



King/Drew Medical Center Workplan Implementation Summary by Initiative



Update Through:

5/27/05

Initiative	Overall Progress Update
Governance	The Hospital Advisory Board (HAB) held an all day orientation session on May 9th. The agenda included General Overview of the Healthcare Field; Role of the HAB, Relationship to BOS; History of King-Drew Medical Center; Regulatory Compliance; KDMC Market & Programs; Organizational Structure; Board Membership Roster; Event Reporting Process; Medical Staff Organization & Functions; Nursing – Patient Care Services; Human Resources; Financial Management & Reporting; Physical Layout – Floor Plans; and Navigant Reporting Process. The Quality and Planning/Finance Committees began monthly meetings. The Steering Committee membership was defined, their charter identified and they have been meeting weekly with KDMC management to address current issues.
Management/Structure	Executive and key management recruitment continues. Cabinet and senior leadership continue to meet weekly to review operational issues, workplan progress, regulatory preparedness and performance measure progress. KDMC executives meet with DHS leadership every Thursday to discuss operational and human resource issues. KDMC Interim CEO is an ex officio member of the HAB, other executives participate in committees as appropriate. Inter-disciplinary activities occur at Medical Exec meetings and with joint practice groups that have been established in the OR, ED, OB and Psychiatry.
Risk Management	The review and modification of key patient policies and procedures continues at department level. Current KDMC policies and procedures are being reviewed against DHS policies and procedures by issue. Modifications (as indicated) are to be finalized at department level with review by leadership. UHC Patient Safety Net Facility implementation planning continues with a project leader to be identified.
Regulatory	<p>The hospital's plan of correction in response to the October, 2004 CMS survey was completed and submitted to CMS May 12th. Revisions are underway. Mock surveys are being conducted weekly by KDMC staff to self assess current compliance with JCAHO standards and CMS Conditions of Participation for which the hospital was previously cited. Results from these surveys are communicated to senior leadership the week following each survey. The Regulatory Readiness Committee continues to meet and maintain oversight of the organization's state of regulatory preparedness. The Committee has accelerated it's frequency of scheduled meetings to bi-weekly from monthly.</p> <p>Bi weekly Patient Safety Leadership Walk Rounds have been initiated. Rounds have been completed on two patient units by KDMC leadership. The purpose of the rounds is to create a culture of safety by encouraging open and honest communication regarding patient safety, barriers to teamwork, "near misses", and error reporting. These rounds are designed to develop an environment whereby individuals have a heightened awareness of patient safety issues and are armed with the skills to evaluate his or her environment for potential harm. Issues identified from these rounds are documented in a log and a discussion with senior leadership for resolution. Leadership provides feedback by attending a unit staff meeting to report back on corrective actions.</p>
Performance and Quality Improvement	<p>The first meeting of the Quality Oversight Committee (QOC) occurred on May 27th; action items included modification and finalization of QOC charter, review of current performance metrics and recommendations on tracking performance improvement metrics. The performance improvement structure and performance improvement plan are being revised to reflect the newly created committee reporting.</p> <p>The Clinical Pertinence Review program continues to evolve conducting concurrent record review across all services. Reviews of all deaths continue with referrals as appropriate for further review i.e. route cause analysis, department review, etc. The route cause analysis process is being revised using the VA methodology and ensuring the coordination with DHS Quality Improvement Program.</p>
Infection Control	The Infection Control Committee has approved deletion of 12 unit specific policies and procedures (P&P) due to redundancy of information. An Infection Control Health Fair was held on May 25th and 26th to 'roll out' the new Infection Control Plan, inform attendees of new isolation P&P, educate attendees on types of isolation, e.g., Airborne, Droplet and Contact. In-service was provided on glucometers, with requirements for return demonstration. The Affinity system has been updated to limit selections for type of isolation to Airborne, Droplet and Contact, with IC Practitioners being the only personnel able to enter this data. Dialysis machines are now being tested monthly for endotoxins.



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Budget	Met with the HAB Planning and Finance Committee on May 24th and presented a report on the financial status of KDMC and discussed a draft format for the dashboard/performance indicator report. Efforts continued to restructure cost centers to accommodate the eCAPS transition for FY 05-06. Work with department chairs continues to identify necessary changes to the cost center locations for various personnel.
Productivity	A revised "chart of accounts" has been distributed to all areas for final confirmation/modification. The chart of accounts is scheduled to be finalized by June 15th, and once finalized it will be reflected in the FY05/06 cost center structures and RSR (Responsibility Summary Report). After the new cost center structure is finalized, Finance and IS will work to test run Unit of Service statistics, utilizing the Affinity data source as much as practically possible. In parallel, Finance will work with KDMC leadership to review and select job positions that are included for the productivity monitoring tool, while the selection of job positions will be communicated to DHS Finance to run LCD download appropriately. The time frame of the implementation of productivity monitoring tool may need to be modified to make the efforts coordinated in relation to the scheduled eCAPS implementation.
Space Planning	Plans for OR renovation, interim locations of services and units during construction and equipment requirements have been reviewed. Began meeting with physicians and other key departments to discuss move implications and plans. Timelines and plans for Psychiatry and OR renovations were reviewed with DHS and the Chief Administration Office (CAO). On June 7th a presentation will be made to OSHPD and the state licensing board on the plan. A presentation is scheduled for June 7th to the Board of Supervisors (BOS) for approval to begin contracting with construction companies for preparation of temporary space. A presentation is planned for June 21st to the BOS of the multi-phased plans for Psychiatry and OR construction. On August 31st a review by the BOS of KDMC overall progress of the initiatives will be made for consideration of that progress and its impact on the construction efforts. Additionally, there are plans to present to DHS the week of May 30th a proposal to relocate all of outpatient pharmacy to the second floor of the Trauma center. This proposal includes minimal space reconfiguration and lower costs with increased efficiency as well as the ability to fill all outpatient prescriptions in the new space. However, barriers due to use of space on the same floor as Women's Health may exist.
Environment of Care	The bulletin for the recruitment of an experienced Safety Officer will be posted May 25th. The Safety Assistant start date was May 9th and he is in the process of completing mandatory training and orientation for the new position. The annual review of all safety policies and procedures is in progress and will be completed by June 30th. The seven 2005 Environment of Care (EOC) Safety Management Plans have been drafted and are under review.
Facilities Management	An Environmental Services (EVS) policy for cleaning medical equipment has been developed and is being reviewed. Inservice training of EVS staff on procedures to clean the equipment has begun. Two training modules have been implemented, with completion certificates to be issued to the attendees. The remaining modules are being developed. A facility refurbishment plan has been revised to incorporate painting of patient rooms on a 3-month schedule, details of room availability must be worked out. Regulatory agencies have been identified with a spread sheet to be developed listing pertinent information such as permit data, agency inspections, and locations of the various rules and regulations binders (books) within the Plant Management Shops / Offices.
Materials Management	The invoice processing move was put on hold until e-CAPS is implemented. Communication of the Online Requisitioning (OLR) roll-out has begun. The finalization of the Product Evaluation and Standardization Committee charter and membership is in process. Working to identify projects for specific cost savings opportunities. Focused efforts on recruitment continue with two new hires in May, twenty-one positions remain open.
Contracted Services (Respiratory)	The intubation weaning protocol and standing orders are being finalized. Patient statistics to determine entrance for the weaning protocol have been collected. Education of respiratory therapy staff is underway and education plan for Nursing is being developed for implementation.
Contracted Services (Dietary)	Overall the action steps have been completed on target and the work plan is on schedule.
Contracted Services (Security)	Overall the action steps have been completed.



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Communications	<p>The public relations effort has moved forward during the month of May. Key accomplishments include the creation of the KDMC HAB website, which will be updated monthly with Board agendas/minutes and supporting documents. The first employee Q&A session has been scheduled for June 22nd with the Interim CEO, and we are currently scheduling for July/Aug/Sept. Kae Robertson, Navigant Managing Director responsible for the overall project was featured as a guest on the KCET issues/public affairs program "Life and Times," as was Dr. Garthwaite.</p> <p>A story on the King Drew reform momentum to Telemundo network was postponed for a later date. The department has serviced multiple public records requests to the LA Times. New equipment that was ordered for the newsletter has arrived which will facilitate production and better layout/graphics. We are in the process of creating an employee advisory board and will launch the effort at the June 22nd open forum.</p>
Case Management and Utilization	<p>Incorporated routine reporting of denials, TARs, and pending MediCal as part of overall hospital performance statistics. Initiated Case Management interdisciplinary rounds on selected units. The purpose of the rounds is to integrate thinking about appropriate utilization of services and discharge planning as routine and a continuous part of the patient care plan. These interdisciplinary teams including doctors, nurses, social services, and case managers. Planned roll-out throughout the hospital by the end of June. Initiated routine reporting and tracking of all ventilator dependent patients to enable early identification of readiness for transfer and to more rapidly identify a facility more appropriate for the level of care for the patient. This will enable the hospital to open more ICU/Telemetry beds to new patients and reduce length of stay in the ED due to waiting for these types of beds.</p>
Capacity and Throughput	<p>The One Stop Bed Program was kicked off this month to expedite the timely transfer and discharge of patients. When a patient requires an admission or a transfer bed the staff on the nursing units enter the bed request into Affinity and page the new Patient Flow Manager/Shift Supervisor. All discharges will be immediately entered into Affinity and a notification of the Patient Flow Manager/Shift Supervisor will make recommendations on appropriate bed assignment. The Flow Nurse Manager will focus on facilitating admissions from the ED and transfers to and from other facilities via the MAC system following EMTLA guidelines.</p> <p>They will coordinate with Admitting and Registration to complete the admission/transfer process providing education to charge nurses and staff on appropriate placement of patients. This role is also responsible for reviewing staff scheduling and utilization practices to assure the optimum number of staffed beds will be available. They will also work with facilities to identify maintenance issues and repairs to prevent the unnecessary closure of beds.</p>
Physical Therapy	<p>All of the recommendations have been completed and implemented, the clinical outcomes will be tracked and monitored over a six month period of time. The target date for clinical data collection is November 30th.</p>
Emergency Services	<p>A new Visitor Policy has been developed. The Nurse Manager is communicating progress in the emergency room to nursing staff twice a week as well as addressing quality issues that occur throughout the week. A plan is being developed with the Clinic Director to develop a plan to ensure that clinic patients are not directed toward the ED of care/services unless appropriate. Planning to relocate corner's office to use the existing space for family grieving lounge. The joint practice group supported a recommendation to recruit and develop a patient advocate role for the ED providing 16-hour coverage.</p>
Perioperative Services	<p>The Sponge Count Policy was approved on May 27th and OR staff were educated on the new policy. Competencies have been developed, and the staff will have 30 days to ensure that they are following the policy correctly by meeting the competency. A detailed equipment list was developed for the renovation including the OR, PAR, OSA, LDR and 2I. Flooring and wall colors were chosen for the new ORs. A new OR documentation system for Pre-op, Intra-op, PAR and care plan was formalized. The Surgical Site Side Verification Policy has been completed. The OR will be conducting a trial of the Neptune Fluid Recovery System in upcoming weeks. Central Sterile will not be outsourced during OR renovation there was not a vendor available to meet KDMC goals. To maintain in house control of Central Sterile, new equipment will have to be purchased.</p>



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	A consolidation and sharpening of all instruments should be completed by the end of June. KDMC received approval to move forward as a facility with the ORSOS system upgrade which will allow better management of the OR schedule and linkage of the OR inventory with usage patterns. This will facilitate the goal of having the right instruments and supplies available; at the right place; and at the right time. Currently piloting preoperative patient tools to improve presurgical evaluations. Suite utilization remains low despite closure of one OR in mid-March due to environmental safety issues and the reduction of one night team/room. Cases have decreased 13% from March to April with a 15% decrease in case minutes. Department leadership will continue to evaluate the number of open rooms and times required given impending renovation.
Med Admin - Clinical Programs and Medical Departments	Department Chair performance reviews have been completed defining the Chair's role as clinical leaders for their departments with primary responsibility for clinical programs. Worked with HR to prepare AMD UM and Clinical Programs positions to be posted. Initial agreement was reached with Intensivist to provide ICU coverage. Annual Bylaws were reviewed and updates are scheduled to be made in June. Worked aggressively with departments and individual physicians to assist with physician retention with a focus on Radiology and ED.
Med Admin - Medical Staff Affairs	Completed inputting of specific resident supervision prerogatives into CACTUS and distributed a final draft for Chair and PSA Exec review and sign-off. PSA Exec approved resident supervision policy. Convened three medical staff and two resident open forums to discuss hospital status and projects, staff morale, residency programs, regulatory issues and supervision. The Medical Director distributed a letter regarding residency supervision expectations to every resident and attending. The frequency of PSA Executive Committee meetings has increased to address urgent clinical and medical staff issues focusing on challenges facing the facility. Began review of department peer review files and quality measures as a first step in integrating and transitioning information into credentials files. Began collecting physician specific info from critical clinical event reviews for physician credential files. Increased collaboration and addressed all known physician and allied health practitioner HR issues with Performance Management Department.
Med Admin - Quality, Performance Improvement, Utilization and Case Management	Case review and root cause analysis proceeding according to plan; root cause analysis of 3 major cases completed week of May 24th with physicians involved in the case reviews at departmental level.
Med Admin - Administrative Issues / Medical Admin	Streamlined the Physician On-Call schedule to support ancillary and clinical operations. An assessment was completed of the administrative support for the clinical departments. A proposed reconfiguration of the support staff will be developed upon further analysis and review. This assessment included the review of any clinical department directors that support the Department Chairs. Additional County resources/support will be required to proceed and complete the physician work force analysis.
Nursing Services - overall	<p>A formal process was established for staff scheduling to include a Director-level signature approval prior to posting of schedules, and monthly scheduling work -training sessions for managers. Beginning in June all nursing schedules will be posted without holes. A system was developed to track travel/registry requests monthly based on need so that contract gaps are eliminated. The Nursing Performance Improvement Plan was revised with an educational roll out for staff. A prevalence skin assessment was completed, results and recommended solutions due back to leadership team by June 30th. An interim wound and skin nurse in place to develop wound and skin program for KDMC. The permanent position has been posted with a target date August 15th to have permanent person in place.</p> <p>CNO and Clinical Director recruitment continues; two candidates screened for CNO with none progressing in the process. One Clinical Director candidate progressed in the process, with the search to continue. A time card approval process was developed for nurse managers and directors to ensure accuracy of hours worked. An online shift report tool was implemented to monitor required/actual staff by census with narrative explanation of variances. The tool will be completed by house supervisor at 6am, 2pm and 10pm each day and monitored by the CNO and leadership team to ensure meeting required nursing ratios. A comprehensive review of license verification is complete. All staff without valid licenses were terminated. Completed reviews and revision of policies for Code Blue, Transport, I&O, Heights/Weights, Fluid Management and Code Purple.</p>



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Information Technology - overall	<p>The IT Group continues to meet every other week to review outstanding IS needs/requests, IS-related Recommendations and IS-related Action Steps from other initiatives and implementations that may require DHS' intervention. 10.8 new IT positions and duty statements were submitted to the budget the DHS allocation is pending. Recruitment of IT staff is very slow and many candidates have elected not to come to KDMC at this time. 9 total vacancies, 1 filled this period. Two additional contract programmers approved for hire via QuadraMed Contract, 1 contract staff started April 25th. A week-long meeting was held in May to plan out the GE PIS cluster installation. The GE PIS strategy was changed to allow each cluster to install PIS server controlling their own PIS implementation with DHS-wide enterprise requirements.</p> <p>ORSOS has a signed PO in process for the upgrade and a group of IT staff and users met to discuss opportunities to improve functioning. ANSOS software/hardware PO has been signed the hardware has been delivered. A database administrator is being recruited to complete the transition work. Developing a local implementation plan for Online Requisitioning targeting implementation in July. COGNOS software will be used for managing the performance measures of the KDMC Implementation plan. Training for Congas was held May 2-11 for KDMC IT and related staff. PLATO software has been recommended/approved for clinical pertinence tracking for JCAHO preparation. PO for PLATO software is in process. The Fox HIPAA Assessment was reviewed and recommendations and action steps will be added to the workplan.</p>
Health Information Management - overall	The planning and assessment of HIM file room reveals OSHPD fire violation. An alternate plan was developed to reduce the number of active records thereby increasing available space to correct cited privacy issues. The Pharmacy scanning module was viewed and discussed at the IT meeting to determine feasibility for use in the HUB clinic. Continued improvements are being made to refine the Critical Incident Review Process, to date 149 charts have been reviewed by the RN staff. Training for four of the RNs was initiated for performing Clinical Pertinence Reviews on 4A, 3C, ED, CCU and Telemetry to identify documentation and medical record deficiencies in preparation of the JCAHO survey.
Human Resources - overall	During the month of May, Human Resources continued to actively recruit for the 8 key senior management positions. Several resumes were received and forwarded to KDMC executives and DHS management for review and interviews. Regulatory compliance continues to meet twice a month to ensure processes are coordinated and action is taken. The orientation and re-orientation package has been finalized and inservice training will begin in June. Training for all levels of employees have been ongoing, particularly in the areas of Performance Management, Time keeping, and Employee Relations. Completed PE's are now at approximately 80% with continuing efforts to achieve 100% compliance. Performance Management function has hired additional staff to assist in reducing the discipline backlogs.
Radiology	The crisis related to radiologists staffing continues. We are aggressively pursuing 24-hour per day teleradiology services with final report to compliment all modalities and our ability to provide reports much more expeditiously.
Laboratory/Pathology	Completed the consolidation of two departments, chemistry and special chemistry, as part of the core laboratory. Data collection of the Provider Satisfaction Survey was completed with 123 completed surveys (16%); data analysis to follow. On May 3rd the laboratory initiated phlebotomy services for the psychiatric unit. Staff training, inservices, and operational logistics were handled throughout the month. On May 16th, the laboratory introduced a revised STAT test menu and guidelines approved by the Laboratory Advisory Committee and the PSA committee. On May 13, the laboratory initiated remote printing of STAT test results to the ED. The laboratory also continued providing hands-on phlebotomy training for nurses in the ED, as well as training for new nurses entering KDMC, including travelers. Approximately 200 nurses have undergone the training with improvements identified including a 50% in hemolysis and lower blood contamination rates (a formal outcomes analysis is underway).



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	On May 17th the laboratory, HIM, and nursing managers developed an action plan to secure the filing laboratory reports in patients charts. The program will go into effect on May 1st, following two pilot runs the week of May 23rd. During the month of May 2005, the laboratory automated POCT urinalysis and pregnancy testing using the Status analyzer. The automation of this test removes 100% of the subjectivity interpreting test results, thus enhancing quality of care. The laboratory department continues supervisory coaching and employee recognition programs, including a celebration during the National Laboratory Week held in April 2005.
Pharmacy	A follow-up meeting with Local 660 to discuss security cameras scheduled for June 1st. Pharmacy no longer has viewing capability of DVR. 5 pharmacists were given pharmacist competence reassessment and all passed, with an average 75% increase in score (89-100% total), demonstrating the value of 6-week intensive training conducted by pharmacy management. Medication Safety Task Force planning meeting held on May 25th with the first weekly meeting scheduled for June 1st to review and categorize medication events on a weekly basis. Awaiting decision for physical relocation of clinical pharmacy office (for expedited cart fill) and outpatient pharmacy relocation to move forward with these initiatives. McKesson software upgraded concluded successfully on May 2nd.
Cardiology	Finalization and initiation of the implementation of the work plan.
Neuroscience	Finalization and initiation of the implementation of the work plan.
Ambulatory Services - overall	Initial workplan developed. Further revisions with KDMC leadership need to be made. Accountabilities for implementation need to be established.
Programs & Services - overall	Initial draft of Recommendations to be reviewed and revised with action step, timelines and accountabilities established.