services:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Admissions, Annuals & Progress Notes	Chart Audit	90% completed as required	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Rehabilitation Services)	RMS	Rehab Therapists will each have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Vocational Services)	RMS	Vocational Counselors will each have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Occupational Therapy)	RMS	OTRs will each have at least 8 patient contact hours weekly COTA will have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
Number of Contact Hours (Addiction Services)	RMS	Substance Abuse Counselor will have at least 16 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly

¹ DPH timeliness requirements - report submitted within seven calendar days; Corrective Action Plan (CAP) submitted within thirty calendar days

Number of Contact Hours (Education Services)	RMS	State School Teacher will have at least 20 patient contact hours weekly	<ul style="list-style-type: none"> • Governing Body • QRS • Programming 	Quarterly
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Director of Social Services:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Social Work Treatment Notes	RMS	90% of treatment notes are completed as required ²	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Number of Contact Hours (Social Work)	RMS	At least two groups per week	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Treatment Plan	RMS	90% of treatment plans include discharge related interventions	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Psychosocial Assessment	Social Work Audit	90% of admission/annual assessments are timely per policy	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Psychosocial Assessment	Social Work Audit	90% of assessments are thoroughly completed	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Psychosocial Assessment	Social Work Audit	90% of assessments include required elements regarding discharge	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Social Work Progress Notes	Social Work Audit	90% of progress notes are timely per policy	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Social Work Progress Notes	Social Work Audit	90% of progress notes include required elements	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

Health Information Management (HIM) Supervisor:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee Reported To</u>	<u>Frequency of Reporting</u>
Admission/Annual Assessments	HIM Audit	90% of Discipline Assessments (Psychiatry Nursing, Psychology, Social Work, Rehab) completed	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Admission/Annual Assessments	HIM Audit	90% of Discipline Assessments (Nursing, Psychology, Social Work, Rehab, Psychiatry) are timely	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Discharge Summaries	HIM Audit	90% within 30 days of discharge	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Concurrent Chart Quality Audit (treatment plans, progress notes, etc.)	HIM Audit of 4 charts on every unit	90% compliance with each element	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Consult Binder	Binder Review	100% MD orders for referrals are completed	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Conservator Notification	Excel Spreadsheet	90% of all medical interventions will have documentation of conservator notification in the progress notes	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

² At least 2 social work groups per week (minimum required patient contact)

Supervising Pharmacist:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Adverse Drug Reaction	Pharmacy access database	Increase reporting of ADRs to baseline 4 individuals per month	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Medication Events	MERFs/RMANS	Increase reporting of events to baseline 15 per month	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Opioid Prescribing	Pyxis	100% will be reviewed by pharmacy for appropriateness	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Pyxis Overrides	Pyxis	Overrides will remain within 10% of baseline monthly average	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly
Pyxis Overrides	Pyxis	80% of overrides will be appropriate and include a valid reason entered by the RN	<ul style="list-style-type: none"> • P & T • QRS • Governing Body 	Quarterly

Director of Staff Development:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Annual Trainings (LMS)	Monthly Workforce Development Compliance Report	85% training compliance within 30 days of expiration	<ul style="list-style-type: none"> • Staff Development • Governing Body • QRS 	Quarterly
Annual CSS, CPR & Safewards (Live)	Monthly Workforce Development Compliance Report	85% compliance within 30 days of assignment	<ul style="list-style-type: none"> • Staff Development • Governing Body • QRS 	Quarterly
CAPS/retraining (LMS)	Monthly Workforce Development Compliance Report	85% training compliance within 30 days of assignment	<ul style="list-style-type: none"> • QRS 	Monthly
CAPS/retraining (Live)	Monthly Workforce Development Compliance Report	85% training compliance within 30 days of assignment	<ul style="list-style-type: none"> • Staff Development • QRS 	Monthly
New Hire Survey	Survey Monkey	85% of respondents indicate “good” or “excellent” in response to Q2, Q3, Q4, Q5, Q6 & Q7	<ul style="list-style-type: none"> • Staff Development • Governing Body • QRS 	Quarterly

Chief Medical Officer:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Suicide Prevention	Audit	100% of admission suicide screenings are completed on the Admission Psych Evaluation (WFH-314) and those with low/mod/high risk resulted in full assessment (WFH-632)	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Suicide Prevention	Audit	90% of Admission Psych Evals have interventions which correspond to assessed level of risk	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Suicide Prevention	Audit	100% of episodic screeners are completed (WFH-106) per policy and those with low/mod/high risk resulted in full assessment (WFH-632)	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Suicide Prevention	Audit	90% of episodic Suicide Assessments (WFH-632) have interventions which correspond to assessed level of risk	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Medication Orders	Audit	90% of orders are clearly written with required elements	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Treatment Plans (weekly, monthly, annuals & FTPs)	Audit	100% of treatment plans audited will include required elements in the present status	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Monthly Notes	Audit	100% of psychiatry monthly notes audited will include required elements	<ul style="list-style-type: none"> • ECMS • Governing Body 	Quarterly
Special/Constant Observation	SSRS Reports	10% decrease in the number of special observations for POS/POO	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly

Chief Nursing Officer:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Patient Engagement	Audits/Excel Spreadsheet	100% engagement when patient does not attend group	<ul style="list-style-type: none"> • Programming Committee • QRS • Governing Body 	Quarterly
Pain Management	Audit/Excel Spreadsheet	<p>100% of pain assessments will be completed per policy at admission and upon return from hospital</p> <p>100% assessed will include interventions in treatment plan as indicated</p>	<ul style="list-style-type: none"> • Nurse Executive Committee • P&T • QRS • Governing Body 	Quarterly

Milieu Management	Audit	90% compliance with policy	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Group Activities	Audit	MHA/FTSs will conduct 3 activities 1 st and 2 nd shift, 7 days a week, 100% of the time	<ul style="list-style-type: none"> • Programming Committee • QRS • Governing Body 	Quarterly
Restraint/Seclusion	MAD Audit	90% of required elements will be in compliance	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Critical Test Results	Excel Spreadsheet	100% timeliness of reporting from lab to MD, per policy	<ul style="list-style-type: none"> • QRS • Governing Body 	Quarterly
Staff	Nurse Supervisor Staffing Reports	Trend data to establish benchmarks: Call Out Rates, Overtime Rates (mandatory), Overtime Rates (voluntary)	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

Director of Advocacy:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Grievances	Advocacy Report	90% met w/ client within 3 days of receipt	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Grievances	Advocacy Report	90% closed with resolution within 21 days	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Grievances	Advocacy Report	Decrease number of grievances by 10% annually	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Complaints	Advocacy Report	90% met w/ client within 7 days of receipt	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Complaints	Advocacy Report	90% closed with resolution within 21 days	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Complaints	Advocacy Report	Decrease number of complaints by 10% annually	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Patient Satisfaction Surveys	QA Spreadsheet	50% patient participation by each unit, each service and the hospital	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly
Patient Satisfaction Surveys	QA Spreadsheet	Hospital average score of 3.5 or higher	<ul style="list-style-type: none"> • Steering Committee • QRS • Governing Body 	Quarterly

Psychology Chair:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Group Notes	Psychology Audit Tool	90% of group progress notes are present and include required elements	<ul style="list-style-type: none"> • QRS 	Quarterly
Individual Notes	Psychology Audit Tool	90% of individual progress notes are present and include required elements	<ul style="list-style-type: none"> • QRS 	Quarterly
Orientation Checklist & Competencies	Psychology Audit Tool	100% of all new psychologists receive training and orientation as required	<ul style="list-style-type: none"> • QRS 	Quarterly
Admission IIPE	HIM Audit	90% of admission evaluations completed per policy timeframe	<ul style="list-style-type: none"> • QRS 	Quarterly
Monthly Notes	HIM Audit	90% of monthly notes are completed per policy timeline and are labeled appropriately	<ul style="list-style-type: none"> • QRS 	Quarterly
Contact Hours (Psychology)	RMS	W1, W2, W3 & D2S - 60 hours per month W4 & W6 ³ – 60 hours per month D1N ⁴ , D2N, D3N, D1S, D3S – 90 hours per month Psychotherapy Service Psychologist – trending to identify a meaningful benchmark ⁵	<ul style="list-style-type: none"> • QRS 	Quarterly
Outside Consultants	Contract Review	90% of reports will be completed per timeliness guidelines	<ul style="list-style-type: none"> • Governing Body 	Annually

Ambulatory Care Services (ACS) Service Medical Director:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee Reported To</u>	<u>Frequency of Reporting</u>
ED Visits/Admissions	Excel Spreadsheet	100% of patients who require medical intervention or hospitalization 3 or more times in 90 days will undergo a case review process	<ul style="list-style-type: none"> • Advisory Board • Governing Body • QRS 	Quarterly
Falls	Excel Spreadsheet	Decrease number of falls by 10% annually 100% of patients who experience 3 or more falls	<ul style="list-style-type: none"> • Governing Body • QRS • Falls Committee 	Quarterly

³ W6 supervising psychologist is expected to provide 48 hours of service per month given supervisory responsibilities beyond those of a non-supervisory clinician.

⁴ D1N supervising psychologist is expected to provide 48 hours of service per month given supervisory responsibilities beyond those of a non-supervisory clinician.

⁵ Given that the Psychotherapy Service Psychologist is a newly filled position, at this point the Psychology department is still collecting data toward this purpose.

		<p>within a 30-day period will undergo a case review process</p> <p>100% of patients who experience a serious fall will undergo a case review process</p>		
Community Medical Appts	Excel Spreadsheet	90% scheduled within 2 business days from referral date	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
WFH Consultant Appointments (Podiatry, Optometry & Neurology)	Excel Spreadsheet	90% of appts will occur within 30 days from referral date	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Dental Appointments	Excel Spreadsheet	90% of scheduled dental appointments will be kept	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Dietary Appointments	Excel Spreadsheet	90% of patients will be seen within 2 business days of referral	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Physical Therapy Referrals	Excel Spreadsheet	90% of patients will be seen within 2 business days of referral	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Speech Language Pathology Referrals	Excel Spreadsheet	90% of patients will be seen within 2 business days of referral	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Documentation	Excel Spreadsheet	90% of all medical interventions will be documented in the patient chart.	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly

Infection Preventionist (IP):

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Hand Hygiene	Observation audits/excel spreadsheet	Following revised auditing process, 90% compliance with 5% annual improvement	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly
Flu Vaccine Program (either vaccination or signed declination)	IT Database	<p>100% program participation –employees (students, contractors, volunteers)</p> <p>20% annual improvement per unit in patient participation</p>	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly
Hospital Acquired Infections (HAI)	MAR, rounds, order sheets	Not to exceed 0.75% baseline threshold	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly
CPAP Cleaning	MARs & excel sheet	100% compliance w/ required cleaning	<ul style="list-style-type: none"> • Infection Prevention • QRS • Governing Body 	Quarterly

Antibiotic Stewardship

Antibiotic Stewardship (Infection Preventionist)	Chart audit	100% of patients prescribed antibiotics will include proper chart documentation by prescriber, including valid reason for use, time out 48-72hrs if applicable, resolution of infection, and inclusion of diagnosis in Treatment Plan	<ul style="list-style-type: none"> • ABS Committee • QRS • Governing Body 	Monthly Quarterly Quarterly
Antibiotic Stewardship (Infection Preventionist)	Chart audit	100% of patient prescribed antibiotics will include proper chart documentation by nurse including signs/symptoms, effect of antibiotic after 72 hours, interventions in Treatment Plan	<ul style="list-style-type: none"> • ABS Committee • QRS • Governing Body 	Monthly Quarterly Quarterly

Chief Operating Officer:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
Treatment Hours	RMS	80% of patients will receive 20 hours or more per week of treatment hours	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
MHAS-20 (non-ANE)	Labor Relations	Decrease the number of documented work rule violations by 10% annually	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Treatment Plan Timeliness	RMS	90% timely completion	<ul style="list-style-type: none"> • ECMS • Nurse Exec • Unit Directors Meeting • Governing Body 	Quarterly
Treatment Plan Quality	Unit Director Audit	80% of treatment plans audited include required elements ⁶	<ul style="list-style-type: none"> • Governing Body • QRS 	Quarterly
Focused Treatment Plans	Audit	90% completed within one business day of being opened	<ul style="list-style-type: none"> • ECMS • Nurse Exec • Unit Directors Meeting • Governing Body 	Quarterly

⁶ Required elements include: 12. Do all disciplines have services listed in the plan? 14. Does the treatment plan reflect patient specific active treatment services that are consistent with the current clinical presentation of the patient? and 23. Are there staff and/or patient signatures indicating that the patient received a copy of their treatment plan, or that they refused?

Chief of Forensic Services:

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency of Reporting</u>
Time from TL to CR	Excel Spreadsheet	Decrease time from TL to CR by 10% annually	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
Active TL Patients	Excel Spreadsheet	Increase total number of patients in active TL process by 10% annually	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
PSRB Reports	Excel Spreadsheet	80% of reports will be completed per required timeframe	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
Competency Reports	Excel Spreadsheet	80% of reports will be submitted for review 7 days prior to court	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually
Competency Notes	HIM Audit	90% compliance with session/documentation every 10 days	<ul style="list-style-type: none"> • QRS • Governing Body 	Semi-annually/ Annually

Director of Environment of Care (EOC):

<u>Indicator</u>	<u>Data Source</u>	<u>Performance Goal/Benchmark</u>	<u>Committee(s) Reported To</u>	<u>Frequency Reported</u>
EOC Rounds	Worxhub	Decrease in the number of findings by 10% annually	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Work Orders	Worxhub	Decrease completion time by 10% annually	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Work Orders	Worxhub	80% completed within 30 days of submission	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Hot Spots	Excel Database	80% completion rate of rounds	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Hot Spots	Excel Database	80% accuracy of rounds data	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly
Workman's Comp	HR	Trend baseline in order to identify benchmark	<ul style="list-style-type: none"> • Governing Body • QRS • EOC 	Quarterly