carf EUROPE

GUIDELINES FOR SUBMITTING A QUALITY IMPROVEMENT PLAN

Attached is a form for your use in submitting a Quality Improvement Plan (QIP). Quality improvement efforts are regarded by CARF as integral and critical facets of the accreditation process. Guidelines for completing the form are as follows:

1. Respond to all standards identified.

2. Include a brief response that indicates the steps that have been taken or are being taken to address the recommendation. Indicate estimated dates for completion of "in process" items, where appropriate. Do not repeat the wording of the recommendation from the survey report in your QIP.

3. Do **not** include any copies of your organisation's forms, policies, procedures, memos, pamphlets, documents, or other attachments with the QIP. CARF will only review your written response to each recommendation.

Upon receipt of the QIP, CARF will review your progress toward addressing the recommendations and acknowledge the plan in a letter to your operational leadership. The QIP will be included in the packet of materials sent to the next survey team. During the next survey visit, the team will review this further to make the determination whether the actions you have taken have brought your organisation into conformance to the standards. Additional information concerning the interpretation of specific standards is available by calling CARF.

Please note that the submission of a QIP within 90 days (45 days for a preliminary survey) following your initial notice of accreditation is a CARF Accreditation Condition and is required to maintain accredited status. For more information refer to the Accreditation Conditions in the current standards manual.

We encourage you to approach the completion of the QIP as an additional opportunity to enhance the quality, value, and outcomes of your services. If you would like further assistance, please do not hesitate to contact us at 001 (520) 325-1044.

Please send the completed QIP to asc@carf.org via email.

If you are unable to submit the QIP electronically, you may send the completed plan via regular mail to the Tucson, Arizona, office or fax it to (520) 495-7080 [fax to 001 (520) 495-7080 from outside the US and Canada].

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QUALITY IMPROVEMENT PLAN

Return to CARF by 10/12/2018

Company ID: 208196

Sunnaas sykehus HF
Bjornemyrveien 11
1450 Nesoddtangen
NORWAY

Survey Number: 106027
Accreditation Decision: Three-Year Accreditation
Accreditation Expiration Date: 6/30/2021
Survey Date(s): 6/6/2018–6/8/2018
Standards Manual(s): 2017 Medical Rehabilitation

Completed by (Name): Gøril Otterlei

Date Completed: 10/2/2018

Job Title: quality manager

Standard Number for Recommendation	Step(s) to Address the Recommendation	Completion Date (Actual or Estimated)
1.K.2.a.(1)	Establish a working group to develop a short, systematic course for patients outlining patient rights during their stay. The course is integrated into the patients' tailor-made curriculum. The course material and invitation to the course include the name and contact information of the instructor so that the patient will know who to contact if he/she has questions. *Responsible: Head of Competence Unit*	March 1, 2019
2.A.1.a.(3) 2.A.1.a.(4)	The management coordinator creates a template to capture the scope of service in hours and days for each program. Department managers use the template to document the scope of their interdisciplinary offering in hours and days for their respective departments. The management coordinator ensures publication on the hospital's website. *Responsible: Management coordinator for creation of template and final publishing; department managers for use and return of template.*	January 1, 2019
2.B.20.d.(3)	Interdisciplinary teams ensure that the patient's family and support system is included in the patient's program and treatment plan such that impact on the family/support system can be taken into account. Families are asked about preferred timing and preferences for therapy schedule, family training, family conferences/meetings and involvement of other support systems. The interaction network develops a systematic approach	January 1, 2019

	for asking and facilitating family and support system preferences regarding participation in the patient's program. Use of virtual meeting rooms will be an important tool in this process. *Responsible: Head of Cooperation Department – in cooperation with interaction network*	
2.B.26.c.(2)	Increase use of virtual meeting rooms so that conference appointments with family/support systems are scheduled at a time convenient for them. Develop guidelines to ensure implementation, including options for offering conferences outside of normal working hours. *Responsible: Integration manager as head of integration network*	June 1, 2019
2.B.29.c. 2.B.29.d.	Create systems to measure the degree of effect of the education provided to persons served, families and support systems. Develop learning goals and assessment tests for each program. Develop webinars, videos of teaching sessions, to be published on the hospital's website to support continuous learning. *Responsible: Head of Competence Unit*	October 1, 2019
2.E.4.d. 2.E.4.g.	Develop procedures that ensure that all necessary age-specific equipment is available in the unit for children and adolescents. The child/adolescent and his/her family's needs are taken into account when developing the schedule. *Responsible: Head of Unit for Children and Adolescents*	April 1, 2019
3.A.15.b.(1)(a) 3.A.15.b.(1)(b) 3.A.15.b.(1)(c) 3.A.15.b.(2) 3.A.15.b.(3) 3.A.15.b.(4) 3.A.15.b.(5)(a) 3.A.15.b.(5)(b) 3.A.15.b.(5)(c)	Conduct a written analysis of collected information related to *unplanned transfers, discharges to long-term care and expiration*. The analysis will include: - goals related to *unplanned transfers , discharges to long-term care and expiration* - evaluation of trends and results of previously implemented measures - if needed, measures for improvement and/or plans for education and training of personnel Develop and implement analysis template for annual systematic assessment and action taking. *Responsible: Head of department for* - *Brain injury specialty program* - *Spinal cord injury specialty program* - *Stroke specialty program* - *Multitrauma, neurological and burn specialty program*	April 1, 2019

3.A.16.c.(1)(a) 3.A.16.c.(1)(b) 3.A.16.c.(1)(c) 3.A.16.c.(1)(d) 3.A.16.c.(2) 3.A.16.c.(3) 3.A.16.c.(4) 3.A.16.c.(5)(a) 3.A.16.c.(5)(b) 3.A.16.c.(5)(c)	Conduct written analysis based upon systematic collection of follow-up data, including goals set for specific areas of outcome. The analysis will include: - An assessment of the development and effect of previously implemented measures - If needed, measures for improvement and/or plans for education and training of personnel Develop and implement analysis template for annual systematic assessment and action taking.. *Responsible: Head of department for* - *Brain injury specialty program* - *Spinal cord injury specialty program* - *Stroke specialty program* - *Multitrauma, neurological and burn specialty program*	June 1, 2019
3.B.4.a. 3.B.4.b.(1)(a) 3.B.4.b.(1)(b) 3.B.4.b.(1)(c) 3.B.4.b.(2) 3.B.4.b.(3) 3.B.4.b.(4) 3.B.4.b.(5)(a) 3.B.4.b.(5)(b) 3.B.4.b.(5)(c)	Conduct written analysis based upon systematic collection of data, including goals set for specific areas of outcome. - No-shows - Cancellations - Dropouts The analysis will include: - An assessment of the development and effect of previously implemented measures - If needed, measures for improvement and/or plans for education and training of personnel Develop and implement analysis template for annual systematic assessment and action taking. *Responsible: Head of Department for Outpatient program*	April 1, 2019
3.H.33.a.(1)(a) 3.H.33.a.(1)(b) 3.H.33.a.(1)(c) 3.H.33.a.(1)(d)(i) 3.H.33.a.(1)(d)(ii) 3.H.33.a.(2)(b) 3.H.33.a.(2)(c) 3.H.33.b.(1)(a)(i) 3.H.33.b.(1)(a)(ii) 3.H.33.b.(1)(a)(iii) 3.H.33.b.(1)(a)(iv) 3.H.33.b.(1)(a)(v) 3.H.33.b.(1)(b)(ii) 3.H.33.b.(1)(b)(iii) 3.H.33.b.(2) 3.H.33.b.(3) 3.H.33.b.(4) 3.H.33.b.(5)(a) 3.H.33.b.(5)(b) 3.H.33.b.(5)(c) 3.H.33.b.(5)(d)	The brain injury specialty program gathers information on satisfaction from families, support systems and referral sources in the areas of a. Clinical practices/behaviors b. Degree of inclusion of persons served c. Outcomes achieved d. Information received about program Conduct written analysis based upon systematic collection of data, including goals set for specific areas of outcome (a, b, c, d.) The analysis will include: - An assessment of the development and effect of previously implemented measures - If needed, measures for improvement and/or plans for education and training of personnel Develop and implement analysis template for annual systematic assessment and action taking. *Responsible: Head of Department for Brain Injury specialty*	January 1, 2020

	program	
3.J.15.a.(1)	Programs that offer spinal cord injury rehabilitation provide trained and competent peer support that reflects the characteristics of the persons served. Implement a system to ensure that peer supporters have individual meetings with persons served. Conduct pilot project with spinal cord specialty program first, whereby a meeting with a peer supporter is included in patient schedule. The manager for Professional Education contacts peer support organizations to identify possibilities for cooperation. *Responsible: Head of Competence Unit*	May 1, 2019
3.K.20.b.(1)(a) 3.K.20.b.(1)(b) 3.K.20.b.(1)(c) 3.K.20.b.(1)(d) 3.K.20.b.(1)(e) 3.K.20.b.(1)(f) 3.K.20.b.(2) 3.K.20.b.(3) 3.K.20.b.(4) 3.K.20.b.(5)(a) 3.K.20.b.(5)(b) 3.K.20.b.(5)(c)	The stroke specialty program conducts an annual analysis of follow-up information on stroke patients in areas 1-6 in the standard; 1. Aspiration pneumonia. 2. Falls. 3. Falls with injuries. 4. Other injuries. 5. Re-hospitalizations. 6. Unplanned medical visits/encounters. Conduct written analysis based upon systematic collection of data, including goals set for specific areas (1-6) in the standard. The analysis will include: - An assessment of the development and effect of previously implemented measures - If needed, measures for improvement and/or plans for education and training of personnel Develop and implement analysis template for annual systematic assessment and action taking. *Responsible: Head of department for Stroke Specialty Program*	January 1, 2020
3.K.24.a.(1) 3.K.24.a.(2) 3.K.24.a.(3) 3.K.24.a.(4) 3.K.24.b.(1)(a) 3.K.24.b.(1)(b) 3.K.24.b.(1)(c) 3.K.24.b.(1)(d) 3.K.24.b.(2) 3.K.24.b.(3) 3.K.24.b.(4) 3.K.24.b.(5)(a) 3.K.24.b.(5)(b) 3.K.24.b.(5)(c)	Establish a measurement indicator (% of persons served) to measure compliance at discharge with evidence-based guidelines for managing diabetes, hyperlipidemia, hypertension and stroke prophylaxis. The stroke specialty program conducts an annual analysis of follow-up information on stroke patients in areas 1-4 in the standard. 1. Diabetes 2. Hyperlipidemia. 3. Hypertension. 4. Stroke prophylaxis. Conduct written analysis based upon systematic collection of data, including goals set for specific areas (1-4.)	January 1, 2020

	The analysis will include: - An assessment of the development and effect of previously implemented measures - If needed, measures for improvement and/or plans for education and training of personnel Develop and implement analysis template for annual systematic assessment and action taking. *Responsible: Head of department for Stroke Specialty Program*	
3.L.10.b.	To increase the possibility of a successful treatment, the psychologist in the pain team conducts a pre-treatment assessment of each person prior to the initiation of treatment. *Responsible: Head of department for Pain Program*	April 1, 2019