

# HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department of Public Safety  
Prisons

SECTION: Administrative – Performance  
Improvement and Risk Management

POLICY # AD II-1

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SUBJECT: Performance Improvement Plan

ORIGINAL/SUPERCEDES DATE: July 2007  
EFFECTIVE DATE: AUGUST 15, 2017  
REVISED DATE: July 2017  
REVIEWED DATE: July 2017

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## References

4<sup>th</sup> Edition Standards for Adult Correctional Institutions:  
4-4408, 4-4422, 4-4423, 4-4424

2016 Standards Supplement:  
4-4380M (1-HC-2A-01)

### PURPOSE

The purpose of the Performance Improvement Plan is to ensure that Health Services develops a quality management program that designs processes well, monitors, measures, analyzes and evaluates performance to improve patient outcomes and improve organizational soundness and performance. The goals are to have an appropriate balance between good outcomes, excellent care / services, and costs; to understand the relationship between perception of care, outcomes, and costs, and how these three issues are affected by processes carried out by facilities within Prisons, and to recognize that the Division's performance of essential and crucial functions significantly affects the quality and value of services provided.

### POLICY

The constitutional obligation, grounded in the Eighth Amendment, and statutory requirement (GS 135-40.7(5)) requires Health Services to provide offenders access to quality care provided by competent health care professionals.

The Performance Improvement Plan addresses our goals to:

- View correctional facilities as public health stations that significantly impact the health status of the larger community.
- Improve the health status of the offender to get the best value for the total tax dollars spent.
- Meet the community standard of care
- Provide sound medical practices
- Provide appropriate care
- Provide care that will positively impact the public health sector
- Ensure consistency with the mission and goals of the Department of Public Safety – Division of Adult Correction Prisons.

### Authority

The development and maintenance of the Health Services Performance Improvement Plan is delegated to the Deputy Director of Health Services. The Deputy Director of Health Services delegates authority for the oversight of the plan to the Continuous Quality Improvement (CQI) Committee. The Deputy of Health Services delegates the authority for the coordination of the plan to the Health Services Risk Manager.

### PLAN

#### I. Executive Roundtable

- A. The Executive Roundtable is composed of Prisons Health Services Core Group of Senior Management Team and the Performance Improvement Staff.

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- B. Responsibilities of the Risk Management/Quality Improvement section:
  - 1. Develop and implement the Performance Improvement (PI) Plan.
  - 2. Insuring all Health Services Staff receive education in Continuous Quality Improvement (CQI).
  - 3. Insuring that the PI activities promote survey readiness by various accrediting agencies.
  - 4. Being a role model for PI principles for Prisons' staff.
  - 5. Setting priorities on monitoring activities, conducting CQI Projects and other PI efforts.
  
- C. In fulfilling the above duties, the Risk Management/Quality Improvement section performs the following tasks:
  - 1. Reviews data on performance indicators and actions taken for improvement. Directs appropriate parties to implement additional corrective or improvement action, if needed.
  - 2. Reviews and takes necessary action (informs Discipline Heads/Executive Leadership), if needed, for risk management issues identified.
  - 3. Reviews statewide CQI Projects and reports status to the Executive Leadership.
  - 4. Determines resource needs and makes recommendations to the Deputy Director of Health Services.

## II. Performance Improvement Plan Overview

### A. The PI Plan has four integral components:

- 1. Monitoring and evaluation of performance and indicator data
  - a. Peer Review
  - b. Healthcare Records Reviews
  - c. Committees – Mortality Review, Pharmacy and Therapeutics, CQI, etc.
  - d. Departmental (Nursing, Dental, Medical Records, Pharmacy, Behavioral Health, UR, Social Work, etc.)
  - e. Risk Management
  - f. The health authority meets with the facility or program administrator quarterly and submits reports on the Health care system and plans to address issues raised.
  - h. These quarterly reports may include (but not limited to) use of healthcare services by category, specialist referrals, numbers of prescriptions written, and lab and x-ray tests completed, infirmary, on and offsite hospital admissions, serious injuries, illnesses or deaths, and number of offsite transports for medical or mental health reasons.
  
- 2. Continuous Quality Improvement (CQI):
  - a. Each facility will develop a multidisciplinary Continuous Quality Improvement Committee that will collect, trend and analyze the data obtained both from Health Services and internally.
  - b. CQI Projects will be initiated as a means of planning, intervening and reassessing.
  - c. Health Services disciplines will establish measurable goals and objectives as part of the Continuous Quality Improvement Program which will be reviewed annually and updated as needed.
  - d. Chart reviews by responsible physician or designee
  - e. Reviews of prescribing practices as part of the P/T Committee
  - f. Comprehensive Program Review readiness
  - f. Monitoring of Corrective Action Plans by the facility Health Services management and Health Services Risk Management/QI section initiated post Operational Program Reviews, post Comprehensive Program Reviews and external audits/reviews.

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- g. Development of educational and training elements will be based on findings of internal reviews, external audits and CQI efforts.
  - k. Each policy, procedure, and program will be reviewed annually by appropriate authority, revised as necessary, bear the date of review/and or revision and Source of Reference. All policy revisions will be reviewed and signed/dated by the Deputy Director of Health Services and the Chief of Health Services.
- 3. Risk Management
    - a. Routine monitoring and tracking
    - b. Sentinel event reviews
    - c. Litigation
  - 4. Competence in job performance
    - a. Personnel file is one comprehensive package: job description, NCVIP work plan, interim reviews and evaluations, competency assessments
    - b. Core competencies (ex. Medication administration, nursing, etc.)
    - c. Age specific, population specific
    - d. Credentialing and privileging (tied to professional peer review data)

### III. Delegation of Responsibility for Implementation

- A. The Performance Improvement Plan is carried out collaboratively with an organization-wide approach. This means that Performance Improvement principles and techniques are utilized throughout Health Services.
  - It is expected that each facility will develop a Health Services Multidisciplinary CQI Program that includes at least annual monitoring of the fundamental aspects of the facility's health care system: intake/transfer process, access to care, continuity of care, emergency care, hospitalizations, and adverse patient events including deaths. The CQI Program will include monthly healthcare record clinical chart reviews of at least 5% (up to 25) patient health records.
  - All facilities will also review critiques of disaster drills, deaths, environmental inspection reports, offender healthcare grievances and infection control issues.
- B. The Risk Manager drafts the design of the annual PI plan based on the results of the previous plan's evaluation, American Correctional Association (ACA) Standards, and in accordance with administrative code. The Risk Manager maintains documentation of the implementation of the PI Plan. This includes coordinating the development, monitoring and evaluation of division level performance indicators, and continuous quality improvement efforts. The Risk Manager collects information regarding departmental PI plan implementation, IE: copies of PI plans, departmental indicator reports, and status reports on CQI Projects. The Risk Manager assists and monitors CQI committee activities as it relates to collecting, evaluating, and taking action on PI data. The Risk Manager collates aggregates, analyzes and reports PI information to the Executive Leadership and Discipline staff meetings.

### IV. Monitoring and Evaluation of Performance

All Health Services facility management staff is expected to monitor and evaluate the performance of patient care and facility functions.

- A. **Quality Control:** Health Services Department Heads shall identify tasks, duties and processes, which require monitoring. Any concerns resulting from these monitors will be reported through the chain of command and a

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Performance/Quality Improvement Plan will be implemented and submitted to Discipline Leadership and the Risk Management/QI section.

**B. Performance Indicators:** Performance indicators are measurement and assessment tools used to monitor and evaluate identified high risk, high volume or problem prone functions which affect, directly or indirectly, patient outcome(s). Data obtained through monitoring and evaluation of indicators raise important quality of care issues, which may lead to identifying opportunities for improvement and/or risk management issues, and assist in evaluating job performance and/or clinical competence.

1. Each indicator addresses at least one of the following functions:
  - a. Care and Assessment of Patients
  - b. Management of Information
  - c. Infection Control
  - d. Offender's Rights and Ethics
  - e. Human Resources
  - f. Continuity of Care
  - g. Patient Education,
  - h. Environment of Care
2. Every indicator specifies the monitoring methods for determining compliance and evaluating for trends and patterns, and has a compliance standard (threshold, trigger or standard) for measurement.

**C. Performance Improvement Model**

A Performance Improvement Model is really a way of management or philosophy. It should be used in staff meetings, committee meetings, CQI teams, etc.

**SUGGESTED MODEL: FOCUS-PDCA**

**F** - Find a Process to Improve

**O** - Organize a Group-Frontline People who do the process or work

**C** - Clarify Current Knowledge- "How is it done now"?

**U** - Understand Variation-identify what you want to achieve and compare with what is currently done.  
Identify the difference

**S** - Select Improvement/Change strategies

**P** - Plan how to implement the improvement or change -assign responsibilities and due dates

**D** - Do it - May do on trial or test basis

**C** - Check or study – Monitor, track, follow up and evaluate effectiveness - This is a very important step. It gives you data to validate that this is a needed change and if any additional revisions are needed.

**A** - Act - Based on evaluation, change if needed and repeat the PDCA Cycle

**V. Continuous Quality Improvement (CQI) Efforts**

1. CQI Projects: Involves the design of a new process or the analysis of an existing process to improve the care, treatment and services to patients. CQI projects may also address services provided to internal and external customers who have an impact on patient care outcomes and/or organizational performance.
2. Continuous Quality Improvement Projects may be initiated and conducted by facilities, departments, disciplines, services, committees, or proposed to and approved by the CQI Committee when the process studied affects multiple departments, services or disciplines. CQI project proposals may be submitted to the

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Risk Manager or CQI Committee by any employee or committee. The CQI Committee may initiate a CQI project in response to performance indicator findings, data or risk management monitoring.

3. Improvement projects are to possess the following characteristics:
  - a. Based on the Health Services mission, goals and objectives;
  - b. Based on the needs and expectations of patients, staff and others as identified.
  - c. Based on American Correctional Association standards and regulations
  - d. Involve collaboration with appropriate departments/services and disciplines.
    - (a) A quality team is organized and is composed of those directly involved in the process to be improved.
    - (b) Analyzes the process
    - (c) Evaluates the effectiveness of improvement strategies and actions
    - (d) Improvement actions and implementation of new processes shall be implemented through proper channels of approval.
    - (e) Improvement actions may be tested rather than full-scale implementation

## VI. Annual Evaluation

In January of each year, the CQI Committee discipline team members will conduct an evaluation of the previous year's PI Plan for their respective disciplines. The evaluation will be submitted to the Health Services Risk Manager no later than the 2<sup>nd</sup> Monday in January. The Risk Manager will consolidate each discipline annual evaluation of the PI Plan and present to the Executive Leadership and CQI Committee in January. The disciplines' evaluation shall include but is not limited to:

- 1) A summation their disciplines PI Plan
- 2) PI accomplishments such as CQI projects, improvements in policy development/review process and Comprehensive Program Review readiness
- 3) Performance or compliance problems/issues such as those reflected in PI indicator reports and strategic plan progress report.
- 4) The evaluation shall be instrumental in the review and revision of the PI Plan for the upcoming year.

  
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Terri Catlett, Deputy Director of Health Services      Date 7/17/17

SOR: Risk Manager