King Faisal Specialist Hospital and Research Centre (Gen. Org.)
Performance Improvement Plan (PIP)

PURPOSE

The purpose of the Performance Improvement (PI) Plan is to outline the King Faisal Specialist Hospital & Research Centre's (KFSH&RC) (Gen. Org.) approach and methodology for Hospital-wide Performance Improvement activities. The Performance Improvement Plan is complementary to the Quality and Safety Management Plan (QSMP) for the area of performance improvement.

INTRODUCTION

The PI Plan is based on organization-wide involvement in the planning and the implementation of PI activities to meet and exceed customers' expectations. Quality Management Department (QMD) develops the plan that is reviewed by the Performance Improvement Council (PIC) members prior to submission for approval. Performance Improvement (PI) work is separate from project management professional (PMP) work as:

Performance Improvement (PI) work	Project Management Professional (PMP) work
• Current Practice • Continuous • Improvement	• New Practice • Temporary • Unique

GOALS

- Improve patient care outcomes.
- Streamline hospital processes to improve the quality, safety, and efficiency of the provided services as an element to achieve being a High Reliability Organization (HRO).
- Improve the working environment to enhance patient, visitors, and staff satisfaction.

OBJECTIVES

- Establish organization-wide priorities for PI Projects
- Integrate Performance Improvement with the Hospital quality, risk, and safety activities
- Develop and implement mechanisms to measure, review and improve services performance
- Deliver an organization-wide educational plan for PI
- Provide support in establishing Organization-wide indicators
- Ensure implementation of standardized "Robust Performance Improvement" (RPI) methodologies across the Organization including, Lean, Six Sigma, FOCUS-PDCA, Change Management, etc. into one improvement framework, structure, and method called I.A.C.T.
- Develop local Performance Improvement work through local PI representatives (RPI Coaches)
- Design new processes and redesign the existing processes to ensure the delivery of safe, timely, efficient, effective, equitable, patient-centered and appropriate care and/or service to maintain the status of being High Reliability Organization (HRO).

PERFORMANCE IMPROVEMENT APPROACH

Performance Improvement activities undertaken to improve the care and services should address, whenever possible, the domains of quality as defined by the Institute of Medicine (IOM):

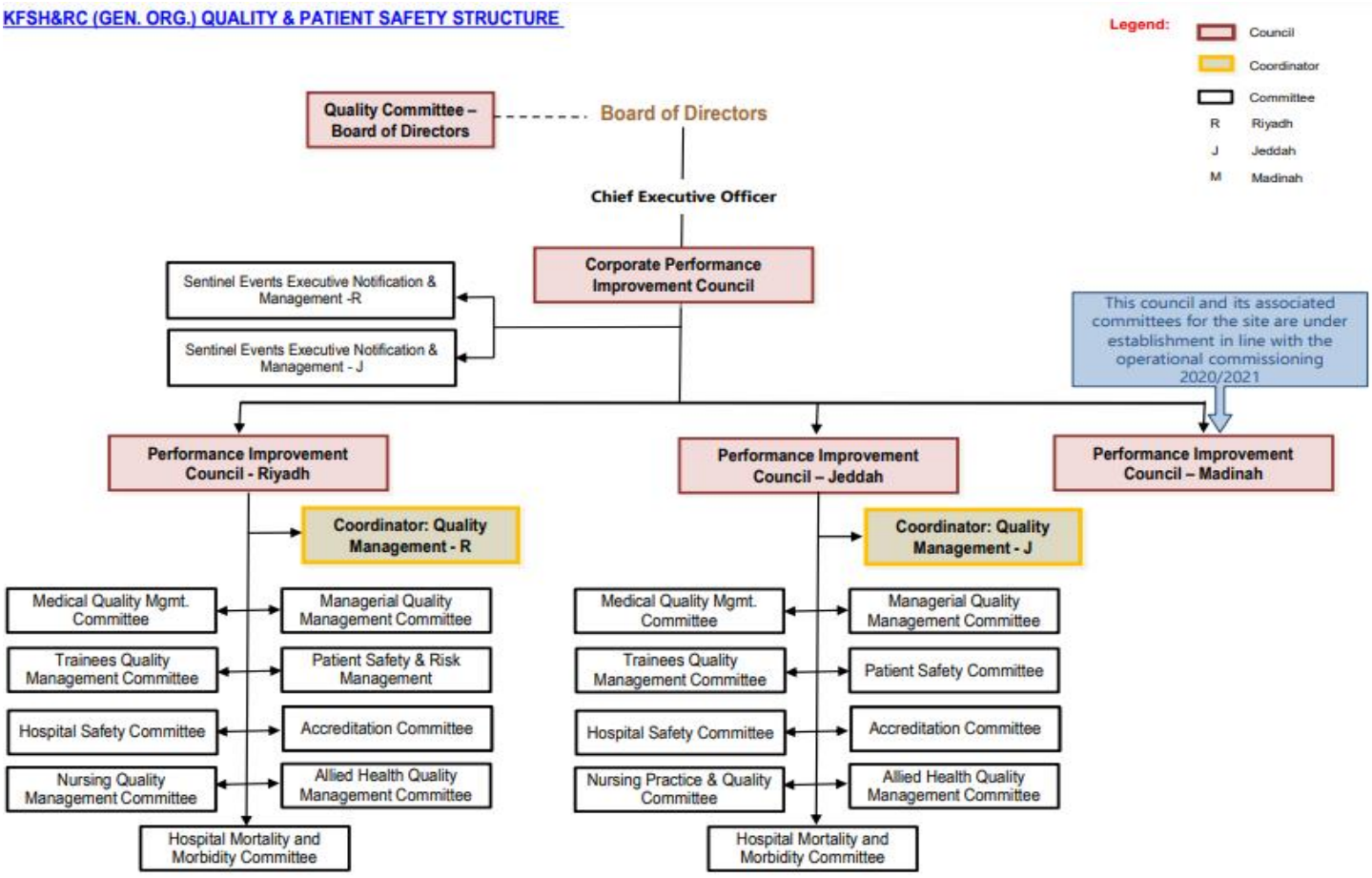
- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Timely**: Reducing waits and potentially harmful delays
- **Effective:** Providing services based on scientific knowledge to those who would benefit, and refraining from providing services to those not likely to benefit.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and resources.

- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, location, and socioeconomic status.
- **Patient-Centered**: Providing care that is respectful of, and responsive to individual patients' preferences, needs and value ensuring that all clinical decisions are based on patient values.

RESPONSIBILITY

The Board of Directors Chairman approves the Hospital Quality and Safety Plan and oversees its implementation through the Hospital Quality and Safety structure. QMD is responsible for coordinating the implementation of the plan with each senior manager throughout the Organization. The Hospital Quality & Patient Safety structure is outlined in Figure 1:

Figure 1: KFSH&RC (Gen.Org) Quality and Patient Safety Structure



PERFORMANCE IMPROVEMENT COUNCIL (PIC) (CFO-R: 755 & CFO-J: 021)

The General Manager or Deputy Chief Executive Officer (DCEO) of the sites chairs the PIC that is composed of members from the senior managers. The Council provides executive oversight and direction for performance improvement, patient safety, risk management, safety, and accreditation activities. The Director of Quality Management coordinates the PIC meetings every two (2) months. The Chairs of the following committees: Patient Safety and Risk Management; Hospital Safety; Accreditation; Hospital Mortality and Morbidity; Nursing Quality Management; Managerial Quality Management; Allied Health

Quality Management and Trainee Quality Management attend the PIC and their updates are part of the council agenda. The PIC chairman forwards the issues raised from the quality and safety committees to the applicable senior manager or committee for review and appropriate action(s). QMD coordinates the process until actions are completed.

QUALITY MANAGEMENT DEPARTMENT – RIYADH, JEDDAH, AND MADINAH

QMD consists of sections outlined in the organization structure approved by the CEO. Each section develops its own plan. The plans will outline the main functions performed by the section and the interaction with other quality management sections' plans.

The Director of Quality Management Department is the coordinator of the PI Council. Representatives from QMD participate in each Quality Management Committee acting as a resource and facilitator for the PI activities.

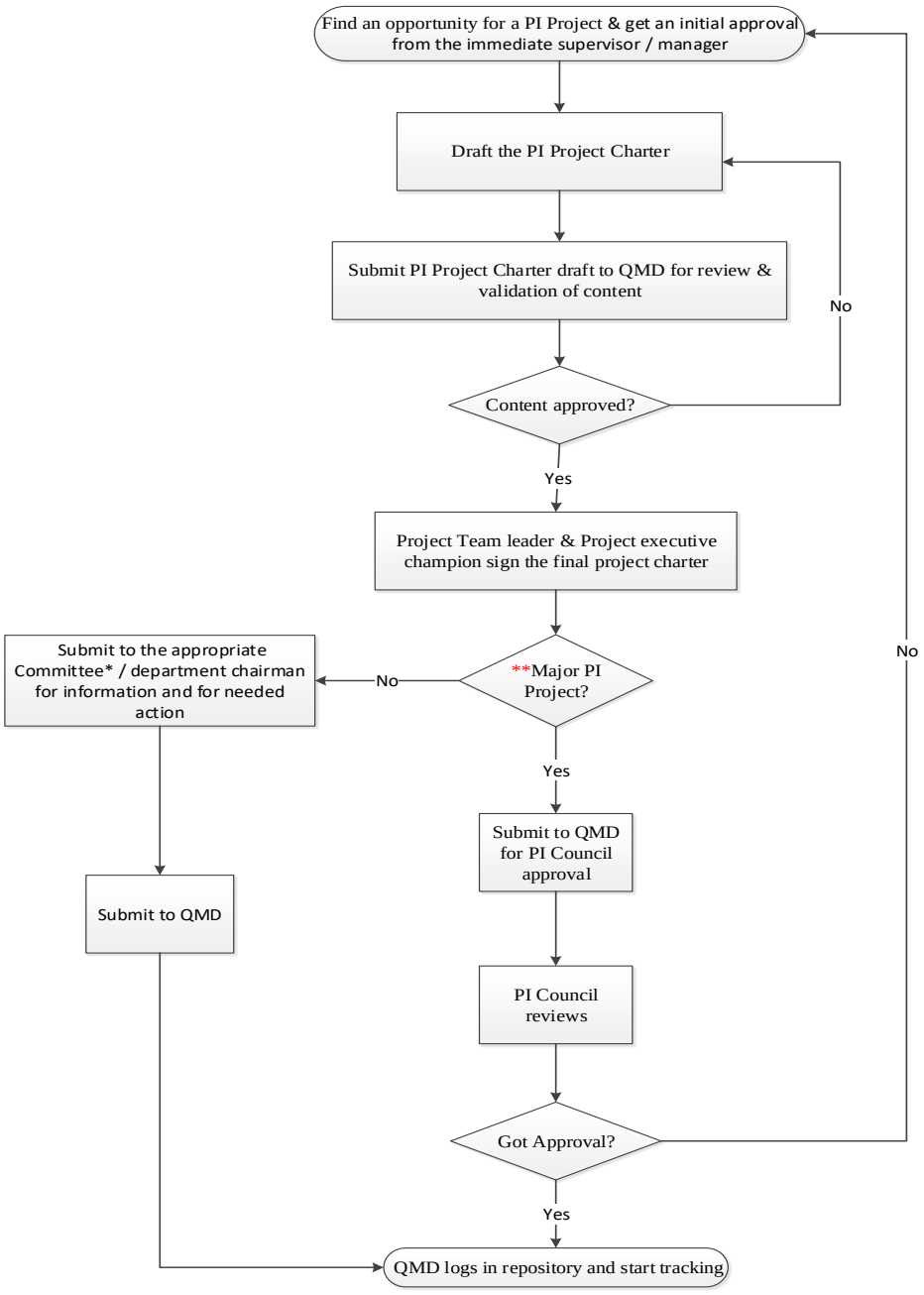
The following are examples of specific roles and responsibilities of QMD related to the PI Plan:

- Facilitate the development of PI indicators/measures Performance Improvement Projects, and Clinical Pathways by trained Local Quality/Safety/PI representatives.
- Provide consultation and coaching on PI issues
- Assist in data management
- Train staff in the use of KFSH&RC's standardized PI framework and method (I.A.C.T.), PI principles, tools, and methodologies
- Develop an organization-wide educational program for PI
- Facilitate the implementation of Lean, Six Sigma, and other PI tools throughout the Organization using KFSH&RC's standardized PI framework and method (I.A.C.T.)

QUALITY MANAGEMENT COMMITTEES ROLE

- Facilitate Group/Division/Department quality related activities (PI, Patient Safety, Risk Management Accreditation, and Hospital Safety) directly and through trained local representatives. (I.e. Coach, Champion, etc.)
- Facilitate the development and monitoring of Group/Division/Department quality indicators
- Provide follow-up and coaching on quality related issues
- Promote awareness of activities and data as approved by the PIC
- In collaboration with QMD, provide education on PI tools and data management as needed
- Conduct at least one (1) departmental/divisional PI project annually
- Submit a quarterly report to the PIC related to issues identified pertaining to their progress in achieving the goals of their PI Projects, if any
- Submit an annual report to PIC and QMD

PI Project Approval Process Flow



***Appropriate Committees:**

- **Nursing Quality Management Committee**
- **Medical Quality Management Committee (MQMC)**
- **Managerial Quality Management Committee**
- **Allied Health Quality Management Committee**
- **Hospital Mortality & Morbidity Committee (M&M)**
- **Hospital Safety Committee**
- **Patient Safety and Risk Management Committee**
- **Accreditation Committee**
- **Trainee Quality Management Committee**

****Major:**
Projects requiring resources beyond department / division control including hospital wide projects

PERFORMANCE IMPROVEMENT (PI) PROJECT SELECTION

- Aligned with the Hospital's Vision, Mission, Values and Strategic Plan
- Priorities set by the Quality Board of Directors committee and the Performance Improvement Council including strategic priorities
- Supports the needs and expectations of customers: patients, families, employees and other concerned parties
- The best available practice that is evidence-based
- Incidents/Risks identified through Quality Information System (QIS)
- Performance issues related to:
  - **Problem-prone**
  - **High-volume**
  - **High-risk**
  - **High-cost**
- Accreditation requirement

CONSIDERATIONS FOR PERFORMANCE IMPROVEMENT PROJECTS

- The resources required for implementing the improvement
- The time required to complete the improvement project
- The cost-effectiveness of the project

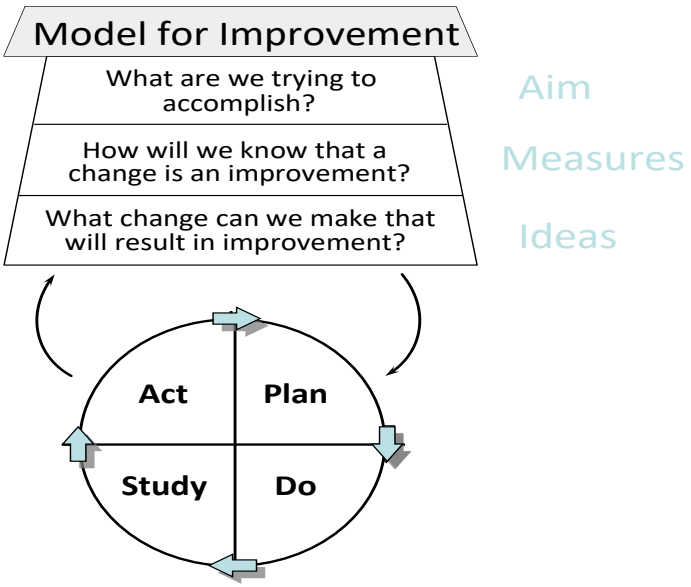
PERFORMANCE IMROVEMENT METHODOLOGIES

Performance Improvement methodologies share the same systematic approach of planning, measuring and improving. KFSH&RC (Gen. Org.) will adopt the Institute of Healthcare Improvement (IHI) model, FOCUS-PDCA, Lean Principle, Six-Sigma's DMAIC, 100 Day's Challenge/Improvement (Rapid Cycle Improvement), Change Management theory, and other quality improvement methodologies. Due to the shared systematic approach, KFSH&RC (Gen. Org.) will combine the evidence based methodologies into **one standardized framework**, methodology, and approach for all improvement work. This singular framework and methodology will be called **I.A.C.T.**

There are several quality tools that help in understanding the various processes and steps of improvement work within the I.A.C.T. Framework and model. A detailed description of the PI methodologies and quality tools are given through education. For any PI project, a PI charter and PI Project progress documentation should be filled and submitted for review to QMD (Appendix A).

PI METHODOLOGIES

I. IHI MODEL



II. FOCUS -PDCA

STEPS TO IDENTIFY AND DEFINE PI OPPROTUNITIES - FOCUS	
F	**Find – an opportunity for improvement** Find a process that needs improvement. Define the process and its customers. Decide who will benefit from the improvement. Understand how the process fits within the Hospital's system and priorities.
O	**Organize – a team** Select a team that is knowledgeable in the process. Determine team size, members who represent various levels in the Organization, select members, and prepare to document their progress. Members should be the owner of the process, who know and own the process.
C	**Clarify – the current process** Clarify the current knowledge of the process. Define the process as it is and as it should be. The team reviews current knowledge and then must understand the process to be able to analyze it and differentiate the way it actually works and the way it is meant to work.
U	**Understand – the source of the process variation and the problem** Understand the causes of variation. The team will measure the process and learn the causes of variation. They will then formulate a plan for data collection, collecting the data, using the information to establish specific, measurable, and controllable variations.
S	**Select – the improvement** Select the potential process improvement. Determine the action that needs to be taken to improve the process (must be supported by documented evidence.)

PDCA

The P-D-C-A phase allows the team to pursue that opportunity and review its outcome.	
P	**Plan – the improvement** Plan the improvement/data collection. Plan the change by studying the process, deciding what could improve it, and identifying data to help.
D	**Do – the improvement** Do the improvement/data collection/data analysis. Execute the plan on a small scale or by simulation
C	**Check – the results** Check the data for process improvement. Observe the results of the change. Document the results of the change. Modify the change, if necessary and possible.
A	**Act – to hold the gain** Act to hold the gain/continue improvement. Implement the change if it is working. If it fails, abandon the plan and repeat the cycle

III. LEAN PRINCIPLES

The Five (5) Steps of Lean	
Specify Value	Identify a specific service that meets the customer's needs at a specific time and a specific price or cost (e.g. improve the travel process, patient-focused)
Identify the Value Stream	The value stream is a set of all specific actions necessary to produce a specific service. Identify and categorize every step in the producing of a service. Identify and eliminate waste (non-value-added activities) in the process from the customer perspective.
Flow	Provide the service from the beginning to the end without delay or interruption that is without waste. Flow is horizontal (e.g. provide patient care to each patient before moving to the next patient). Techniques of flow: • Standardization • TAKT time • Work balance • Visual Control: 5S (Sort, Shine, Set, Standardize, and Sustain)
Pull	The service is provided to the customer whenever needed. Fulfilling customer demand within the customer's timetable.
Perfection	To make a given process leaner by eliminating even more and more waste.

IV. 100 DAYS CHALLENGE/RAPID IMPROVEMENT CYCLE

This process is designed by Institute for Healthcare Improvement (IHI) to provide a reliable and efficient way to research innovative ideas, assess their potential for advancing quality and safety in healthcare, and bring them to action. Projects are selected by senior leaders and are based on both Hospital's strategic plan and needs. 100 Day's Challenges Cycles/Projects are aligned by the calendar year quarters (January to March, April to June, July to September, and October to December).

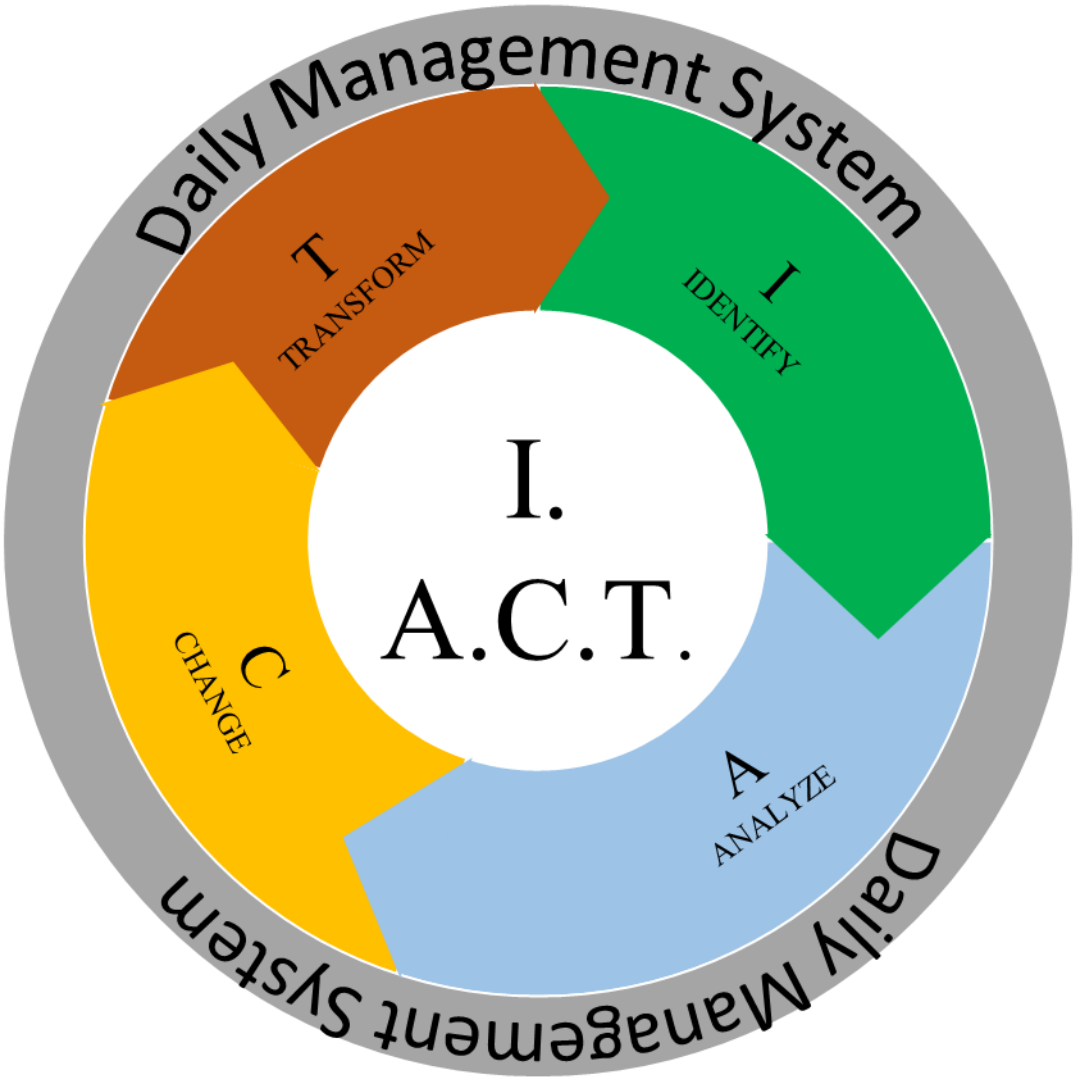
For each 100-Day Challenge Project, the Project Team works together on three (3) distinct phases of work:

- **Phase 1 (Scan):** The initial thirty (30) days of the project are spent scanning the literature and conducting a brainstorming inquiry with key experts and stakeholders pertinent to the selected

project. At the end of the first week, a complete project charter is produced, including the intent and aim of the project and expected deliverables. By the end of the first thirty (30) days, a description of the current process, a set of improvement/deliverables are selected.

- **Phase 2 (Focus):** The subsequent thirty (30) to forty-five (45) days are focused on improvement piloting and testing at the point-of-care and refining ideas about what actually works.
- **Phase 3 (Summarize and Disseminate):** The final fifteen (15) to thirty (30) days of a 100 Day's Challenge/Cycle is used to complete the validation of improvement developed and to prepare a final summary of what was learned and developed during the cycle.

V. I.A.C.T. FRAMEWORK AND MODEL (KFSH&RC's STANDARDIZED IMPROVEMENT WORK MODEL)



I.A.C.T. Phases:

Phase	Sub Phase	Description and Action needed	Evidence
Identify	Opportunity	1) Identify the problem you want to fix or opportunity to improve 2) Develop your project problem statement 3) Seek approval from your direct leadership	FOCUS-PDCA
	Team	4) Identify the project team members.	FOCUS-PDCA
	Baseline	5) Create a "Flow Chart" of the current process (Not the intended planned/practice/policy) 6) Do a Value Stream Map (VSM) and identify the pain points	LEAN (VSM)
		7) Collect and track the baseline data i.e. measure the problem only	Six Sigma (DMAIC)
	SMART Aim	8) Develop your project SMART Aim Statement	IHI
Analyze	Cause Analysis	9) Brainstorm with your team on possible causes (not solutions) of the problem. 10) Prioritize with your team the problem causes by using multi-voting technique	FOCUS-PDCA
		11) Identify with your team the "Root Causes" of the above prioritized causes using the 5-Whys techniques	IHI
	Drivers Diagram	12) Develop the "Key Drivers Diagram":	IHI
	Data Plan	13) Develop a "Data Collection Plan" 14) Define Indicators (outcome, process & balance KPIs) and fill the Indicator Definition Form 15) Do Data Validation if needed	Six Sigma (DMAIC)
Change	Test & Implement	16) Implement each identified interventions from the Drive Driver using one or more of the following tools a. Plan Do Study Act (PDSA) cycles b. 5S Model c. Rapid Improvement Event d. Just Do IT	FOCUS-PDCA + IHI + Six Sigma (DMAIC) + LEAN
	Monitor & Support	17) Monitor the identified measures: a. Establish the "Daily Huddle Board" b. Do Gemba Walk c. Apply Basic Statistics & Graphical Tools	Six Sigma (DMAIC) Lean
Transform	Sustainability	18) Create sustainability plan a. Implement Standard Work b. Mistake Proofing	Change Manag.

	Closeout	19) Close the "Improvement work" and share learnings and celebrate success.	IHI

DAILY MANAGEMENT SYSTEM

Daily Management system is part of visual management; It is a reminder for each group/ division/ department/ section/ unit to identify the status of its individual performance with respect to Quality, Safety, Risk, and Performance Improvement work on a daily basis.

PERFORMANCE IMPROVEMENT (INDICATORS)

Performance Measurement is the process of regularly assessing the results produced by the healthcare delivery systems. It involves identifying the structure, process and outcome that is integral to the performance of the clinical and managerial areas. Indicators might be strategic, Quality, KPI, Operational, Core Measure, etc.

- Selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis allows actions to be undertaken as needed based on data analysis results and the identified performance improvement opportunities.
- QMD shall provide assistance in selecting and defining performance measures, when needed. The performance measurement owner/stakeholder would be responsible for follow-up and monitoring of their specific performance measurements, and in case of additional support, the escalation flowchart should be followed (Appendix B).

KEY PERFORMANCE MEASURES/INDICATORS SELECTION:

Key Performance Indicators (KPIs) are measures that help KFSH&RC (Gen. Org.) management to direct the use of their Organization's resources, maximize patient safety, promote clinical best practices, and increase patient satisfaction. End-users will define the KPIs based on their requirements. PIC whose members represent key personnel in the Organization approves the selected KPIs.

Group/Division/Department should select their indictor/measure based on:

- Mission, Vision, strategic goals and available resources
- Monitoring important group/division/department function over time
- Needs, expectations, and feedback of customers
- High-risk, high-volume, problem-prone processes or targeted areas of study
- Performance Measures or feedback related to Accreditation, Patient Safety, Risk Management or Governmental requirements
- Best available evidence
- Incident Reports
- Morbidity & Mortality data

Measures Selection:

- Selected Performance Indicators shall be unified along with the group/division/department counterpart in Riyadh/Jeddah/Madinah as much as possible.
- Group/Division/Department Performance Indicators will be approved by the appropriate management level.
- The Performance Indicators are reviewed, by the author, on an annual/frequent basis to consider their continued usefulness to the Organization or opportunity to use an improved measure.
- The frequency of measurement depends on the specific structure, process or outcome as well as the purpose. It can occur at one point in time or be repeated overtime.

- Performance indicators should include a comparison of actual performance data with a benchmark, previous validated data/formula for calculating measure, an aggregated rate overtime, or another equally significant signal.
- Performance Indicators data must be translated into useful information.
- Each Performance Indicator shall have a graphical presentation of comparison data that compares actual performance or change over time to the mean/trigger and could include both upper and lower control limits.
- Results are shared with accountable group/division/department/section/unit for action development.
- Action should be taken and documented in response to the indicator which falls outside the limits.
- Group/Division/Department Indicators reports should be disseminated through the Group/Division/Department on a regular basis (quarterly, bi-annually, annually, etc.) also to Quality Management Department and others as requested.
- KFSH&RC (Gen. Org) must use the Performance Indicators' information to draw conclusions about performance and to make judgments and drive change.
  All selected indicators should be documented by using the Indicator Definition form found in the APP: "Data Service Request process APP-45".
  Please refer to Appendix B for the Indicator Escalation Process Flow

CLINICAL PATHWAYS (CP) & CLINICAL PRACTICE GUIDELINES (CPG)

CP/CPG are effective tools to ensure:

- Standardizing clinical care process
- Reducing risks within care processes
- Providing clinical care in a timely and effective manner using available resources efficiently
- Consistently delivering high-quality care using evidence-based practices

Quality Management Department's role is to work closely with departments or services CP/CPG champions to explore the possibility of new CP/CPG as relevant to the department or the service and facilitate its development depending on their priorities. Department service leaders shall demonstrate how the use of the selected CP/CPG has reduced variation in processes and outcomes. In addition, QMD will be working closely with Healthcare Informatics & Technology Affairs (HITA) and medical departments to select order-set from ProVation Library that is applicable to the active CP/CPG. [ProVation: is a software in the Hospital Information System ICIS that have to Order Sets powered by an "Up-to-Date" Decision Support database that improves patient outcomes and quality of care by providing evidence-based order set templates].

DATA MANAGEMENT COORDINATOR(S)

The Data Management Coordinator provides support to QMD in the development and management of all data operations and projects. The support includes collecting, aggregating, analyzing, interpreting, reconciling and validating data, systems or databases developed or coordinated by QMD. In addition, Data Management Coordinator(s) support different types of performance measures/indicators development, updates and follow-up.

SCOPE OF DATA MANAGEMENT

- Support the design, documentation, testing, validation and implementation of systems and software
- Liaise with other sections' specialists to ensure consistency of data management approach
- Oversee the design of data collection

- Provide required support for the analysis, technical validation and display of the data
- Organizes, assesses and monitors all Quality Management Department reporting processes
- Participate in the development and analysis of the Performance Measurement (Indicators) and Performance Scorecards.
- Collaborate with Healthcare Information Technology Affairs (HITA) to produce dynamic reports, dashboards and scorecards for Quality Management Department whenever possible.
- Collaborate with the Performance Scorecard Specialist to update the performance scorecard regularly.
- Provide education and training related to data management.
- Design, deploy, analyze and report Hospital-wide surveys and departmental focus surveys.

DATA WAREHOUSE

The Data Warehouse provides improved access to information and facilitates a Performance Management System for KFSH&RC (Gen. Org.). It is a central repository for selected data from several systems throughout the healthcare enterprise. Data Warehouse takes the volume of data that KFSH&RC (Gen. Org.) collects and stores, and turns it into meaningful reports and analysis that everyone in the Organization can use.

With accessible reports and analysis, KFSH&RC (Gen. Org.) can see results across departments and drill down based on a secure hierarchy to discover underlying causes and understand the "Why" behind its business performance. With timely reports and self-service reporting on KFSH&RC (Gen. Org.) key business drivers, changes are seen when they happen and the right decisions can be made at the right time.

INTERNATIONAL PATIENT SAFETY GOALS (IPSG) SCORECARD

International Patient Safety Goals (IPSG) help accredited Organizations address specific areas of concern in some of the most problematic areas of patient safety. There are currently six (6) goals highlighted by Joint Commission International (JCI) and they are;
Goal 1: Identify patients correctly
Goal 2: Improve effective communication
Goal 3: Improve the safety of high-alert medications
Goal 4: Ensure safe surgery
Goal 5: Reduce the risk of healthcare-associated infections
Goal 6: Reduce the risk of patient harm resulting from falls

QMD along with the Patient Safety Committee and departmental stakeholder, developed indicators for each goal and are tasked to monitor, measure, and provide recommendations to departments responsible for the indicator outcome of each goal on a quarterly basis.

DATA VALIDATION

Data validation is an important tool for understanding the quality of the data and for establishing the level of confidence decision makers can have in the data.

Data validation becomes one of the steps in the process of setting priorities for measurement, selecting what is to be measured, selecting and testing the measure, collecting the data, validating the data, and using the data for improvement (APP-120: “Validation and Publication of Data”).

Data must be validated when:

- The new measure is implemented
- Data will be made public on the Organization's web site or in other ways
- Change has been made to an existing measure
- The data resulting from an existing measure have changed in an unexplainable way
- The data source has changed
- The subject of the data collection has changed

EDUCATION

QMD provides education to all staff to facilitate the understanding of concepts and application of Performance measurement, PI tools and methodologies. Staff should have regular opportunities to participate in PI projects.

All staff are introduced to basic PI concepts, objectives and methodologies during new employee orientation, department staff meetings, through Nursing, Medical, Managerial & Allied Health Quality Management Committees, through Hospital publications, and specific training such as online PI modules available on iLearn, Basic PI Workshop, Advanced PI Workshops, Lean Workshop, and RPI coach certification.

CONFIDENTIALITY

Quality data and information are confidentially maintained in accordance with the guidelines in the Employee Relation Manual (ERM), Effective 09 Ramadan 1436 (June 2017). The ERM states in page #2 of "employee conduct, responsibilities, and disciplinary procedures - Chapter V-2" item 2.11: "Refrain from disclosure or dissemination of information in any manner, concerning job related matters and/or Hospital operations, without prior authorization." and APP- 42 "Confidentiality Policy", effective 24 Dhu Al Qada 1438 (16 August 2017) and Confidentiality Statement GD: 095-1432.

QMD data is password secured in a specific server. The Director of Quality Management Department or his /her designee determines access to this server.

PERFORMANCE IMPROVEMENT PLAN EVALUATION AND REVISION:

The Performance Improvement Council (PIC) will evaluate the plan based on the council annual report and revise it annually or earlier, if deemed necessary.

APPENDIX A: I.A.C.T. CHARTER

KFSH&RC's Robust Process Improvement
I.A.C.T. Charter

Identify

Improvement Project Name:	Strategic Objective (select one):	Department
Click or tap here to enter text.	Strategic Objective SO1	Click or tap here to enter text.

Project Status	Improvement Site:	Project Start Date	Project End Date
Choose an item.	Choose an item.	Enter Start date	Enter End Date

Executive Sponsor	Team Lead	RPI Coach
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Problem: *Why is this project needed?*
State: 1) The Ideal, 2) The Reality, 3) The Consequences, 4) The Proposal.

Quality Domain: Which Healthcare Quality Domain does this project support:
Choose an item.

Baseline (Flow): Map the current process/ problem (Value Stream Mapping (VSM), Timeline, Flow diagram, etc.)
(Create a flow chart and determined value for each step of the process: This will help better understand the Gap from expected performance)

Baseline (Data): Determine the baseline of the problem that has been identified *(Write down the last data points captured)*
Click or tap here to enter text.

Benefit/Impact: What is the main impact/Benefit?
(Please check only one)

- ☐ Contained or reduced costs; Indicate amount----------
- ☐ Improved productivity
- ☐ Improved work process
- ☐ Improved cycle time
- ☐ Increased customer satisfaction
- ☐ Other (please explain)

Click or tap here to enter text.

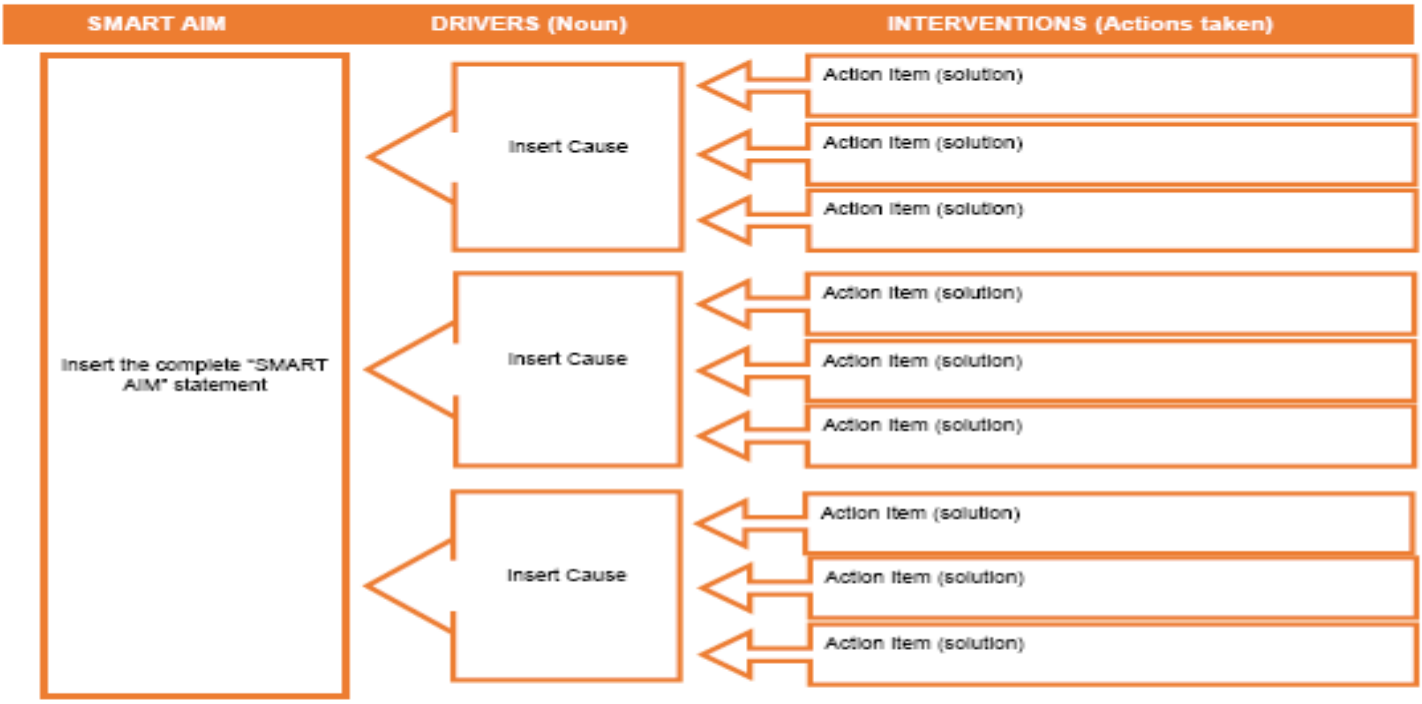
SMART Aim statement: What will the project achieve?
(3-4 words each)

1. What will the project increase or decrease?
   a. Click or tap here to enter text.
2. What is the Group or population affected?
   a. Click or tap here to enter text.
3. Baseline (From what) and goal (To what)?
   a. Click or tap here to enter text.
4. What is the time frame (By when (Date) & sustain)?
   a. Click or tap here to enter text.

KFSH&RC's Robust Process Improvement
I.A.C.T. Charter

Analyze

Drivers Diagram: Brainstorm the possible root causes and solutions to the problem; organize and distribute as needed:
(Drivers are written to start with a 'noun' and are derived from the causes | Interventions are written to start with a verb and are solutions to the cause



Change

Data Management Plan: What are the measures to ensure the improvement is moving in the right direction?

Outcome Measures: (only one) *(The measure that highlights the main problem; i.e. baseline)*	Target/Goal
1. Click or tap here to enter text.	1. Click or tap here to enter text.
Process Measures: (measure for each driver) *(The measure that highlights the drivers and interventions)*	**Target/Goal**
1. Click or tap here to enter text. 2. Click or tap here to enter text. 3. Click or tap here to enter text.	1. Click or tap here to enter text. 2. Click or tap here to enter text. 3. Click or tap here to enter text.
Balance Measures: *(The counter-measure of the outcome measure; i.e. indirect measure)*	**Target/Goal**
1. Click or tap here to enter text.	1. Click or tap here to enter text.

Transform

Results: Insert relevant graphs and charts to illustrate improvement over time.
(Insert relevant graphs, data, charts, etc. | Include the baseline and final outcome measure | Include at least one process and balance measure)

Monitoring methods *(monitoring method to ensure the improvement work is fixed)*	**Sustainment plan** *(How will the work continue to be governed? What is the plan if outcome measure returns?)*
☐ New developed indicator (please specify KPI title) Click or tap here to enter text. ☐ Tracking on the local 'Daily Huddle Board' ☐ Other (please Specify Click or tap here to enter text.	Click or tap here to enter text.
Lessons learned *(lessons learned that others can benefit from this type of project)*	**Team members** *(Please specify team members)*
1. Click or tap here to enter text. 2. Click or tap here to enter text. 3. Click or tap here to enter text. 4. Click or tap here to enter text. 5. Click or tap here to enter text. 6. Click or tap here to enter text.	1. Click or tap here to enter text. 2. Click or tap here to enter text. 3. Click or tap here to enter text. 4. Click or tap here to enter text. 5. Click or tap here to enter text. 6. Click or tap here to enter text.

Note: When starting new project, please complete page 1 (The Identification phase) then e-mail it to: PIQMDR@kfshrc.edu.sa

Thank You

Just-Do-It Form

Intervention Title: .....

Lead Name: ..... Date: .....

Step 1. What are you trying to achieve:

Current **practice**
Current Problem / situation in two words
.....
.....

Targeted Practice
Enter target practice
.....
.....

Step 2. Classify the root cause (reason) of the gap using 5 whys:

What is the: Problem/issue/ Pain point?

Why? .....

Why? .....

Why? .....

Why? .....

Root cause
.....

Step 3. Choose the solution to solve the most common reason/ cause:

Actions	Involved Person	Time Frame
List all actions taken to solve the problem (one action per bullet)	*List the assigned person for each action*	*List the estimated time frame for each action*
•	•	• .....
•	•	• .....
•	•	• .....
•	•	• .....
•	•	• .....

Step 4. List the lessons learned and the standard work to prevent reoccurrence

Lessons Learned	Standard Work
List the impact of this improvement and how it might affect other sections /units/departments	*Education and monitor any incident complaint related to*
•	• .....
•	• .....
•	• .....
•	• .....
•	• .....

Note: Please complete the form then e-mail it to: PIQMDR@kfshrc.edu.sa ... **Thank you.**

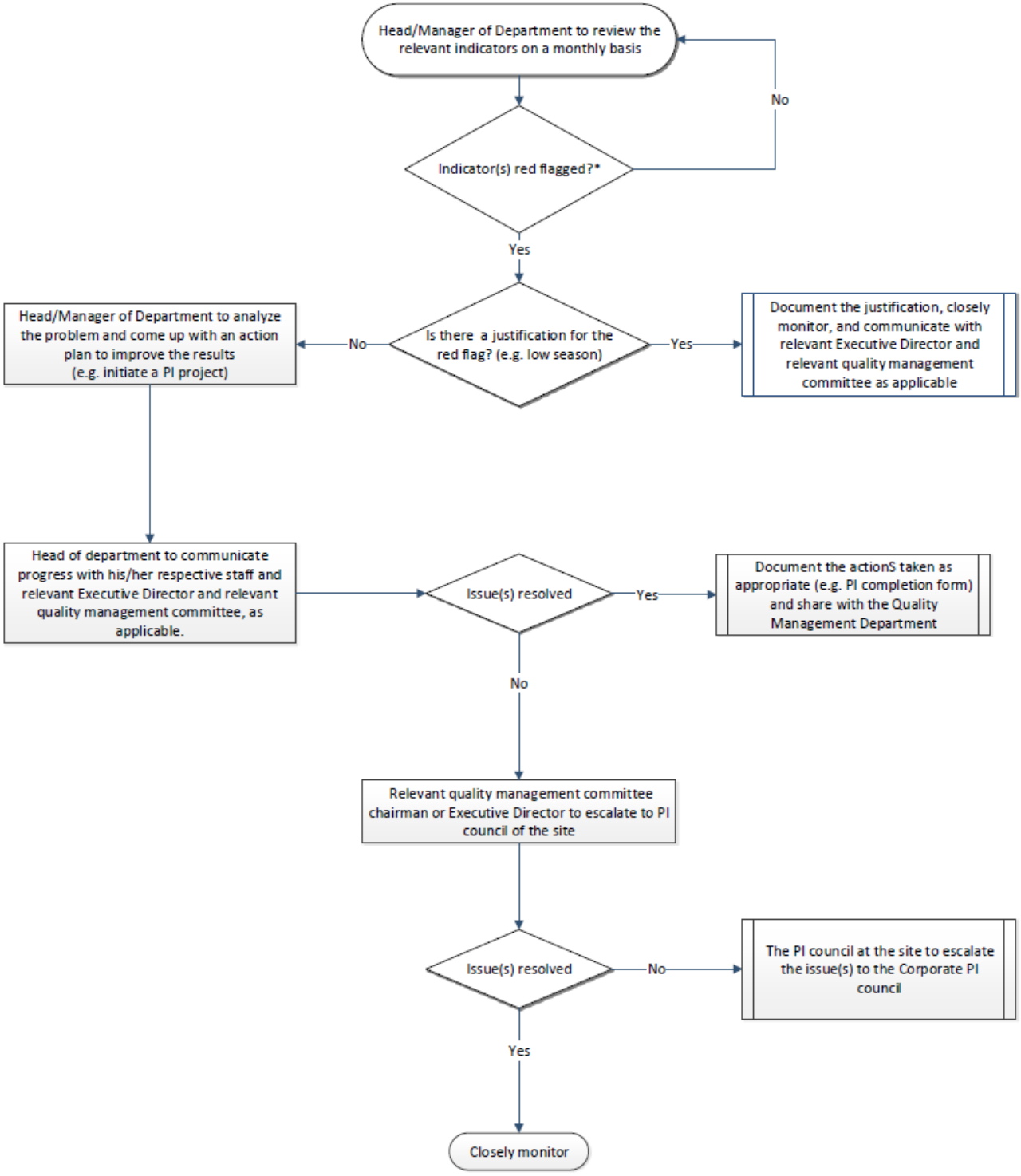
PROJECT PROGRESS DOCUMENTATION FORM

Project Title:
Team Leader:
Department:

PDCA	Actions/Tasks	Timeframe	Status
PLAN • *Plan your improvement, assign tasks to members with the timeframe* • *Plan your data collection*			
DO • *Implement your actions* • *Collect your data* • *Educate and train*			
CHECK • *Compare your results with the baseline data* • *Monitor your change consequences*			
ACT • *If the outcome is achieved, implement and maintain your improved actions* • *If the outcome is not achieved, restart the PDCA cycle with new actions*			

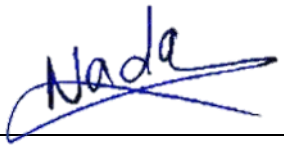
Attachments:
Quality tools used (example: Fishbone diagram, Pareto, Process map, 5 S model etc…)
Baseline and implementation Data report (example Run chart, Control Chart, Pie, etc….)

APPENDIX B: **INDICATOR ESCALATION PROCESS FLOW**



Synopsis of the Changes (2019)
Remove the NDNQI Nursing Indicators, the Performance Score Card
Update the RPI checklist and the plan's signatory approval
Add the new RPI_I.A.C.T. Charter
Add Just-Do –It Form

PERFORMANCE IMPROVEMENT PLAN APPROVAL

Reviewed by:  **Date:** 7 January 2021

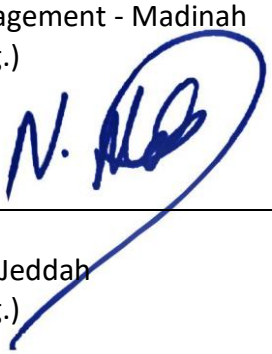
Nada Alharbi
Director, Quality Management Department - Riyadh
KFSH&RC (Gen. Org.)

Date: 7 January 2021

Shorouq Zakariya
Director, Quality Management Department - Jeddah
KFSH&RC (Gen. Org.)

Date: 10 January 2021

Fadwa Abu Mostafa
Head, Quality Management - Madinah
KFSH&RC (Gen. Org.)

Recommended by:  **Date:** 20 January 2021

Dr. Nasser Mahdi
General Manager - Jeddah
KFSH&RC (Gen. Org.)

Date: 20 January 2021

Dr. Nezar Khalifah
General Manager - Madinah
KFSH&RC (Gen. Org.)

Date: 21 January 2021

Dr. Eyad Althenayan
Chief Quality Officer, Quality Management
KFSH&RC (Gen. Org.)

PERFORMANCE IMPROVEMENT PLAN APPROVAL

Recommended by: _____ **Date:** 24 January 2021

Dr. Mohammed Alotaibi
Deputy Chief Executive Officer – Healthcare Delivery
KFSH&RC (Gen. Org.)

Approved by: _____ **Date:** 24 January 2021

Dr. Yaseen Mallawi
Acting Chief Executive Officer – Healthcare Delivery
KFSH&RC (Gen. Org.)