مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre
Gen. Org. مؤسسة عامة

Quality and Safety Management Plan (QSMP)

RECOMMENDED: _____ Date: Jan 4th 2021

Majid Al Fayyadh, MD, MMM
Chief Executive Officer
Secretary General of Board of Directors
KFSH&RC (Gen. Org.)

APPROVED: _____ Date: 14 FEB 2021

H.E. Fahd Al-Rasheed
Chairman, Board of Directors
KFSH&RC (Gen. Org.)

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ABBREVIATIONS

QMD	Quality Management Department
CQO	Chief Quality Officer
CMO	Chief Medical Officer
EDNA	Executive Director Nursing Affairs
EDSC	Executive Director Supply Chain
MD- ICHE	Medical Director – Infection Control and Hospital Epidemiology
D-PC	Director, Pharmaceutical Care
D-EO	Director, Experience Office
BOD	Board of Directors

Overview:

King Faisal Specialist Hospital and Research Centre (KFSH&RC) (Gen. Org.) mission is "to serve society with the highest level of healthcare in an integrated education and research settings that ensures the best patient experience" (Appendix: **A**). With our journey towards becoming a High Reliability Organization (HRO) with the aim to reach Zero Preventable Harm, this brings even more focus on quality improvement and providing safe patient care. Our 2021 Quality and Safety Management Plan (QSMP) continues to support our Strategic Objective SO1 to "create a world class customer experience, quality and safety to our patients" and Strategic Program SP 1.2 "Develop & Execute Relevant Interventions to Ensure Safety & Zero Harm"

In determining our annual QPS priorities we ensure that we align with the National Quality Strategy in Saudi Arabia and Accreditation and Regulation authorities' standards and regulations. The other key framework that informed our plan is our Safety and Reliability Roadmap (Appendix **C**) and the Patient Safety Towards Excellence Framework (Appendix **E**)

PURPOSE:

The intent of the Quality and Safety Management Plan (QSMP) is to provide the framework that will contribute to achieving our vision of "being the specialized healthcare provider of choice" (Appendix: A). The plan outlines the governance, goals and strategies to achieve delivering high quality and safe healthcare. Embedding the journey to be a high reliability organization as a road map to better healthcare outcomes. The plan scope applies to Riyadh, Jeddah and Madinah branches.

There are three (3) subsidiary plans that highlight and describe the components of the QSMP as following:

1. Patient Safety and Risk Management Plan
2. Performance Improvement Plan
3. Accreditation Plan

Additionally, the Environment of Care Safety plan defines the mechanism of the interaction and governance for the nine (9) Hospital Safety Plans (Appendix **F**).

The Quality Management Department (QMD) is responsible for coordinating the implementation of QSMP and other Hospital Quality Plans with the Hospital multidisciplinary committees/teams through:

- Establishment of policies and procedures and best practices that promote compliance with national and international quality and safety standards
- Engagement and support of leadership and staff in quality and safety activities to achieve optimal patient outcomes and patient and family experience
- Incorporation of Performance Improvement (PI), Patient Safety, Risk Management, Accreditation and Facility Safety activities into daily practices
- Achievement of Zero Harm and safety culture through implementing Safety and Reliability best practices and supporting the hospital journey to be a High Reliability Organization (HRO) with emphasis on leadership methods, process improvement interventions and individual interventions. (Appendix **D**)

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- Influencing evidence-based error prevention universal behaviors and skills, and providing methods and best practice tools for effective high reliability leadership that can dramatically reduce individual errors, and thereby reduce events of patient harm
- Promotion of employee safety practices
- Utilization of data-driven decision making through the adoption of measurement tools including scorecards and dashboards for the design or redesign of the processes with the aim of improving safety, efficiency, and patient experience
- Promotion of the principles of a "Learning Organization" through presenting and providing training and education on quality and safety across the organization
- Monitoring and providing feedback to concerned departments about quality and safety related matters
- Supporting oversight and monitoring of contracted clinical and non-clinical services with the aim of ensuring compliance with accreditation standards and quality and safety services delivery
- Recognition of distinguished quality and safety related projects, activities and initiatives
- Promotion of patients and families' engagement to improve patient care outcomes and prevent harm

QUALITY AND SAFETY FRAMEWORK:

KFSHRC will consider the following six dimensions of quality as the guiding quality framework for the organization. The six dimensions will focus on efficiency without ignoring safety and pay attention to effectiveness without neglecting accessibility.

- **Accessibility:** The ability of patients/clients to obtain care/services at the right place and the right time, based on respective needs, in the official language of their choice
- **Appropriateness:** Care/services provided are relevant to the patients'/clients' needs and based on established standards
- **Effectiveness:** Care/services, interventions and actions achieve the desired results
- **Efficiency:** Achieving the desired results with the most cost-effective use of resources
- **Safety:** Potential risks of interventions and the environment are avoided or minimized
- **Patient Experience:** defined as the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care (Reference: https://www.theberylinstitute.org/page/DefiningPatientExp (Appendix: B)

QUALITY AND SAFETY PRIORITY GOALS:

Strategic Objective	Quality Dimensions	SEQ	Priority Goals	Target	Accountability
S01	Safety	P1	Reduce Preventable harm & achieve High Reliability Organization (HRO)	↓ 30%	All Executives & CQO
		P2	Reduce Hospital Acquired Pressure Injury Stage II and Above in all Inpatient Populations	↓ 40%	Quality Aim

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		P3	Reduce Falls with Injury	↓ **40%**	Quality Aim
		Reduce Hospital Acquired Infection			
		P4	Reduce Surgical Site Infections (SSI)	**Below the hospital NHSN pooled mean (2.5)**	All Executives, MD- ICHE & CQO
			Reduce Hospital Acquired Central Lines Associated Blood Stream Infections (CLABSI)	**Below the hospital NHSN pooled mean (1.1)**	
			Reduce Catheter Associated Urinary Tract Infection (CAUTI) (New)	**Below the hospital NHSN pooled mean (2)**	
S01	**Safety**	**P5**	Reduce Medication Prescribing Errors (New)	↓ **20%**	CMO & CQO
		P6	Reduce the Number of Hospital Acquired Venous Thromboembolism (VTE) cases	↓ **40%**	Quality Aim
Strategic Objective	**Quality Dimensions**	**SEQ**	**Composite Priority Goal** / **Priority Goals**	**Target**	**Accountability**
S01	**Patient Experience**	**P7**	**Improve Patient Experience**		
			Overall hospital rating (HCAHPS)	**77.8**	D-EO, EDNA & CMO
			Inpatient pediatrics experience	**87.7**	
			Outpatient experience	**88.2**	
			Emergency room experience	**75.4**	
			Ambulatory surgery care experience	**91.2**	
			Dental services experience	**91**	
			Oncology Outpatient Experience	**87.6**	

Strategic Objective	Quality Dimensions	SEQ	Composite Priority Goal	Priority Goals	Target	Accountability
S01 & S02	Accessibility	P8	Reduce Emergency Department Boarding Time		8 hours	CMO
		P9	Reduce ER waiting time to be seen (Category 3 patients)		50 min	CMO
		P10	Reduce Referral to decision waiting time "hr.		24 hours	CMO
		P11	Increase NP first encounter < 2 weeks		80%	CMO
Strategic Objective	**Quality Dimensions**	**SEQ**	**Composite Priority Goal**	**Priority Goals**	**Target**	**Accountability**
S01	Appropriateness (to add the new KPIs)	P12	Increase the number of active Clinical Pathways		20%	CMO & CQO
		Appropriate Antimicrobial Use				
		P13	Antimicrobial prescribing in accordance with guidelines		60%	Head of Antimicrobial Stewardship Program
			Documentation of Indication		60%	
			Proper Dosing		95%	
			Restricted antimicrobial agents compliant with guidelines		80%	
Strategic Objective	**Quality Dimensions**	**SEQ**	**Composite Priority Goal**	**Priority Goals**	**Target**	**Accountability**
S01 & SO3	Effectiveness	P14	**Improve Transplant Quality Index**			
			1-year graft survival rate for living donor liver transplants for adults		86%	CMO
			1-year graft survival rate for living donor liver transplants for pediatrics		98%	
			1-year graft survival rate for living donor kidney transplants for adults		98%	
			1-year graft survival rate for living donor kidney transplants for pediatrics		98%	

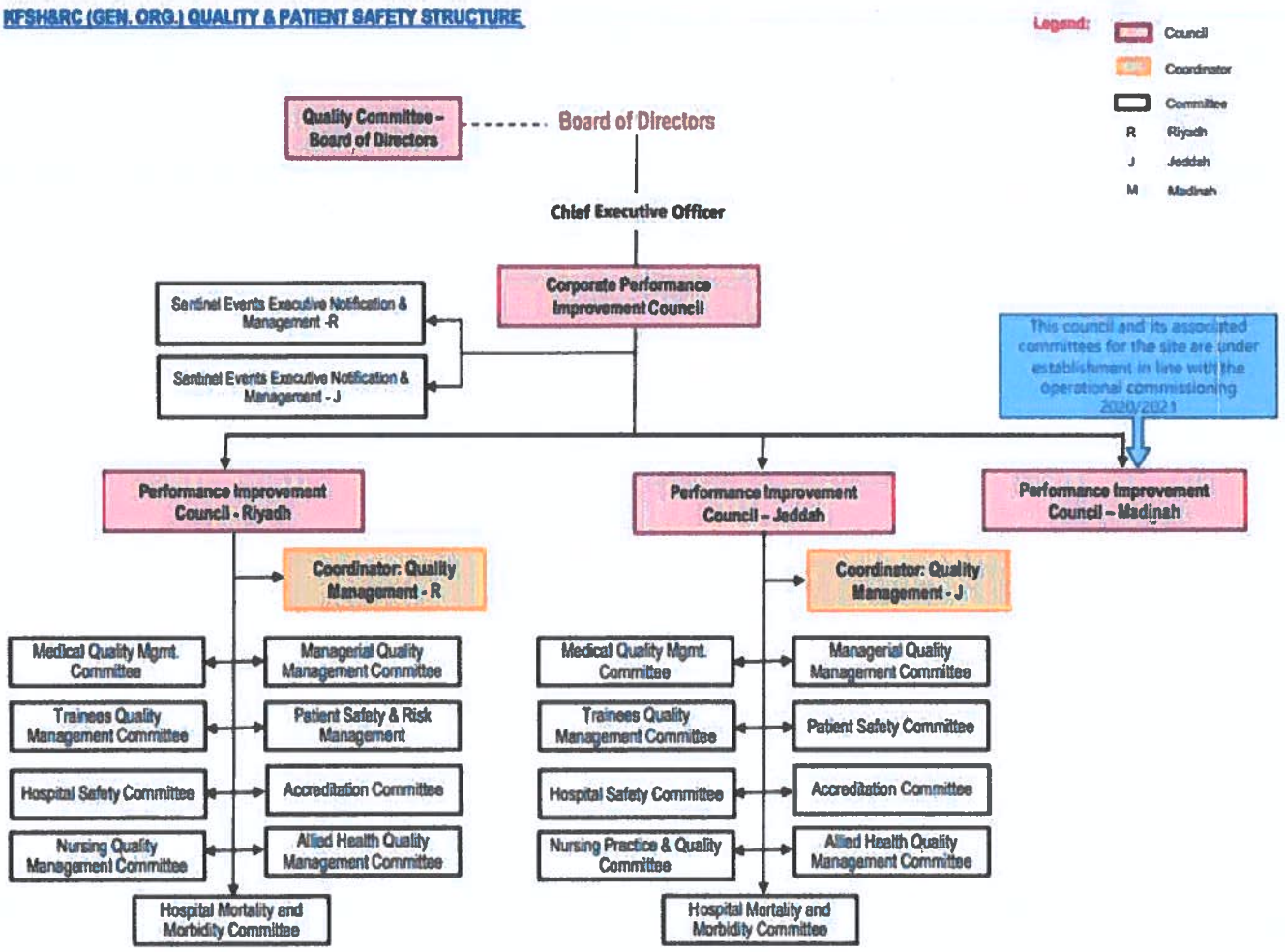
Strategic Objective	Quality Dimensions	SEQ	Composite Priority Goal	Priority Goals	Target	Accountability
S01 & SO3	Effectiveness	P15	**Improve Oncology Quality Index For Adults**			
			100-day patient mortality rate for allogenic stem cell transplant adult patients		**2.50%**	CMO
			100-day patient mortality rate for autologous stem cell transplant adult patients		**0.5%**	
			5-year actual patient survival rate for colorectal cancer in adults		**70.5%**	
			5-year actual patient survival rate for lymphoma for adults		**87.0%**	
			5-year actual patient survival rate for breast cancer for adults		**82.8%**	
		P16	**Improve Oncology Quality Index For Pediatrics**			
			100-day patient mortality rate for allogenic stem cell transplants for pediatrics		**<10**	CMO
			100-day patient mortality rate for autologous stem cell transplants for pediatrics		**0**	
			5-year patient survival rate for Renal Tumors for pediatrics		**94%**	
			5-year patient survival rate for acute lymphoblastic leukemia for pediatrics		**88%**	
Strategic Objective	**Quality Dimensions**	**SEQ**	**Composite Priority Goal**	**Priority Goals**	**Target**	**Accountability**
S01 & SO3	Effectiveness	P17	**Improve Cardiology Quality Index**			
			1-year patient survival rate for heart transplants for adults.		**90%**	CMO
			1-year patient survival rate for heart transplants for pediatrics		**92%**	
			30-day readmission rate for patients on durable mechanically assisted circulatory support devices		**8%**	

Strategic Objective	Quality Dimensions	SEQ	Composite Priority Goal	Priority Goals	Target	Accountability
S01 & S06	**Efficiency**	**P18**	*Reduce Average Length of Stay		**10%**	CMO
		P19	Reduce Percentage of OR Cancellation		**7.5%**	CMO
		P20	Reduce Radiology waiting time Priority 1 (NP: Oncology, Cardiac, TX, Neuro)		**10 Days**	CMO
		P21	Increase-Operating Room (OR) Utilization Rate		**85%**	CMO

AUTHORITY, OVERSIGHT AND REPORTING:

The Board of Directors' Chairman approves the Hospital Quality and Safety Plan and oversees its implementation through the Hospital Quality and Patient Safety structure that is composed of Councils and Committees established for the Riyadh, Jeddah and Madinah branches. The Hospital Quality & Patient Safety structure is outlined in Figure 1:

Figure 1



QUALITY COMMITTEE - BOARD OF DIRECTORS (Bylaws of the BOD Quality Committee, 2019)

A member of the Board of Directors chairs the committee that will monitor and evaluate performance on quality of care for safety, access, efficiency, effectiveness, appropriateness and experience. The committee meetings shall be held whenever needed upon invitation by its chairman. The committee will recommend the approval of the annual quality priority goals. The committee will review structures and policies for an

effective clinical governance platform and the quality reports to external agencies and medico-legal cases. The committee will be updated on sentinel events.

CORPORATE PERFORMANCE IMPROVEMENT COUNCIL (CPIC) (CFO 1337)

The organization Chief Executive Officer chairs the CPIC and provides oversight for KFSH&RC (Gen.Org) Performance Improvement (PI), Patient Safety, Risk Management, Accreditation and Hospital Safety activities. The CPIC focuses on resolving the issues that require awareness, alignment or coordination across Riyadh, Jeddah and Madinah branches. The council meets biannually and receives an update of the corrective actions implemented to prevent recurrence of sentinel events.

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

The Deputy Chief Executive Officer-Healthcare Delivery (DCEO-HD) or the General Manager (GM) of the site 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 and Allied Health 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 actions. QMD coordinates the process until actions are completed.

SENTINEL EVENT EXECUTIVE NOTIFICATION AND MANAGEMENT COMMITTEE (SEENMC) (CFO-R: 1262 & CFO-J: 096)

The DCEO-HD or the GM of the site chairs the SEENMC that is composed of members from the senior managers. SEENMC is conducted within 24 hours of identifying a sentinel event and responsible for ensuring timely reporting, thorough investigation and effective intervention for all potential and actual sentinel events at KFSH&RC (Gen. Org.). It thrives to have immediate corrections of the system to minimize any further harm and prevents recurrence. The SEENMC expedite any immediate morbidity and mortality review whenever specialized peer review is needed, and ensures that patients/families involved in the sentinel events receive timely, accurate and empathetic disclosure about events. The committee also monitors executive interventions and corrective plans and submits a sentinel events report to the CPIC.

NURSING QUALITY MANAGEMENT COMMITTEE (NQMC) (CFO-R: 1459 & CFO-J: 030)

The Executive Director of Nursing Affairs chairs the NQMC. The committee meets monthly and is coordinated by the nursing quality manager. A representative from QMD is assigned to the NQMC.

MEDICAL QUALITY MANAGEMENT COMMITTEE (MQMC) (CFO-R: 1036 & CFO-J: 070)

The Chief of the Medical Affairs (MA) chairs the MQMC and approves nominated members by Departments' Chairmen. Meetings are monthly and coordinated by MA. A representative from QMD is assigned to the MQMC.

MANAGERIAL QUALITY MANAGEMENT COMMITTEE (MAQMC) (CFO-R: 1030 & CFO-J: 026)

The Executive Director of Hospital Operations chairs the MAQMC and approves the committee members assigned by Departments' Directors or Heads. Meetings are quarterly or monthly and the committee is coordinated by either QMD or support services representative.

ALLIED HEALTH QUALITY MANAGEMENT COMMITTEE (AHQMC) (CFO-R: 1035 & CFO-J: 054)

The Director of the Clinical Services appoints the Chairman of the AHQMC. The chairman approves the committee members appointed by the Chairman/Director/Head of each clinical services department. Meetings are monthly and are coordinated by Clinical Services. A representative from QMD is assigned to the AHQMC.

PATIENT SAFETY AND RISK MANAGEMENT COMMITTEE (PSRMC) (CFO-R: 795&CFO-J: 020)

The Deputy Chief Executive Officer Health Care delivery or the General Manger of the site appoints the Chairman of the PSRMC. The PSRMC chairman approves the members assigned by concerned departments. Membership is multidisciplinary with representatives from clinical and non-clinical departments and assigned by the departments' Chairmen/Directors/Heads. The committee provides oversight for Patient Safety and Risk Management activities. PSRMC Meetings are held monthly and are coordinated by QMD.

HOSPITAL SAFETY COMMITTEE (HSC) (CFO-R: 110&CFO-J: 040)

The DCEO-HD or site GM appoints the Chairman of the HSC. The HSC oversees all safety activities related to the management of the environment of care contained within the seven functional areas of safety, security, fire/life safety, emergency preparedness, hazardous materials and waste, medical equipment, and utility management. Including the preparation, implementation, evaluation and revision of the Hospital Emergency (Disaster) Management Program. Meetings are held on a monthly basis and as required and coordinated by the Disaster Clinical Specialist or his/her designee on the site. HSC provides oversight of the Hospital Safety Management Plans (Appendix A). Committee Chairmen of Hazardous Materials Management and Emergency Preparedness Management report to the chairman of the HSC. Other Hospital Safety Plans will be monitored through regular reports to the HSC from concerned departments or committees.

ACCREDITATION COMMITTEE (ACC) (CFO-R: 709 & CFO-J: 057)

The DCEO-HD or the GM of the site chairs the ACC that is composed of members from the senior managers. ACC coordinator organizes the committee meetings that are conducted at least on a quarterly basis or more frequently if

needed. ACC members constitute of representatives from clinical and non-clinical departments. Committee Chairs of Hospital Safety (CFO 110-R), Managerial Quality Management, Medical Quality Management (CFO 1030-R), Nursing Quality Council (CFO 1459-R) and Allied Health Quality Management (CFO 1035-R) are members of the ACC. ACC provides oversight for the Organization accreditation activities to ensure continuous compliance with accreditation standards.

HOSPITAL MORTALITY AND MORBIDITY COMMITTEE (HM&MC) (CFO-R: 177 & CFO-J: 118)

The Chief Quality Officer (CQO) appoints the Chairman of the HM&MC. HM&MC provides oversight of morbidity and mortality occurrences in collaboration with PSRMC. All deaths or complications where deficiencies in the system or practice are identified or suspected are reviewed in depth and findings are shared in a timely manner with the recommendations on how to prevent future occurrences.

TRAINEES QUALITY MANAGEMENT COMMITTEE (TQMC) (CFO-R: 1383 & CFO-J: 1564)

Executive Director of the Academic and Training Affairs chairs the TQMC. TQMC facilitates the implementation of required policies, processes and strategies that ensure that trainees are part of the Quality and Safety program of the Hospital. The committee ensures participation of trainees in quality and safety activities and works as a venue to disseminate quality data to the trainees. The committee meetings are held on a monthly basis or more often as needed and are supported by Academic and Training Affairs and QMD.

QUALITY MANAGEMENT DEPARTMENT (QMD)– RIYADH, JEDDAH AND MADINAH

QMD consists of sections outlined in the organizational structure approved by the CEO. Each section develops its own plan. The plans outline the main functions performed by the section and the interaction with other quality management sections' plans. The Quality and Safety Plan is recommended by the CEO who is the secretary of the BOD and approved by the Chairman of the BOD's. The other Quality plans including Accreditation, Performance Improvement and Patient Safety & Risk Management plans are recommended by the sites DCEO-HD or GM's and approved by the CEO.

QUALITY MANAGEMENT COMMITTEES GENERAL ROLES

- Facilitate Group/Division/Department quality and safety related activities.
- Assist in the development and monitoring of Group Section/Division/Department Accreditation, Patient Safety, Risk Management, Performance Improvement and Quality Indicators
- Follow up with the relevant departments to ensure the development and implementation of action plans to resolve quality and safety concerns.
- Provide quality related education in collaboration with QMD.

QUALITY DIRECTORS OR COORDINATORS ROLES

- Develop and coordinate the implementation of the Group/Division/Department quality management plan utilizing QSMP contents Template outlined in (Appendix B).

- Facilitate Group/Division/Department activities related to Patient Safety and Risk Management as per hospital wide plan (reporting, root cause analysis, creating awareness, and follow up on implementing patient safety initiatives).
- Facilitate Section/Division/Department accreditation activities as per hospital wide Accreditation plan. Specifically, to lead and facilitate quality round. Moreover, to participate in relevant education and to follow up on accreditation linked action plans
- Facilitate Group/Division/Department PI, and data management activities as per hospital wide plan (facilitate at least one department/divisional PI annually).
- Facilitate the development and monitoring of Group/Division/Department indicators and coordinate the development and implementation of the action plan to address issues identified.
- Promote awareness of activities and data as approved by the QMD
- In collaboration with quality management committee chairman/QMD, provide education to the department as needed
- Report to the related quality management committee

COMMUNICATION:

The Board of Directors Quality Committee will recommend and monitor the annual quality priority goals as part of an annual quality plan to the board for approval. The Quality and Safety Plan will be recommended for approval by the Chief Executive Officer who is the Secretary General of the BOD and approved by the Chairman of the BOD.

Upon Quality and Safety plan approval, the Chief Quality Officer will share the approved plan priority goals, targets, Key Performance Indicators and the Activities including Quality Aims and Performance Improvement Projects and improvement initiatives with all departments' Executive Leaders. The CQO will motivate a positive attitude and receptiveness to participating in the journey the organization is undertaking to achieve its priority goals. He will clarify and explain the selected indicators targets and assist in providing regular reports on the progress of achieving them throughout the year.

The Quality and Safety plan is posted on the hospital portal to be accessible to the staff and shared with the members of the quality committees through Quality Management Department's representatives. In addition, the hospital portal and zero harm application post all quality and safety Key Performance Indicator reports in a timely manner. Departmental Quality Information and Zero Harm Boards has been established for hospital units and clinics and it displays information related to each area's quality and safety indicators. That is to increase staff awareness about their unit's performance.

Priority goals achievements are also communicated with the hospital and the community through various hospital media and venues including the Sand-script magazine, general staff meetings, training courses, Quality Days and Forums, Symposiums, Quality Awards Ceremonies, and Tweeter or other social media platforms.

TRAINING AND EDUCATION

An introduction to Quality Management is provided for the new staff at their initial orientation to the hospital. The quality department conducts regular courses on Performance Improvement, Patient Safety, Risk Management and Accreditation (Appendix: **G**). Patient Safety incidents are shared as "Lessons Learned" at various applicable meetings to increase staff awareness and prevent incidents recurrence.

REPORTING:

The Chief Quality Officer will present regular reports to the BOD Quality Committee. The reports shall outline the progress to achieve the quality and safety priority goals, any challenges or adjustments needed for the set targets or planned activities and possible problems or gaps (e.g. resource commitment).
The CQO shall provide proposed action plans in order to achieve the set quality and safety priorities to be reviewed by the committee for approval to grant the needed support.

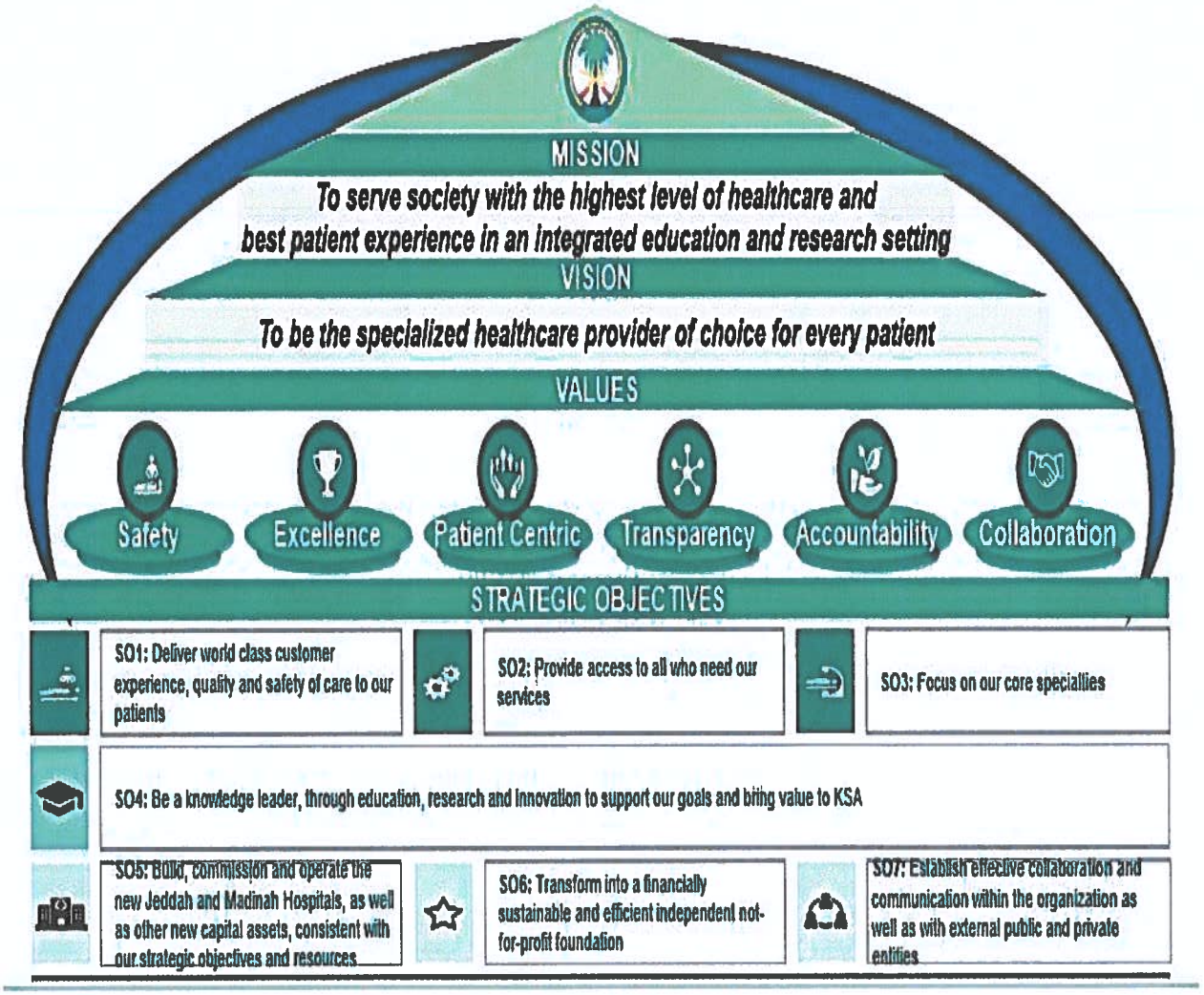
CONFIDENTIALITY

Quality data and information are confidentially maintained in accordance with the guidelines in the Employee Relation Manual (ERM), Effective 09 Ramadan 1436 (26 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 or his /her designee determines access to this server.

EVALUATION AND REVISION

The Board of Directors Quality Committee will evaluate regularly the QSMP plan and will revise and approve the plan annually or earlier, if deemed necessary.

APPENDIX A: KFSHRC STRATEGY



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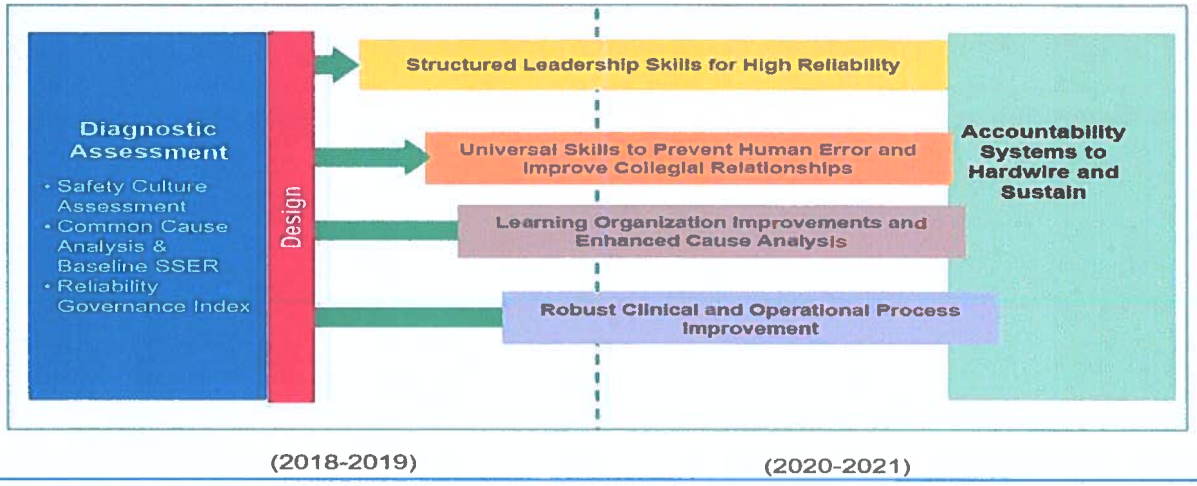
Approved Strategic Programs (16) and Projects (34)

APPENDIX B: NEW BRUNSWICK HEALTH COUNCIL – DIMENSIONS OF QUALITY

Reference: *New Brunswick Health Council- Dimensions of Quality (https://nbhc.ca/dimensions-quality)*

**"Equity" dimension was not considered and was replaced by "Patient Experience"*

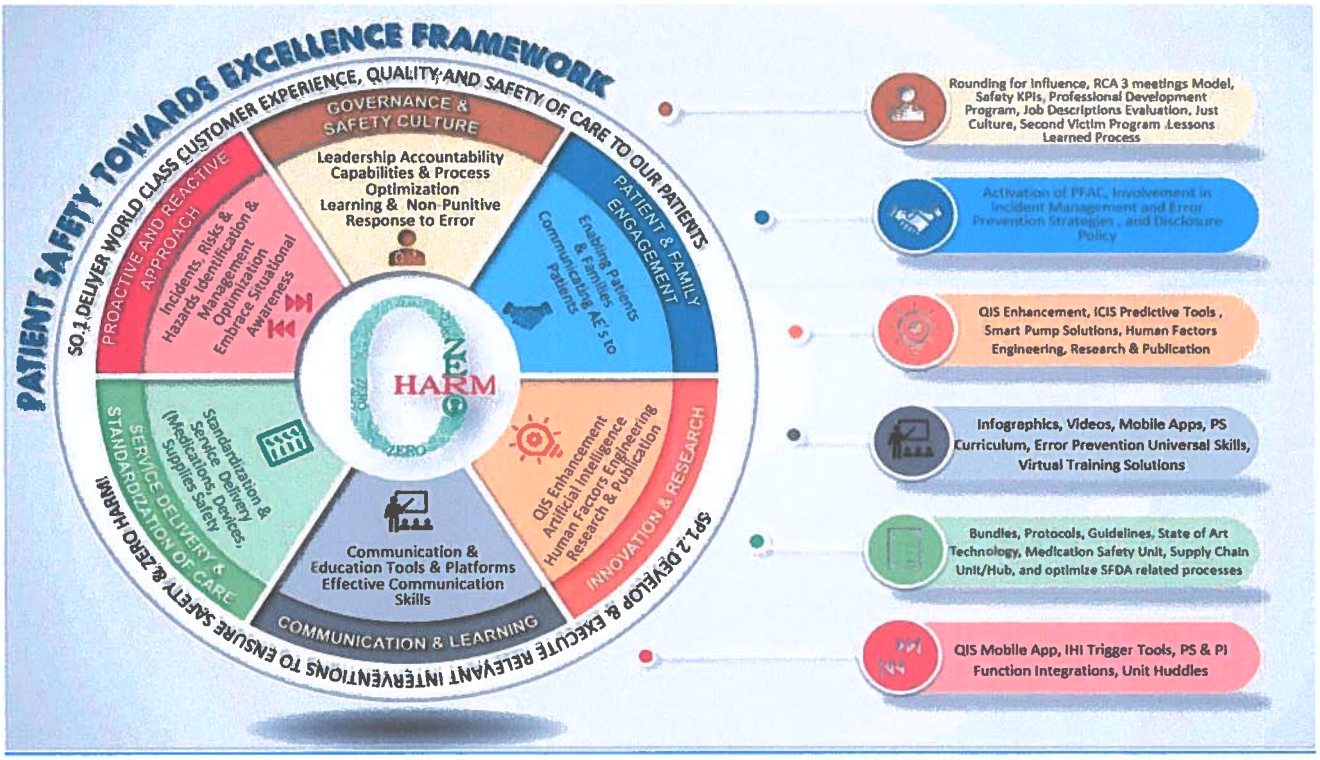
APPENDIX C: HIGH LEVEL SAFETY AND RELAIBILITY ROADMAP



APPENDIX D: ZERO HARM-HRO 5 PRIORITIES

	Priority	Why (Rationale)	What	Impact
Leadership Methods	#5 Rounding for Influence	• Leading to prevent, detect, and manage drift • Reinforcing & Building Accountability for Behaviors	A structured activity, whereby leaders intentionally ***engage*** with staff to: • Reinforce **behaviors** or performance expectation and **review of current improvement activity** • Focus on **Safety, Quality and Service** Expectation • Influence a specific **Behavior Expectation (Universal Skills) & Process Improvement**	Increase Process and Individuals Reliability Prevent Harm
Process Interventions	#4 Daily Huddle Boards	Learning boards provide visual management of new, working, and solved problems. They: • Focus efforts of staff at department level. • Give a shared understanding of problems, causes, and solutions. • Create momentum for more solving of local system issues.	A method for identifying local system issues that impact safe, effective, and patient-centered care • Connects daily work and performance results • Engages the team to find and fix problems • Leaders influence team behaviors: Reinforce expectations & Problem solving thinking	
	# 3 Robust Process Improvement	Redesigning processes to achieve exactly the results intended • Find Problems and Fix Causes • Eliminate variation & process waste • Document improvement and standard work	Blended method of Lean, Six Sigma, Focus PDCA-IHI-Model • RPI Coaches • RPI Tools • Demonstration Projects • Value Stream Mapping • Rapid Improvement Events • Mistake Proofing	
Human Behavior Interventions	# 2- Just Culture	-**69%** perceived that there is a blame culture at KFSH&RC (PSCS 2019) -Accountability system is "partially Deployed" (RGI Assessment 2018) -Each Human Error should have a preceding cause -Each At-Risk Behavior should have a preceding cause Applying Just culture increase reliability by 93%	• Learn more about How and Why errors happen(Causes) • Increase the reporting & Learning of incidents • balance accountability for Human choices and organizational accountability by focusing on individual & system improvement.	
	# 1-Universal Skills for Error Prevention	Adopting behaviors to prevent human error reduces Serious Safety Events by 80% (with more focus on infection control practice & indicators)	One TEAM for Zero Harm - 4 Behaviors and 10 Skills • Think Critically • Effective Communication • Attention to Detail • Mutual Support	

APPENDIX E: PATIENT SAFETY TOWARDS EXCELLENCE FRAMEWORK



APPENDIX F : Hospital Quality & Safety Plans

	Quality and Patient Safety Plans
1	Quality and Safety Management
2	Accreditation
3	Performance Improvement
4	Patient Safety and Risk Management
	Environment of Care Safety Plans
1	Emergency Preparedness Management
2	Hazardous Materials Management
3	Facility Safety Management
4	Utilities System Management
5	Security Management
6	Medical Equipment Management
7	Fire Safety Management
8	Emergency Operations
9	Power Outage

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APPENDIX G: 2021 QUALITY AND SAFETY EDUCATION COURSES AND ACTIVITIES

Quality Improvement / Accreditation	
Foundation Course on Quality Improvement	Full Day
Essential Quality Tools and Statistics	Full Day
Lean at a Glance	Full Day
Accreditations at Healthcare Institutions	Half Day

Patient Safety	
Basic Patient Safety Workshop	Full Day
Root Cause Analysis using 3 meetings model	Full Day
Just Culture workshop	

Risk Management / Disaster Management	
Risk Management workshop	Full Day
FMEA Master Class	Half Day
HAZWOPER Course	2 Days
On-Scene Incident Commander	Full Day

High Reliability Organization Training	
Robust Process Improvement (RPI) Coaches Training	8 Weeks-4 Hours-Training Schedule
Universal Skills for Error Prevention Mandatory Training	3 Hours training Session
High Reliability Skills for Leaders	3 Hours training Session

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APPENDIX H: PRIORITY GOALS INDICATORS DEFINITIONS

Indicator	Definition
Serious Safety Event	The number of serious safety events reported through the electronic safety reporting system as per the HPI Classification.
Hospital Acquired Pressure Injury Stage II and Above Rate	Total number of Hospital Acquired Pressure injuries in one Gregorian month per 1000 patient days.
Falls with Injury	Total number of patient falls the result in injury based on the inclusion criteria reported monthly in QIS (Quality Information system).
CLABSI rate per 1000 central line days	The total number of new CLABSI in a specific time period divided by the number of patient at risk
CAUTI rate per 1000 urinary catheter days	The total number of new CAUTI in a specific time period divided by the number of patient at risk
SSI rate per 100 surgical procedure	The total number of new SSI in a specific time period divided by the number of patient at risk
Medication Prescribing Errors	The percentage of prescribing medication errors from the total number of medication errors
Hospital Acquired Venous Thromboembolism	Any episode of venous thrombo-embolism during admission and within 60 days after discharge that is not present during admission who are not on appropriate measures.
Overall hospital rating (HCAHPS)	Patient satisfaction HCAHPS – Composite: Over all hospital rating (Q21)
Inpatient pediatrics experience	Average score of pediatric patient experiences within inpatient hospital stays, Inpatient ≤ 14 years old
Outpatient experience	Average score of patient experiences with the Outpatient Physician/Nurse Practitioner clinic visits.
Emergency room experience	Average score of patient experiences with the emergency department visits, who were treated and discharged
Ambulatory surgery care experience	Average score of patient satisfaction with same day surgical procedures, tests, treatments and programs
Dental services experience	Average score of patient experience during dental practice or orthodontic service visits
Oncology Outpatient Experience	Average score of patient experiences with the Oncology Outpatient Services (Chemotherapy, Radiotherapy).
Emergency department's boarding time	Measures the median time (hours) spent in the ER by patients who had a decision to be admitted. It measures from when the physician decides to admit the patient to when the patient leaves the emergency room heading to the floor (discharged from DEM or dead in DEM).

ER waiting time to be seen (3)"min"	It is the median time (minutes) to be seen by a physician spent in the ER by patients who are categories as a (3). It is computed from time of patient register in the registration desk till been seen by a DEM consultant for that category. (Seen by a DEM consultant is dropped when the consultant claims the case in FirstNet)
Referral to decision waiting time "hr."	This is the median time (in hours) from when the referred case is uploaded in the referral system to decision (to either accept/not accept/Incomplete) by the appropriate medical department/referred medical department during the period under review
New patients with scheduled appointments that are within 2 weeks	Measures the total number of new patients that received an appointment within 2 weeks vs. the total number of new patients that have both received an appointment and are still waiting for an appointment.
Clinical Pathways	The total number of active Clinical Pathways
Antimicrobial prescribing	The percentage that Antimicrobial prescribing is in accordance with guidelines
Antimicrobial Documentation of Indication	The percentage that the Antimicrobial indication is documented in ICIS
Antimicrobial Proper Dosing	The percentage that the Antimicrobial dosing regimens are right including right dose, right route, and right frequency
Restricted antimicrobial agents compliant with guidelines	The Percentage of restricted antimicrobial agents compliant with restricted use guidelines. Restriction based on prescribing service and/or indication
Transplant Quality Index	A composite index which is a combination of the 4 sub indicators, which are; 1-year graft survival rate for living donor liver transplants for adults, 1-year graft survival rate for living donor liver transplants for pediatrics, 1-year graft survival rate for living donor kidney transplants for adults, and 1-year graft survival rate for living donor kidney transplants for pediatrics. Adults are 18+.
Oncology Quality Index for adults	A composite index which is a combination of the 4 sub indicators, which are; 100-day patient mortality rate for allogenic stem cell transplant adult patients, 100-day patient mortality rate for autologous stem cell transplant adult patients, 1-year progression free survival rate for lymphoma for adults, and 1-year progression free survival rate for breast cancer for adults. Adults are 18+.
Oncology Quality Index for Pediatrics	A composite index which is a combination of the 4 sub indicators, which are; 100-day patient mortality rate for allogenic stem cell transplants for pediatrics, 100-day patient mortality rate for autologous stem cell transplants for pediatrics, 5-year patient survival rate for Renal Tumors for pediatrics, and 5-year patient survival rate for acute lymphoblastic leukemia for pediatrics.
Cardiology Quality Index	Cardiology quality index is the composite of three sub indicators, which are; the 1-year patient survival rate for heart transplants for

	adults, the 1-year patient survival rate for heart transplants for pediatrics, and the 30-day re-admission rate for heart failures. The patients who are tracked for survival rates do not have to be the same patients for both time horizons. Adults are 18+.
Average Length of Stay	The average length of stay (ALOS) is a mean of the Inpatient days of all inpatients at discharge
OR Cancellation	Percentage of OR cancellation
% Operating Room (OR) Utilization Rate	OR Utilization rate is the time (in hours) actually used for patient care plus average turnover time for the reporting period divided by the number of hours available/schedulable
Radiology waiting time Priority 1 (NP: Oncology, Cardiac, TX, Neuro)	The waiting time (in days) to the third available Radiology appointment slot per Modality.

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