Policy and Procedure

McMinnville Free Clinic

RISK MANAGEMENT AND QUALITY ASSURANCE

APPROVED: 8/27/12
LAST REVIEW DATE: 8/27/12

Policy

McMinnville Free Clinic (MFC) will assure high quality of care for its patients and a standard of excellence for its health care professionals by establishing a Risk Management and Quality Improvement and Quality Assurance (QA) Committee to oversee and continuously improve the quality of care.

Procedure

Background: QA Committee will be made up of one or more members from the board and each patient care team, including, but not limited to, Medical Director or designee from providers, nursing, reception & medical records, provider assistants, facilities and social services. Term will be two years, with staggered end dates for each term in January of each year. Meetings will be quarterly, in January, April, July, and October: meeting minutes will be maintained for review as needed.

1. Manage patient care/risk

    a. Annually review patient satisfaction surveys for patient input into quality of care. Surveys will be issued in fall and reviewed by the committee each January, and findings are used to modify policies to improve patient care.

    b. Annually review (in April) the patient care policies/procedures for content and efficacy of implementation, including, but not limited to:

        i. Nondiscrimination

        ii. Patient confidentiality and medical records

iii. Emergency services offered by MFC

iv. Occurrence reporting

v. Dangerous and disruptive individuals

vi. Grievance and complaint

vii. Prescription medication

viii. Clinic flow

2. Manage healthcare professionals care/risk

   a. Annually review volunteer risk assessment surveys for their perceptions of any risks presented by the operation of MFC. Surveys will be issued to volunteers in the fall & reviewed by the committee in January, and findings are used to modify policies to decrease risks and improve operations.

   b. Provide and maintain all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), material safety data sheet (MSDS) manual, hazard/chemical and body fluid spill kits, and red bags and ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes in the MFC office with clear labeling.

   c. Each April, annually review the specific staff policies/procedures that pertain to volunteer safety including, but not limited to:

      i. Credentialing and Privileging

      ii. Grievance and Complaint

      iii. Supervision/Back-up of Clinical Staff

      iv. TB Testing and Immunization

      v. Exposure Control Plan

      vi. Blood and Body Fluid Spill

vii. Hazard Standard

viii. Hazard Material Containment and Disposal

d. Oversight of credentialing and privileging process and any issues that arise related to credentialing and privileging (see credentialing and privileging policy).

e. Manage Provider Peer Review

i. MFC Peer Records Reviews are done throughout the year at each clinic and reviewed in July for needed actions as follows:

1. MD/DO/NP – At each clinic, will review one chart for every seven patients seen; two charts will be reviewed if eight or more patients are seen.

2. PA – per guidelines of Oregon Medical Board practice plan and agreement specific to each PA and their supervising physician

ii. It is expected that:

1. If needs for correction are identified at the time of the review, the professional doing the review will discuss with provider, if available, to answer any questions. If the provider is not available, if they do not feel comfortable discussing the concern with them, or if there is a significant concern, the professional doing the review is expected to express their concern *at that time* to the Clinic Coordinator, and the Medical Director will be made aware to make a determination of action.

2. If signatures or other information is missing, Medical Records staff will do all possible to obtain the missing information as soon as possible.

iii. Every two years a letter will be sent to each Provider indicating the status of their MFC Peer Review Records and the determination of their ongoing work with MFC.

f. Competency reviews (Supervisors Evaluation of Performance) for registered nurses and other licensed professionals at MFC will be completed a minimum of once per month (or as volunteering occurs if less frequent) and will be reviewed in June. A letter will be sent every

two years to the professional regarding the status of the review and the determination of their ongoing work with MFC.

g. Ongoing staff education & training:

    i. QA Committee is responsible to generate staff training & education materials at each quarterly meeting.

    ii. Education materials will be available to volunteers via:

        1. Digital copies emailed to volunteers

        2. Hard copies available at MFC to those without internet access

        3. PowerPoint presentations available on MFC website for easy access by volunteers. Email notification will be sent to pertinent volunteers as these are available.

3. Management Responsibility (Risk Management Committee)

    a. Meet quarterly and review contents of this policy (including any Occurrence Reports or grievances or complaints submitted/filed).

    b. To resolve all possible issues that come up related to this policy.

    c. Make recommendations to the Board of Directors where there are personnel or risk issues that the committee feels are beyond their ability to resolve or if they feel the Board needs to be aware of the actions they are taking (e.g. terminating a Provider or other licensed professional from their work with MFC, insufficient funding to ameliorate a risk that presents itself, etc.). This recommendation should be presented in writing with supporting facts outlined and can be taken/presented to the MFC Board by a member of the QA Committee.

Meeting Schedule:

January: Review Patient Satisfaction Surveys and Staff Risk Surveys

April: Review Policies and Procedures

July: Review peer review information, send letters for nurses and providers

October: Issue patient satisfaction and staff risk assessment surveys

Each meeting will also develop staff education materials and review staff satisfaction surveys

If, because of unexpected events, a meeting is not able to occur in the month scheduled, the meeting will occur in the following month.

Board approved 8/27/12

Jacqui Terrill Cooke, FNP, CNM

Jacqui Terrill Cooke, board president