Exemplary Professional Practice

Quality of Care Monitoring and Improvements

EP33: The Structure(s) and Process(es) Used by the Organization to Allocate And/Or Reallocate Resources to Monitor and Improve The Quality of Nursing, and Total Patient Care. The Nurse Has Responsibility For Ensuring The Coordination Of Care Among Other Disciplines And Support Staff.

York Hospital Nursing’s Mission and Vision serve as the foundation for improving and monitoring the quality of nursing care and the York Hospital Professional Practice model serves to build and strengthen a professional practice environment for our clinical nursing staff which supports our commitment to nursing excellence and quality care.

Our Mission: Working as one to improve health through exceptional care for all, lifelong wellness and health communities of WellSpan Health.

Our Vision: Providers of exceptional care to achieve superior clinical outcomes.

York Hospital (YH) has always been committed to providing quality, cost effective health care services. Professional nursing supports the mission and vision of York Hospital (YH) through a (previously service line, decentralized model) a centralized department of nursing, in an organized, systematic, and integrated care delivery system designed to be the best in the eyes of our patients, family, staff, and community by providing safe, quality and evidence based practice leading to exemplary outcomes. Each professional nurse accepts the accountability and responsibility for his/her professional practice. YH Nurses are committed to participating in decisions about patient care and nursing practice, and commit to uphold professional nursing standards at YH, the state of PA., and the nursing profession.

The York Hospital Professional Nursing Practice Model serves as the foundation for the delivery of quality patient nursing care and depicts how York Hospital professional nurses practice, collaborate, communicate, and develop professionally. The YH model, schematically represented above, is comprised of seven Guiding Principles that ensure seamless, coordinated, interdisciplinary, and evidence-based care to the YH patients and community and direct nursing care at the unit level. The nucleus of the Professional Practice Model, patient centered care, integrating patient centered care with our nursing care delivery model utilizing Relationship Based Care principles.
The YH Nursing Governance/Shared Decision Making (SDM) model is based on Tim Porter O'Grady’s Shared Governance Model. The Shared Decision-Making (SDM) framework, implemented in 2003, is a councilor model, based on York Hospital’s five identified domains of professional nursing practice – clinical practice, professional development, quality, research and leadership.

Since its inception in 1880, YH has been committed to providing quality, cost effective health care services to the individuals and communities it serves. The YH Mission Statement is focused on being a premier community teaching hospital where providing quality, cost-effective health care while supporting excellence in education is the priority.

To help ensure that YH fulfills this commitment, it has created and supports the YH Performance Improvement Process, the primary vehicle through which the hospital measures performance and plans, manages and evaluates improvement efforts. The Performance Improvement Process was created to provide the Board, physicians, management and employees of YH with a consistent, coordinated process for measuring and improving the performance of the care and services provided by the YH and its operating units. Each individual department within the hospital is included in the plan and has responsibility for its implementation. Each works collaboratively to develop improvement plans, identify opportunities for improvement or areas of concern, assess outcomes and participate in improving performance.

There are various organizational committees and decision-making bodies that affect patient care, with the involvement of nurses at all levels of the organization, whose main responsibilities are for the establishing, monitoring, and evaluating practice standards and patient care policies at the system, organizational, and unit levels. Those decision-making bodies (councils and committees) are described in detail below.

Quality Committee of the Wellspan Health Board of Directors

The Quality Committee of the Wellspan Health Board of Directors is ultimately responsible for:

1. Ensuring effective system-wide performance improvement processes are established and maintained;
2. Providing opportunities for improvement are shared among the pertinent system entities; and,
3. Evaluation of the effectiveness of the performance improvement activities through the established Performance Improvement Program occurs as a whole.

Membership on this Board level committee includes the Board Members and support staff, from all Wellspan Health entities:

- Wellspan Health
- Gettysburg Hospital
- York Hospital
- VNA
- South Central Preferred
- Wellspan Medical Group

The WSH Quality Committee is currently chaired by Mr. Michael Barley who possesses and in depth knowledge and interest in quality issues.

The Vice President of Patient Care Services (VPPCS) from YH attends every WSH Quality Committee serving as the voice for patient care and nursing. Astrid and her OOP partners present
quality metrics and programs relating to the YH to this system board committee, usually on a semiannual basis. The most recent YH Quality Report presentation was done in April of 2012 by the VP of Acute Care Nursing Practice and the VPPCS's from all three WellSpan Hospitals: York Hospital, Gettysburg Hospital and the WellSpan Surgical and Rehab Hospital. The presentation included an overview on acute care nursing demographics, clinical quality outcomes, nurse sensitive indicator and nurse satisfaction results.

**Corporate Quality Management**

The WellSpan Corporate Quality Management Department assists the organization improve the quality of nursing and total patient care in a number of ways through three primary functions. Performance Improvement (PI): PI is a systematic study of workflows, processes, and resources that identify opportunities to improve clinical practices and operational activities to positively impact the quality of care and achieve desired goals. PI assists hospital staff by evaluating and understanding the current condition, looking for ways to identify and eliminate waste and errors, helping solve problems and organizing Project Management.

Clinical Quality Data Management (CQDM): CQDM is the connection between PI and the Clinical Effectiveness Team's by providing data that show areas of opportunity and for improvement. The Clinical Quality Data team collects and reports data related to Core Measures, Joint Commission Regulatory standards, Patient Safety Quality Indicators and other clinical Quality Data Reporting. CQDM helps hospital staff and clinicians determine opportunities where using data would be beneficial, assists clinicians in the use of CareScience for reporting data needs, follows Core Measures and other quality trends, and assists in the application of data to evaluate daily practice.

Clinical Effectiveness Teams: WellSpan Health has a long tradition of care providers working collaboratively to develop tools that assure the best possible outcomes of care for our patients. Clinical Effectiveness Teams (CETs), which have been in operation for approximately four years, are WellSpan Health’s organizational structures designed to improve the quality of care and standardize the patient’s treatment plan across the WellSpan System. These teams are comprised of care providers from a variety of disciplines, (physicians, nurses, pharmacists, and others) who are recognized as having knowledge and expertise regarding a particular clinical condition or disease entity across the WellSpan Health System. In addition, these teams have the formal support of WellSpan's administration and clinicians to carefully analyze and implement the best processes of care to assure our patient's receive appropriate, effective health care services. The members of each CET meet regularly to:

- Review the clinical literature and the experience of other organizations in the management of certain disease processes, and research regarding evidence-based “best practices” in the care of the particular condition that is the focus of that CET;
- Develop standardized processes and systems designed to achieve care that conforms to these “best practices”;
- Assist in the implementation and consistent use of these processes and systems;
- Assist in the measurement and evaluation of clinical outcomes.

There are currently ten active Clinical Effectiveness Teams throughout the health care system. They include: Pneumonia, CHR, AMI, SCIP, Stroke, Diabetes, Peri-natal, Chronic Pain, Delirium and ICU.
Once CETs identify standardized processes and systems that are designed to achieve care that conforms to “best practices,” a key component of their responsibilities is to communicate those best practices to relevant providers, and to provide assistance in the implementation and consistent use of those processes and systems. This includes: publication of written guidelines; presentation at hospital medical staff “grand rounds”; and, presentations to other relevant meetings of providers, such as service lines, Medical Staff committees and departments, WellSpan Medical Group, pharmacists, and nursing staffs. Building on our philosophy of interdisciplinary collaboration and our tradition of nursing leadership in quality initiatives, all nine CETs have YH nursing staff as members, and six of the CETs have an YH RN as a co-chair with a physician. 

**WSH MAP Policy #120:** Administrative General – Clinical Effectiveness Teams defines the purpose, procedure, and scope and operation of CETs

### Quality Forum

The Quality Forum is an annual opportunity sponsored by Corporate Quality Management to learn about the considerable work being done throughout WellSpan Health on continuous improvement. The presentations and posters reflect the scope and variety of performance improvement initiatives undertaken during the past year. Staff and teams are encouraged to submit posters for improvement stories with measureable outcomes, small improvement projects that made things better for patients and/or staff members or projects showing rapid-cycle changes providing continual improvement. The Quality Forum, in its fifteenth year, continues to see increasing nursing submissions for improvement projects: 9 Storyboard presentations in 2007 to 29 in 2011. The Quality Forum strives for three objectives:

1. Recognize and reward quality performance by teams throughout the WellSpan Health System
2. Promote continuous performance improvement and deployment of performance improvement practices and principles
3. Enhance the exchange of experiences and organizational learning

### 2011-12 Quality Forum Nursing Story Boards

<table>
<thead>
<tr>
<th>The PI Project team leader (name)</th>
<th>What is the title of your improvement project?</th>
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<tbody>
<tr>
<td>Lori Abel, RN; Michelle DeStefano, RN, MPA, NEA-BC; Stephanie McKoin, RN</td>
<td>Implementation of a Spine Care Pilot to Enhance Patient and Provider Satisfaction</td>
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<tr>
<td>Brenda Artz, RN, MS, CCRN; Deb Davis, RN; Susan Dayhoff, RN, MS</td>
<td>Glycemic Control Mentored Implementation Program Initiative</td>
</tr>
<tr>
<td>Suzanne Beichner, BSN, RN, PCCN; Roxanne Cooley, RN, CEN, CVRN; Mary Ann Jurewicz, BSN, RN; Angela Robinson, MSN, RN, CCRN, CVRN</td>
<td>Shift Hand-Off Change to Verbal Report on T-2</td>
</tr>
<tr>
<td>Nancy Bowling, RN, MBA, NE-BC; Susan Brown, RN, MS, CCNS, CCRN; Bonita Trapnell RN, MS, NEA-BC; Sharon Fruehan, RN, BAN, CIC;</td>
<td>Code Brown</td>
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<tr>
<td>JoSue Livesay, RN; Marsha Braucher, RN-BC</td>
<td>Case Management Follow-up Phone Calls</td>
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**EP33.3 YH Nursing Contributions to the WSH Quality Forum**
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<thead>
<tr>
<th>Name(s)</th>
<th>Presentation Title</th>
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<tbody>
<tr>
<td>Suzan Brown, RN, MS, CCNS, CCRN; Blythe Stover-Baker, RN, MSN, CEN; Bonita Trapnell, RN, MS, NEA-BC; Deborah Lampo, RN, BSN; HELP Team Members</td>
<td>Expert Nurses Armed with Real Time Data Knock Out Sepsis</td>
</tr>
<tr>
<td>Barbara Buchko, DNP, RN; Connie Gutshall, MS, RN, NE-BC; Michele Brown, BSN, RNC-MNN; Adiranne Burgess, BSN, RNC-OB; Tracy Cadawas BSN, RN; Sue Dolla; Jen Folk, RN; Faye Hammers, RNC-MNN; Christy Hersey, BSN, RN; Pam Hollenbach, MS, RN, C; Roxlyn Maugans, MSN, RN; Venessa McWilliams, BSN, RN; Rhonda Puller, RN, IBCLC; Helen Quickel, RN IBCLC; Donna Snyder, BSN, RN</td>
<td>Improving Quality and Efficiency of Postpartum Education during Hospitalization</td>
</tr>
<tr>
<td>Dee Carbaugh, RN, BSN; PHAS Nursing Staff</td>
<td>PHAS Chart Processing From Implementation</td>
</tr>
<tr>
<td>Dee Carbaugh, RN, BSN</td>
<td>Preoperative Preparation of Patients – Implementation at Surgeons’ Office Level</td>
</tr>
<tr>
<td>Dee Carbaugh, RN, BSN</td>
<td>Transforming a Surgery Scheduling Form into a Standardized WellSpan Form</td>
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<tr>
<td>Rebecca Cassel, RN, BSN</td>
<td>Patient Acuity: Safe Patient Assignments Benefit the Patients and the Staff</td>
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<tr>
<td>Carol Coffman, RN, BSN; Marc Mione, RN, BSN, CEN</td>
<td>Expediting Patient Flow at York Hospital</td>
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<tr>
<td>Michelle DeStefano, RN, MPA, NEA-BC, Amy Sietz-Cooley, RN, MS, ACNS-BC; Kimberly Pope, CRNP, FNP-BC; Crystal Buchanan, LPN; Patricia Clymer, LPN</td>
<td>Reducing 30-Day Readmission – Continuum of Care Delivery Model</td>
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<tr>
<td>Julie Assi, LPN; Michelle DeStefano, RN, MPA, NEA-BC</td>
<td>Visit Summaries: Medical Group Ambulatory Visits</td>
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<tr>
<td>Wendy Evangelista, BSN, MS; Jan Mlodzikowski, BSN; Gail Kerchner, RN; Jodi Acri, BSN; Lori Lerew, BSN; Peggy Salabsky, RN</td>
<td>Surviving Bundle Billing in Dialysis: Does Bigger Mean Better</td>
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<tr>
<td>Julie Floyd, RN, BSN, CEN</td>
<td>Providing a Means for Nurses to Obtain Trauma Continuing Education Credits: Compartment Syndrome in the Extremities and Abdomen</td>
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<tr>
<td>Michele Johnson, RN, BSN; Amy Gerhart, RN, BSN; Tina Taylor, RN, BSN</td>
<td>Problem List Project: Managing Post Acute Care Transfer DRGs</td>
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<td>Name and Credentials</td>
<td>Presentation Topic</td>
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<tr>
<td>Keith R. Jones, RN, BSN</td>
<td>Cervical Collar Placement with Suspected Neck Injury</td>
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<tr>
<td>Kelly Koontz, MSN, RN-BC; Ann Kunkel, RN, BSN, CPUR</td>
<td>Measuring Transitions of Care Using Quality Data</td>
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<tr>
<td>Lynne Moul, BSN, RN, NE-BC</td>
<td>MSICU Infusion Therapy</td>
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<tr>
<td>Michele Schonbrunner, CRNP</td>
<td>Pelvic Exenteration Scheduling</td>
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<tr>
<td>Barrett Skandera, CRNP</td>
<td>Treating Vitamin D Deficiency to Improve Statin Tolerability</td>
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<tr>
<td>Cynthia Stermer, MS, RN-BC, ACNS-BC</td>
<td>Nursing Initiatives Reduce CAUTI Rates and Improve Patient Outcomes in the Surgical Service Line</td>
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<tr>
<td>Tamela Sterner, RN, BSN, M.Ed, BC-NE; Sharon Douglas, RN, BSN, PCCN</td>
<td>Utilization of the Cardiovascular patient Advisory Council to Improve Quality and Delivery of Care</td>
</tr>
<tr>
<td>Barbara Taylor, MS, CCNS; Julie Staub, BSN, RN; Mary Rojahn, RNC; Stacy Balderson, BSN, RN</td>
<td>Keeping Babies Warm: Low Birth Weight Infants</td>
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<tr>
<td>Bonita Trapnell, RN, MS, NEA-BC; H. Darius Gray, RN, BSN</td>
<td>York Hospital GI Suite Throughput Improvement</td>
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<tr>
<td>Sandy Tompkins, RN, CDE, CBN, MBA</td>
<td>Increasing Throughput: Bariatric Surgery Preoperative Program</td>
</tr>
<tr>
<td>Sandra Young, MSN, RN, CVRN II; Angela Robinson, MSN, RN, CCRN, CVRN</td>
<td>Improving Patient Education Recall with Teach Back</td>
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<tr>
<td>Jennifer Will, BSN, RN; Christie Leviste Magsino, BSN, RN, NM</td>
<td>Bed Huddle – Improving 4 Main Patient Satisfaction Scores from the NRC Picker Report</td>
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**York Hospital Board of Directors**

At the hospital level, the YH Board of Directors is ultimately responsible to carry out the hospital performance improvement responsibilities and accountabilities. Their role is to:

- Assume ultimate responsibility and accountability for the quality of clinical care, competency of practitioners, and provided services.
- Ensure that an effective hospital-wide Performance Improvement process is established and maintained;
- Ensure that identified opportunities are appropriately resolved. Provides resources for problem resolution as necessary;
- Evaluate the effectiveness of the performance improvement activities performed throughout the hospital.

Membership on this board includes the following multidisciplinary team:
• Community members
• President of Wellspan Health System
• President of YH
• three elected Medical Staff members from YH
• Staff support attendees:
  o YH VP-PCS
  o YH VPMA
  o YH VP-Operations
  o President and Vice-President of the YH Medical Staff
  o WSH VP-Legal Affairs
  o WSH SVP- Care Management
  o WSH SVP-Finance
  o WSH SVP Organizational Development

The YH Board is the oversight body for the quality of patient care services rendered at YH. The quality reports are provided by a variety of individuals, most often by the Vice-President of Medical Affairs (VPMA) and VP-PCS (who serve as co-chairs of the YH Performance Improvement Council).

**Vice President Patient Care Services**

The VPPCS is accountable at the highest level of the hospital for quality and performance improvement. The role and accountability for the VPPCS/CNO for quality improvement is hardwired into the CNO position description as follows:

a. **General Summary:**
   1. Develops and implements plans for providing quality multidisciplinary care to patients.
   2. Develops and implements ongoing programs to measure, assess and improve the quality of care delivered to patients.

b. **Duties and Responsibilities:**
   1. Represents the strong voice of Nursing and patient care in the Office of the President, YH Board of Directors and all other executive level forums responsible for setting system strategy and having the potential to impact patient care or influence the practice of Nursing.
   2. Participates in strategic planning, goal setting, budget preparation and priority setting, and program development in collaboration with the Senior Leadership Team, Office of the President, Nursing Leadership Team, medical staff, nursing staff and others as appropriate.
   3. Develops and implements hospital-wide nursing practice and patient care programs for the delivery of patient care within the organization.
   4. Implements as effective, ongoing program to measure assess and improve the quality of care delivered to patients.
   5. Ensures appropriate clinical and support resources and skill mix are in place to provide quality care to patients and ensure a safe workload for clinical nursing staff.
   6. Establishes efficient and effective systems that support the delivery of patient care, the quality of patient care across the system for all disciplines; and the achievement of quality patient outcomes.
7. Establishes the infrastructure to promote and support the embedding of utilization of evidence-based practice and involvement in nursing research for nurses at all levels in the organization.

The VPPCS plays a key role in the assessment, execution, and evaluation of YH performance improvement plan (MAP Policy No. 629). Astrid Davis attends all YH Board meetings and provides essential nursing updates and reports to the Board. Over the course of the last two years, Astrid has informed the Board of many critical YH quality care initiatives such as giving updates to the YH Board about Performance Improvement and Quality Outcomes by reviewing the quality report that is generated by the members of the YH Performance Improvement Council. Astrid gives these updates, which include many nursing practice outcomes every other month. In addition, she also shares special nursing accomplishments, such as publications and awards, when appropriate.

As referenced in the JC plan for provision of nursing care, Astrid has the ultimate authority and responsibility for establishing standards for nursing practice and care delivery, as well as spearheading the advancement of nursing professional practice at YH. She has the ultimate responsibility and authority for the development and implementation for the hospital plan for the provision of nursing care, treatment and services to those patients requiring nursing care. Astrid is a member of key system and hospital decision-making forums which address quality and patient care issues including:

- Wellspsan Board Quality Committee
- Wellspsan Clinical Performance Council
- Wellspsan Performance Council
- Wellspsan Patient Safety Committee
- Wellspsan Risk and Claims Management Committee
- Office of the President
- YH Performance Improvement Council
- Medical Executive Committee
- Medical Staff Credentialing Committee
- YH Infection Control Committee
- YH Patient Safety Committee
- YH IHI Steering Committee

York Hospital Performance Improvement Committee

At the hub of the YH performance improvement oversight is the YH Performance Improvement Council which is chaired by the VPPCS and the VP Medical Affairs. Astrid has just recently enhanced the leadership structure by changing the chairmanship to a partnership between the staff nurse chair of the SDM Practice Council and the Medical Staff Director of Quality and Safety. Membership to this committee is multidisciplinary in nature with each medical director and clinical director representing each of the hospital’s departments as active participants, as well as the shared decision making Chair of the Nursing Quality (PI) Council and representatives from key hospital departments. The Nursing Quality (PI) Chair submits a monthly report to the YH PI Committee on hospital quality indicators including falls, restraints, HAPU’s, pain management, medication errors and CAUTI’s. This committee membership demonstrates that all nursing leadership has the responsibility and accountability for performance improvement initiatives at the unit, service line, hospital, and system level. The major responsibilities of the YH Performance Improvement Council are the following which is outlined in the YH MAP Policy No. 629: entitled: “York Hospital Performance Improvement Program.”
This committee’s major governance and responsibilities includes the following:

- Approves and oversees the implementation of the annual YH Performance Improvement Plan;
- Reviews and evaluates performance improvement activities of Service Lines, Departments and key functions;
- Monitors compliance with JC standards via the Continuous Survey Readiness Program;
- Reviews sentinel and adverse events and determines improvement opportunities;
- Reviews safety issues and identifies improvement opportunities;
- Reports results to the YH Board of Directors & Medical Executive Committee, as appropriate;
- Communicates information regarding the system-wide initiatives;
- Recommends presentations for Annual Celebration of Quality Forum.

In addition, other interdisciplinary membership includes the following:

- Clinical or Administrative Director from the following departments:
  - Pathology
  - Imaging
  - Pharmacy
- Risk Manager
- Safety Officer
- Patient Safety Officer
- Director, Care Management
- Director, Quality Management
- Director, Infection Control
- Director, Regulatory Compliance
- The SDM Nursing Chair (Staff RN) or designee from the Hospital-wide Nursing Performance Improvement Council
- Nursing PI Coordinator for Nursing Administration
- Support and Clinical Department Directors on an as needed basis
- Vice President – Operations

**Performance Improvement Planning Process**

YH leaders are responsible and accountable for effectively assessing, developing, implementing, and evaluating the performance of the organization’s management, clinical, and support processes in order to facilitate positive patient outcomes and positive organizational outcomes. Leaders are accountable for facilitating an organizational culture that is committed to improving organizational performance, patient and staff safety; just culture; reducing patient harm (risk); and analyzing the effectiveness of their systems and processes. In addition, leaders are responsible for ensuring and securing adequate resources to meet the organizational quality goals and that staff are adequately educated in executing and evaluating performance improvement within their scope of practice.
The performance improvement planning process occurs on an annual basis. Each YH Department develops an annual Operating Plan which includes annual objectives pertaining to the following System wide strategies:

- Community Health Improvement
- Clinical Outcomes
- Service
- Financial Performance
- Market Position
- Physician Partnerships
- Human Resources
- Infrastructure

Performance improvement objectives are identified and prioritized within each Operating Unit. System wide Improvement Objectives are established by the YH Performance Improvement Council (PIC) by utilization of the following prioritization criteria:

- Patient Safety
- Effectiveness
- Timeliness
- Efficiency
- Equity
- Patient Centeredness
- Financial Impact
- Chance of Success
- Link to Strategic Plan
- Ability to Measure Outcome
- Organizational Capacity
- Scope of Projects that offer the greatest opportunity for interdisciplinary involvement
- Champion Availability
- Enhanced Employee-Physician Satisfaction

The performance improvement objectives for each YH Department are approved by the Performance Improvement Council on an annual basis. A summary listing of all objectives can be found in the WellSpan Health Blue Book and YH Operating Plan for each new fiscal year. The plans are revised as necessary throughout the year. Interactive and open communication between all Departments responsible for Quality and Performance Improvement is expected. Regular reports regarding progress towards meeting established objectives are made to the YH Performance Improvement Council (PIC), and the WellSpan Health Quality Committee of the Board, on a regular basis.

The PIC reviews pertinent clinical and organizational information at each of its monthly meetings. The information reviewed is summarized and includes the following:

- Patient events, interventions, and results
- Customer Service / Patient Satisfaction (NRC Reports and other surveys)
- Medication Use / Errors
- Operative and other procedures
- Use of blood and blood components
- NSIs
- Core Measure Data
- Utilization Management data and trends
- Evaluate outcomes of process changes
- Infection Control data
- Performance measures from acceptable databases
- Customer demographics and diagnoses
- PI projects from administrative departments
- Research data
- Resuscitation results

The model for the YH performance improvement process is the Plan-Do-Study-Act (PDSA) cycle for improvement, as well as Lean 6 Sigma tools (e.g., A3 and 5S). The structure and effectiveness of the Performance Improvement Program is evaluated on an ongoing basis to assure that the YH is meeting the goals established within this plan. At least annually, the Performance Improvement Plan is reviewed and revised, as appropriate, by the YH Performance Improvement Council. At a regular meeting of the PIC before the start of each new fiscal year, the members review the overall content of the plan and consensus is obtained on any necessary or proposed changes.

York Hospital Nursing

The Professional Nursing Staff have been integral members and active participants on all quality committees, forums, and interdisciplinary clinical effectiveness teams to ensure that high quality of patient care is being delivered. For example, nurses from all levels of the organization participate in hospital-wide Nursing Quality (PI) Council and YH Performance Improvement Committee. Nurses present quality projects and initiatives at both the system and hospital levels (at the corporate Quality Management’s annual “Quality Forum,” and semi-annual YH Nursing Quality (PI) presentation days. Nurses are key leaders on Clinical Effectiveness Teams; and, in addition, our infrastructure for enhancing our evidence-based practice and nursing research based upon increased fiscal allocation, has significantly expanded nurse’s opportunities to apply evidence based practice principles, nursing research, and increased scholarly activities.

Through our strong shared decision-making structure, the Chair of the Nursing Shared Decision Making (SDM) Nursing Quality (PI) Council is also a designated member of the YH Performance Improvement Committee (PIC) as outlined in MAP Policy No. 629. In addition, the SDM Nursing Quality (PI) Council Chair, or designated representative, reports on activities of the Council semi-annually to the YH – PIC.

The SDM model is comprised of seven councils: Practice, Nursing Quality (PI), Professional Development, Leadership, Evidence Based Practice (EBP) and Nursing Research, Nursing Informatics (NIC) and Coordinating councils, all of which recommend changes in nursing practice and standards based upon sound evidence based practice. Parallel functions occur in unit-based councils as part of the SDM model. These unit-based councils make recommendations to the hospital-wide SDM Nursing Councils, as well as, review and evaluate proposed changes from the hospital SDM Councils. The unit based councils are represented on Departmental councils which discusses and shares input and insights on suggested or proposed changes in nursing practice and policy that may affect an entire department and its patient-specific populations. The Department councils serve to further integrate the shared decision making processes and broaden communication of all new or revised policies and
standard to the entire staff. Hence, all of our SDM Councils are responsible and accountable for the provision of quality outcomes for patients, staff, and organizational levels based upon the council’s specific mission, vision, and stated responsibilities and accountabilities. The communications between the YH PIC and the SDM Councils is further enhanced and facilitated by the presence of Nursing Clinical Directors at both organizational bodies; the CDs serve as both a liaison and advisor to the SDM councils.

To formalize the processes used by nursing for establishing, monitoring, and evaluating practice, standards and patient care policies at the unit and organizational levels, the policy ADM-005: “Performance Improvement Programs and Nurse Sensitive Indicators” as created and implemented in 2002 and continues today. This policy compliments the YH MAP Policy No. 629: “Performance Improvement Program” in that ADM-005 serves to focus unit level activity on the WellSpan Health Strategic Plan (Blue Book initiatives) addressed by Manual of Administrative Policy.

The goal of Nursing Policy No. ADM-005 is to provide an understanding of the importance of nursing quality and performance improvement, in general, and the importance of Nurse-Sensitive Indicators impacting patient quality outcomes at YH. It also serves to promote consistency of data collection and reporting for the ultimate goal of improved health care delivery to all patients in support of improved patient care outcomes and patient satisfaction.

**YH Nursing SDM Quality Council**

The hub of our nursing specific performance improvement activities and initiatives is our Nursing SDM Nursing Quality (PI) Council. The Nursing Quality Council’s primary function is to educate and involve every nursing staff member in performance improvement activities. We believe an empowered nursing staff will improve patient outcomes. The Council desires to maintain the prestigious recognition of YH as an excellent community provider of patient care- gained by achieving or exceeding the ANA standards of excellence as a designated “Magnet” hospital- through demonstrating nursing excellence and the quality of its healthcare delivery.

The Nursing Quality Council of York Hospital is the arm of shared decision-making (SDM) that coordinates, promotes and evaluates nursing performance improvement activities at the hospital, service line, and unit levels. Professional nursing members facilitate and validate excellent evidence based nursing practices for our patients, our nursing staff and for members of management and administration. The Nursing Quality Council incorporates the IOM’s 6 Aims of Healthcare: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity to address the WSH Strategic Plan (Bluebook) and York Hospital Operating Plan objectives.

Membership in the YH Quality (PI) Council Includes:

- Chair and Chair-Elect of PI Council
- Staff RNs (8)
  - Oncology - 1
  - Medical Service Line - 1
  - Surgical Service Line - 1
  - Behavioral Health - 1
  - Emergency Department - 1
  - Women and Children - 1
  - Cardiovascular Service Line – 1
• Neurosciences Service Line - 1
  • Director of Center for Nursing Excellence & Innovation
  • CNS (2)
  • Nurse Manager
  • Clinical Director (Advisor)
  • Ad hoc: Nursing PI Specialist, Director Quality Management

The accountabilities and work of this council include:
• Support system/hospital/service line/unit based quality and safety initiatives
• Ensure bulletin boards on units contain current information within the last three months, facilitate graphics and display data that is meaningful, translatable, understandable, and articulated to all staff.
• Develop an education plan for staff that ensures competency in data analysis and interpretation, as well as on PI tools and processes.
• Ensure the action plans for PI and patient safety are meaningful and show progression to achieve benchmarks.
• Implement evidence-based practice changes to improve nursing quality as it relates to NSIs.
• Ensure dissemination and interpretation of all NSI and PI plans.
• Exceed the mean of NDNQI NSI mean for each nursing unit.
  • Review those action plans for content and progress
• Identify areas not covered by NDNQI to implement/develop PI plans to monitor patient outcomes.
• Collaborate with EBP/Research Council for potential PI projects.
• Provide semi-annual nursing PI presentations to assist in the dissemination of PI projects throughout York Hospital.
• Oversee the peer review process.

A consistent process of our SDM PI council is to ensure that our quality indicators are within acceptable ranges and defined benchmarks. YH Nurse-sensitive Indicators (Falls, Restraints, HAPU, CAUTI and BSI’s) in addition to DOH, CMS and JCAHO quality indicators are reviewed and monitored monthly at each YH SDM Quality (PI) Council meeting. For units whose NSI’s or quality metrics fall below the benchmark for two consecutive months or indicate any negative change to the baseline (e.g. increase in patient fall rate), unit based Quality/PI councils are accountable for the creation of action plans on a quarterly basis that specially address a plan for improvement. This is a good example of a peer to peer expectation of unit compliance for those designated quality indicators.

These action plans are carried out by the unit-based Practice Councils and unit based Quality/PI Councils who, through our care delivery design have been given Level 3 authority to coordinate and implement practice changes to the care delivery model that will ultimately improve the identified outcomes. In addition, all the SDM councils have been engaged in improving the nursing care delivery model in a stringent systematic process.

The guidance provided from the YH SMD Quality (PI) Council to the unit-specific Quality (PI) Councils asks all units to present what has been studied during the past six months, what were the results of the study or analyses, and what patient outcomes were addressed. The format for sharing
unit PI initiatives has led to **Semi-Annual PI Presentation Days** where staff can choose to present their data either by poster presentation or an oral presentation.

In order to assure widespread distribution of the above mentioned quality data outcomes and other quality initiatives, the following examples demonstrate mechanisms for ensuring comprehensive dissemination to all stakeholders within YH:

1. The WSH “Clinical(s)” Web based data portal
2. The Clinical Effectiveness Teams – databases
3. The Magnet Nursing Web Portal
4. The Nursing Dashboard (NDB) Reports and INET Web Portal
5. Nursing Affairs PI Coordinator Distribution E-mails for Updated NDB documents
6. Nursing SDM PI Council Semi-annual reports to the Wellspan Health YH PIC
7. Nursing Affairs PI Coordinator Reports to the SDM PI Council
8. Semi-annual Presentations to the SDM PI Council by Nursing Units.

The table below depicts our committee/councilor structure and reporting relationships of the unit-based PI councils to the Wellspan Health Quality Committee of the Board:

<table>
<thead>
<tr>
<th>Wellspan Health Quality Committee of the Board</th>
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<tbody>
<tr>
<td>VP - Patient Care Services</td>
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<table>
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<tr>
<th>Wellspan Health Clinical Performance Council (CPC)</th>
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<tr>
<td>VP-Patient Care Services</td>
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<table>
<thead>
<tr>
<th>York Hospital – Performance Improvement Committee (PIC)</th>
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<tbody>
<tr>
<td>VP- Patient Care Services -- Co-Chair with VPMA</td>
</tr>
<tr>
<td>Clinical Directors, Nursing SDM Quality Council Chair, Nursing Quality Coordinator</td>
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<table>
<thead>
<tr>
<th>Nursing Shared Decision Making (SDM) Quality Council</th>
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</thead>
<tbody>
<tr>
<td>Staff RN Chair and Chair Elect, 7-Service Line RN Reps, Clinical Director Liaison, Nurse Manager Rep</td>
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<thead>
<tr>
<th>Service Line – Councils</th>
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</thead>
<tbody>
<tr>
<td>RN Service Line Chair, Staff Nurse Representatives from each unit, Clinical Director, Nurse Managers, Unit Clinical Nurse Specialists, Unit Nurse Educators,</td>
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<tr>
<th>Unit Specific SDM PI Councils</th>
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<tbody>
<tr>
<td>Unit RNs, and Educators/CNS</td>
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</table>

Additionally, throughout YH there exist many multidisciplinary teams, committees, and task force organizations, upon which nursing staff from all levels of the organization participate. Below depicts several of these multidisciplinary committees and task forces:

- Pain Management Committee
- Sedation Committee
- Falls Prevention Task Force
- Resuscitation Committee
- Patient Safety Committee
- Institutional Review Boards (2): Medical-Surgical and Cancer
• Bioethics Committee
• Pharmacy and Therapeutics Committee
• Critical Care Committee
• Medication Safety Committee
• Infection Control Committee
• Bariatric Steering Committee
• Trauma Work Group
• Patient Experience

Summary
Quality is a top priority and area of intense focus throughout YH and WHS. There is a robust infrastructure in place from the unit level, nursing, hospital and system levels in WellSpan for the purpose of identifying quality initiatives, determining the strategy to achieve the desired outcomes and measurement strategies to ascertain the success of the quality journey. Nurses are engaged and involved every step of the way in this quality focus. Resources are allocated at every juncture in the process to ensure that the quality of nursing care and patient care meets our standards of excellence.