Quality Assurance Performance Improvement

Joint Provider/Surveyor Training
April 1, 2014

Please note that the actual presentation may differ from the handout provided through LARA due to any changes in state or federal processes that occurred after the presentation was submitted for distribution.

Objectives

- Identify the five elements for framing Quality Assurance and Performance Improvement (QAPI) in the nursing home
- Discuss how to implement effective Performance Improvement Projects (PIPs)
- Explore the sources of feedback, data systems and monitoring
- Demonstrate the effective use of Root Cause Analysis (RCA) to identify systems problems
- Describe the Plan Do Study Act (PDSA) framework for improvement
Accelerating Improvement – Transforming nursing homes through continuous attention to quality of care and quality of life

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)

A philosophy that no matter how good we are, there is always room for improvement

<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Quality Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FOCUS</strong></td>
<td><img src="Image" alt="List of Quality Assurance Focus" /></td>
</tr>
<tr>
<td><strong>GOAL</strong></td>
<td><img src="Image" alt="List of Quality Assurance Goal" /></td>
</tr>
<tr>
<td><strong>WHO IS INVOLVED</strong></td>
<td><img src="Image" alt="List of Quality Assurance Who" /></td>
</tr>
<tr>
<td><strong>DRIVEN BY</strong></td>
<td><img src="Image" alt="List of Quality Assurance Driven By" /></td>
</tr>
<tr>
<td><strong>WHEN OCCURS</strong></td>
<td><img src="Image" alt="List of Quality Assurance When" /></td>
</tr>
<tr>
<td><strong>OTHER DIFFERENCES</strong></td>
<td><img src="Image" alt="List of Quality Assurance Other" /></td>
</tr>
</tbody>
</table>
Background – mandated by Affordable Care Act

Context – regulatory process rooted in quality improvement

QAPI is the systematic approach to corporate compliance

Proactive effort to use data to understand and improve your own problems (internal governance)

“Taking a step beyond quality assessment and assurance (QAA)... performance improvement is the key ingredient, catapulting the QAA movement from its inadequate assessment of compliance to a movement deep rooted in quality improvement.”

- Dr. Rosalie Kane, University of Minnesota

Final rule may be issued in 2014

Nursing homes must have a QAPI program in place (with written plan) a year after final rule

CMS has developed tools and resources that are available to all nursing homes to increase likelihood of successful rollout

http://go.cms.gov/Nhqapi. Visitors to the site may also email any questions to: Nhqapi@cms.hhs.gov

Rollout June 2013 S&C: 13.37-NH. QAPI at a Glance

Process tool framework released February 20, 2014

Further recommendations will be coming

- How plans of correction may be aligned with QAPI
- How to align the survey/regulatory process with QAPI
- How to involve patients and families in QAPI

Additional tools and survey training will be forthcoming
Five Elements of QAPI

- Design and scope
- Governance and leadership
- Feedback, data systems and monitoring
- Performance improvement projects (PIPs)
- Systematic analysis and systemic action

Design and Scope

- Ongoing and comprehensive
- Full range of services offered by the facility
- Address clinical care, quality of life, resident choice and care transitions
- Safety and high quality with all clinical interventions
- Autonomy and choice in daily life for residents
- Best available evidence to define and measure goals
Governance and Leadership

Responsible for:

• Setting priorities for the QAPI program
• Building on the principles identified in the design and scope
• Setting expectations around safety, quality, rights, choice and respect
• Ensuring that staff is held accountable
  
  *In an atmosphere free of fear of retaliation for reporting quality concerns*
New Tool: Examples of Performance Objectives for Job Descriptions

Job Role: Nursing Home Administrator

- Receive direction from the owner/board of directors on QAPI goals and clearly communicate these to staff.
- Communicate regularly on the progress of QAPI work to the owner/board of directors, employees and other stakeholders.
- Establish overall QAPI objectives for the organization and assign responsibility for their fulfillment.
- Accept responsibility and oversee development of QAPI plan, including policies for ensuring that QAPI activities are given high priority in the overall management of facility operations.
- Foster an organization-wide commitment to quality assurance and performance improvement both verbally and non-verbally (i.e., via actions and attitude).
- Allocate sufficient financial, material and human resources, including training, to carry out QAPI activities.
- Ensure QAPI in the organization includes a mechanism for obtaining resident and family input to consider as potential areas for improvement.
- Create and maintain a consistent process (e.g., scheduled rounding, active participation on quality committees) to stay informed of all QAPI efforts underway, including their progress and achievements.
- Provide oversight and enthusiastic support of QAPI activities.

Job Role: Director of Quality / Quality Leader / QAPI Coordinator

Feedback, Data Systems and Monitoring

This element includes:

- Using performance indicators to monitor a wide range of care processes and outcomes
- Reviewing findings against benchmarks and/or targets the facility has established for performance
- Tracking, investigating and monitoring adverse events that must be investigated every time they occur
- Implementing action plans to prevent...
“Measurement is only a handmaiden to improvement... but improvement cannot happen without it.”
- Don Berwick

Sources of Data

- Proprietary
  - abaqis—Medline
  - My Innerview
  - Point Right
  - Long Term Care Trend Tracker
  - Corporate Systems

- Family and resident council
- Staff feedback
- Staff and Resident satisfaction surveys
- MDS data- 672, 802 reports
- Oscar reports
- Quality Measures based on MDS data
- Casper report
- Nursing Home Compare
  http://www.medicare.gov/NursingHomeCompare
Understanding your Quality Measures

• QM's are valid data available to the public
• QM's are used by the State Survey Agency
• QM's are used by CMS
  – Nursing Home Compare/Five Star Rating
  – Partnership for Dementia Care
  – QIO projects (MPRO)
• QM's are used by Accountable Care Organizations.
### Five-Star Quality Rating System

**Long-Stay Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent whose need for help with daily activities has increased</td>
<td>Late loss ADLs (bed mobility, transfer, eating and toileting). Two changes by one level or one change by two levels</td>
</tr>
<tr>
<td>Percent of high-risk residents with pressure ulcers</td>
<td>High risk (impaired bed mobility or transfer, comatose, or malnutrition). Stage 2-4 pr. ulcers</td>
</tr>
<tr>
<td>Percent of residents who have had a catheter inserted and left</td>
<td>Long-stay residents who have had a Foley in the last seven days.</td>
</tr>
<tr>
<td>Percent of residents who were physically restrained</td>
<td>Physically restrained daily—lap buddy, chair prevents rising, etc. (bolsters don’t count)</td>
</tr>
<tr>
<td>Residents with UTI</td>
<td>In the last 30 days</td>
</tr>
<tr>
<td>Moderate to severe pain</td>
<td>Long-stay with almost constant or frequent moderate to severe pain in last five days or very severe horrible</td>
</tr>
<tr>
<td>Falls with major injury</td>
<td>Bone fractures, closed head in LAST YEAR</td>
</tr>
</tbody>
</table>
Five-Star Quality Rating System

<table>
<thead>
<tr>
<th>Short-Stay Measures</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of residents with pressure ulcers that are new or worsened</td>
<td>New or worsening Stage 2-4 pressure ulcers</td>
</tr>
<tr>
<td>Percent of residents who self-report moderate to severe pain</td>
<td>At least one episode of moderate/severe or horrible/excruciating pain in last five days</td>
</tr>
</tbody>
</table>

All of the nine quality measures (QMs) are given equal weight.
Your goal should be that 0% of your residents trigger the QM.
Your score for the Five-Star is calculated by how you compare with other nursing homes in the Nation (percentiles) except ADLs (state comparison).

Partnership to Improve Dementia Care

**WDS 3.0 Measure: Percent of Long-Stay Residents Who Received An Antipsychotic Medication**

<table>
<thead>
<tr>
<th>Measure Specification</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>All residents with a diagnosis of dementia who have an initial admission to a facility on or after the target period.</td>
<td></td>
</tr>
</tbody>
</table>

**WDS 3.1 Measure: Percent of Short-Stay Residents Who Newly Received An Antipsychotic Medication**

<table>
<thead>
<tr>
<th>Measure Specification</th>
<th>Calculations</th>
</tr>
</thead>
<tbody>
<tr>
<td>All residents with a diagnosis of dementia who have an initial admission to a facility on or after the target period.</td>
<td></td>
</tr>
</tbody>
</table>
Facility Review Process

- Review the QM report and select the measure to review
- Select a separate sample of residents for each QM that will be reviewed for potential problems
- Review the care for each sampled resident related to the QM being reviewed
Facility Level Review Includes Data Needed to Perform RCA

- Make conclusions about the quality of care for each resident in your sample
- Decide if there is a facility wide opportunity with the QM after reviewing the care for each resident in your sample
- Discuss conclusions of the QM investigation with your team
Resident Level Review—More Data for RCA

- **Assessment** — accuracy and decision-making
  - Does the minimum data set (MDS) accurately reflect the status of the resident during the assessment period?
  - Is the assessment information accurate?

- **Care planning**
  - Has the condition represented by the QM been addressed in the resident's plan of care?
  - Is there a problem with the development of a plan of care for this resident related to the QM?

More Resident Level Data for RCA

- **Implementation**
  - Is staff knowledgeable about the plan of care and providing the care and services described in the care plan?

- **Evaluation and Monitoring**
  - Has staff responded to the changes in this resident's condition related to the QM?
  - Have the effects of the care plan goals, interventions, and implementation been reviewed and modified as necessary to promote the best outcomes for the resident based on an accurate and current assessment?
  - Is there a problem with the monitoring and evaluating the outcomes of the care and services provided for this resident related to the QM?
**Sources of Data Related to Readmissions**

Table 1: Primary Diagnoses on Claims of All Hospitalized Medicare Nursing Home Residents in FY 2011

<table>
<thead>
<tr>
<th>Primary Diagnosis Category</th>
<th>Percentage of Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of pleural effusion, hypotension</td>
<td>8.8%</td>
</tr>
<tr>
<td>Congestive heart failure, cardiomegaly</td>
<td>5.8%</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>9.3%</td>
</tr>
<tr>
<td>Infection pneumonic, ventilator</td>
<td>4.6%</td>
</tr>
<tr>
<td>Acute renal failure</td>
<td>3.8%</td>
</tr>
<tr>
<td>Complications of device, implant, or graft</td>
<td>6.3%</td>
</tr>
<tr>
<td>Respiratory failure, insufficient, or arrest</td>
<td>2.7%</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>2.4%</td>
</tr>
<tr>
<td>Complications of surgical procedures or medical care</td>
<td>2.4%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD) and bronchiectasis</td>
<td>2.4%</td>
</tr>
<tr>
<td>Delirium, dementia, and amnestic and other cognitive disorders</td>
<td>2.2%</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>2.1%</td>
</tr>
<tr>
<td>Fluid and electrolyte disorders</td>
<td>2.0%</td>
</tr>
<tr>
<td>Failure of vent of heart (top)</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

One-quarter of Medicare nursing home residents experienced hospitalizations in FY 2011, and Medicare spent $14.3 billion on these hospitalizations.

Of the 5.5 million Medicare residents who stayed in nursing homes for at least 1 day in FY 2011, 825,765 (15.4 percent) experienced hospitalizations. The majority of hospitalized residents (67.8 percent) transferred from nursing homes to hospitals only once. Twenty percent transferred two times, 7.2 percent transferred three times, and the remaining 5 percent transferred four or more times (see Figure 1).
Medicare Nursing Home Resident Hospitalization Rates

• CMS Recommendations
  – Develop a quality measure for hospitalization rates
  – Instruct state survey agencies to review the proposed quality measure as part of the survey and certification process

  • Office of Inspector General (OIG) report released November 2013 OEI-06-11-00040

Skilled Nursing Facility Readmission Quality Measure

• New QM not yet released
• Harmonizes with hospital wide readmission measure
• Determines risk factors for readmission and has a risk adjustment model
**Sources of data found on Advancing Excellence in America’s Nursing Homes website**

www.nhqualitycampaign.org

**Advancing Excellence Goals**

- Consistent assignment
- Staff stability
- Person-centered care and decision-making
  - Pain
  - Pressure ulcers
  - Antipsychotics
  - Hospitalizations
  - Mobility
  - Infections
## Two Tracking Tools

<table>
<thead>
<tr>
<th>Advancing Excellence Safely Reduce Hospitalizations Tracking Tool</th>
<th>INTERACT Hospitalization Rate Tracking Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Fields are Identical</td>
<td></td>
</tr>
<tr>
<td>Layout and Functionality Identical</td>
<td></td>
</tr>
<tr>
<td>Outcome Calculations are Identical</td>
<td></td>
</tr>
<tr>
<td>Use Data on Monthly Outcomes Tabs to Participate in AE</td>
<td></td>
</tr>
<tr>
<td>High-level process measures captured in the same tool as associated outcomes*</td>
<td>Detailed process information recorded separately in the companion QI Review Tool*</td>
</tr>
</tbody>
</table>

*The INTERACT QI Review Tool would also complement the AE Tracking Tool.

## Safety Reduce Hospitalizations

### PREDICTING QUESTIONS

**Exercise Process**

- What pattern do we see in our hospitalization rates?
- In what time period does a patient go home from hospital?
- How many days are we most of our admissions for hospitalization?
- What day of the week are most of our admissions from the hospital occurring?
- What day of the week are most of our discharges to the hospital occurring?

**Which groups are most affected?**

- What proportion of our hospitalizations have dementia?
- How many patients were admitted to the hospital?
- How many patients were transferred to the hospital?
- What are the highest numbers of patients?

**Exuberant scenarios**

- Are any of the scenarios for hospital admission made by the medical director, a covering physician, or by a physician's assistant?
- Is there a particular condition that requires that an or to be admitted to the hospital?
- Are residents falling ill? If so, how are they admitted to the hospital?
- Is there a process in place to communicate the fall to the family?

**Processes and Resources to Consider**

- Has the number of patients on the team increased?
- How many of the patients are being discharged?
- How many of the patients are being discharged to a nursing home?
**Using your 2567 as a source of data**

- Not best way of identifying problems!
- Still can provide data that facilities must analyze and incorporate into QAPI
- Analyze and do RCA before writing plan of correction
- Read and re-read for comprehension of entire report

**Statement of Deficiencies CMS 2567**

- Not best way of identifying problems!
- Still can provide data that facilities must analyze and incorporate into QAPI
- Analyze and do RCA before writing plan of correction
- Read and re-read for comprehension of entire report

**Anatomy of your CMS-2567**

**Three Basic Components**

**1) Regulatory reference**
- A survey data tag number
- The CFR or LSC reference
- The language from that reference which specifies the aspect(s) of the requirement with which the entity was noncompliant
- An explicit statement that the requirement was “NOT MET”
- Review State Operations Manual Appendix PP for each tag cited. CMS website
Anatomy of Your CMS-2567

2) Deficient Practice Statement
   • The specific action(s), error(s), or lack of action (deficient practice),
   • Outcome(s) relative to the deficient practice, when possible
   • A description of the extent of the deficient practice or the number of deficient cases relative to the total number of such cases,
   • The identifier of the individuals or situations referenced in the extent of the deficient practice, and
   • The source(s) of the information through which the evidence was obtained.

3) Relevant facts and findings
   • The facts and findings relevant to the deficient practice, answer the questions: who, what, where, when and how. They illustrate the entity's noncompliance with the requirement or regulation.
   • Sources of evidence may include:
     • Observation(s)
     • Interview(s)
     • Review of record(s) and other document(s)

Deficient Practice Statement Examples

1) F 279 Comprehensive Care Plans
   Based on observation and record reviews the facility did not ensure that the plan of care was developed for 1 (Resident #7) of 15 sampled residents in accordance with an assessment.
   Resident #7's care plans did not include steps (gripper socks) to prevent recurrence of falls and the use of a side rail for positioning and balancing in bed.
Deficient Practice Statement Examples

• Process problems identified?
  – Assessment results not making it to the care plan.

• How do you measure/evaluate your improvements to this process?
  – Audit of assessments and related care plans for consistency
  – Accuracy rate?

Deficient Practice Statement Examples

2) F 309 Quality of Care

Based on interview, observations and record review, the facility failed to comprehensively assess pain including non-verbal sign/symptoms and provide treatment to ensure comfort during transfers and therapy for 1 of 5 residents (R1) reviewed for pain in a sample of 8.

This failure resulted in a decline in transfer ability and from a stand pivot transfer to a total lift transfer.

Deficient Practice Statement Examples

• Process problems identified?
  – Assessment of pain, treatment of pain during transfers and during therapy. Proactive approach to prevention of pain.

• How do you measure/evaluate your improvements to this process?
  – Audit of pain assessment and treatment process related to ADL’s and therapy. Interview and observations for consistency. Pain ratings scale?
3/3/2014

Deficient Practice Statement Examples

3) F 314 Pressure Sores
Based on record review and interview, the facility failed to timely identify/assess, measure and obtain treatment orders and provide timely turning and repositioning for 1 of 6 residents (R14) reviewed for pressure sores in the sample of 15.

This failure resulted in R14’s three Stage II, one Stage III and one Stage IV pressure sores not being identified, measured and/or treated until the pressure sores were identified as Stage II’s, III and IV.

Deficient Practice Statement Examples

• Process Problems Identified?
  – Identification of pressure areas, measurement and treatment, Repositioning process, Documentation of all components related to wound care.

• How do you measure/evaluate your improvements to this process?
  – Audit of each component of the process.
  – Consistency and accuracy?

Performance Improvement Projects

The facility conducts Performance Improvement Projects (PIPs):

• To examine and improve care or services in identified areas
• Typically a concentrated effort on a particular problem in one area of the facility or facility wide
• Involves gathering information systematically to clarify issues or problems, and intervening for improvements
• Selected in areas important and meaningful for the specific type and scope of services unique to each facility
New Tool

QAA PI

- QAA Committee (Steering Committee) identifies need for Performance Improvement Project
  - Looks at data
  - Prioritizes
- Charters a Performance Improvement Team
  - Team does root cause analysis
  - Initiates interventions by Plan-Do-Study-Act

Project Charter Includes:

- Description of Problem to be solved
  - Initial data that makes it a priority
- Goal
- Scope
  - Entire building or one unit
  - Timeline—start date and end date
- Project sponsor, director and manager
- Decisions should be made with input from team
New Tool

Teams

Cooperate
And Reap
Greater
Rewards

Why Teams?

• No one works alone in health care!
• None of us is as smart as all of us!
• Each team member becomes an owner of the change
• Everyone learns and everyone teaches
• Teamwork begins to tear down walls and break down barriers between departments
Performance Improvement Team

- Type of members depend on purpose of the team
- Generally each team should be composed of interdisciplinary members
- It is important to include residents and families
- Leadership must support the team through action and resources

Gaining Acceptance

- Define the purpose of the team
- Know why each person is on the team
- Build trust; make decisions by consensus
- Establish ground rules
- Set team goals
- Promote creative and productive behaviors and responses

Conduct Productive Meetings

- Performance Improvement Teams should meet regularly to maintain momentum and complete objectives
- Need an agenda
- Keep minutes of team meetings
- Manage the time of the meetings
- Spread the improvement!
Steering Committee and Team Collaborate on Identifying Goal/Aim

- Written goal/aim (make it attainable)
- What are we hoping to accomplish?
  - How much?
  - By when?

Think Smart

Your goal should be SMART

S - Specific
M - Measurable
A - Attainable
R - Relevant/ reasonable
T - Time-bound

Measuring Your Data

- What will you measure?
  - Outcome measure
    - No falls with injury
    - Baseline
    - Re-measure
  - Process measure
    - Hourly rounding?
    - Department heads on unit at shift change
- How will you measure?
Systematic Analysis and Systemic Action ~ Facility Specific

Facility Expectation:
• To develop policies and procedures and demonstrate proficiency in the use of RCA

Systemic Actions:
• Look comprehensively across all involved systems to prevent future events and promote sustained improvement
• Focus on continual learning and continuous improvement

Use Root Cause Analysis for Proactive Improvement

• Resident level RCA
  – One resident may be a clue that there is a systems problem that will affect more residents
  – Consider “near misses”
  – Consider family comments
  – Consider staff feedback
• Facility level systems problems must always be considered while you are analyzing the data

Root Cause Analysis

The highest level cause of a problem is called the root cause.

The root cause is “the evil at the bottom” that sets in motion the cause-and-effect chain that creates the problem(s).
Root Cause Analysis

Risk Factors
- Pressure Ulcer
  - Weight loss
  - Terminal prognosis
  - Multiple co-morbidities
- Falls
  - Poor impulse control
  - Memory loss, poor safety awareness

Root causes
- No individualized plan to maintain weight
- No end stage care plan
- Do we communicate about “at risk” residents every shift?
- Do we have a plan for high risk times for this resident?
- Do we have enough “eyes”?
- Do we have enough activities?

“WHY?”
“How are we delivering care?”

Fishbone Diagram

Identify the problem or symptom on the nose of the Fish
- Diagonal bones
  - Manpower (Personnel)
  - Materials/Equipment
  - Methods/Procedures
  - Environment
  - Management/Policies
**Levels of Causes**

- Residents have knowledge deficit about pain management.
- Patients not on scheduled pole meds.
- Survey citation.
- Quality concern.
- Corporate concern.
- Resident concerns.

**Identify Causal Factors**

- Ask repetitive “why’s”
- Discover all influencing factors
  - **Direct** - apparent reason for the problem
  - **Contributing** - process elements and underlying system issues that created the environment in which a problem was more likely to occur

**Root Cause Analysis of F-Tag 323 Example**

“The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents”
Deficient Practice
Statement

“… the facility failed to have an effective system to ensure resident safety through monitoring and supervision for Resident R#1…”

“R#1 was his own responsible party. The facility assessed R#1 as a dependent smoker and developed a plan of care for supervised smoking.”

“On 12/21/13 R#1 exited the facility with the assistance of staff… was left outside unsupervised… found off facility property by a staff member leaving for lunch…”
“...found unresponsive in his motorized wheelchair on a two lane residential side street, in front of a semi truck.”

Findings Include: Smoking Policy

• 1) Permitted smoking in a designated area outside of the facility... all residents who smoke will be screened using the Safe Smoking Evaluation Form

Findings Include: Smoking Policy

• 2) Residents may only smoke under staff supervision, in designated smoking area...
Findings Include:
Record Review

• R#1 with diagnoses to include quadriplegia, autonomic dysreflexia, insomnia and severe depression without psychosis…. MDS … had assessed R#1 without cognitive impairment.

Findings Include:
Weather History 12/21/12

• Average temperature 34.8 degrees F, wind chill average was 22.8 degrees F and the average wind gust was 31.5 miles per hour.

Findings Include:
Interview CNA #1

• Was aware R#1 required supervision when smoking but R#1 could do what he/she wanted when off of the facility grounds, since R#1 was his/her responsible party.
Findings Include: Interview CNA #2

- R#1 had to go off facility property to smoke unsupervised, and did not think R#1 could physically light a cigarette… aware R#1 required supervision… but could do what he/she wanted… was own responsible party.

Findings Include: Interview LPN #3

- Let him out the door to outside. R#1 knocked on door about 15 minutes later to get assistance to retrieve fallen cell phone and had a lit cigarette… R#1 lit own cigarettes.

Findings include: Interview LPN #3 Cont.

- Normal for R#1 to stay outside for extended periods of time… unaware of where R#1 went… aware R#1 required supervision when smoking… but could do what wanted… was own responsible party.
Findings Include: Interview R#1

- He stated he was supposed to be supervised when smoking but when he went off the property he could smoke unsupervised if he wanted… if not he would have to smoke at designated times in the designated area.

Findings Include: Review of Agreement to Accept Responsibility Form

- No documentation for 12-21-12. 36 different previous entries incomplete for contact info, expected return date/time and no signature of person accepting responsibility.

Findings Include: R#1 Care Plan

- Revealed smoking would be supervised, smoking materials kept at nursing station and to monitor compliance with smoking policy.
Findings Include: R#1
Care Plan

• Not signing self out when leaving the facility... propelling wheelchair after hours outside... no intervention to address these actions or monitor the residents whereabouts and safety.

Findings Include: Record Review and Interview

• Resident had a history of going outside to smoke unsupervised. Staff would let the resident out and he would knock when he wanted back in.

Findings Include: Record Review and Interview - Nursing Notes

• 10/21/12 – “Resident has went out of facility constantly to smoke.”
• 10/22/12 – “Continues to get up during the night and to go out of facility several times to smoke.”
### Problem Statement

<table>
<thead>
<tr>
<th>WHY?→</th>
<th>Root Cause(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.</td>
</tr>
<tr>
<td></td>
<td>2.</td>
</tr>
<tr>
<td></td>
<td>3.</td>
</tr>
</tbody>
</table>

To validate root cause, ask the following: If you removed this root cause, would this event or problem have been prevented?

---

### Root Cause(s)

- Resident found off facility property unresponsive...
- No one was supervising him once he left building...
- Confusion regarding R#1’s rights...
- History of leaving property not addressed...
- Smoking policy not followed...

To validate root cause, ask the following: If you removed this root cause, would this event or problem have been prevented?

---

### Select the Root Cause

- Accomplished through analysis of direct and contributing factors
- A root cause is a most basic event or condition that, if eliminated or modified, would keep a problem from recurring
- Can encompass several contributing factors
- Controllable, solvable force that explains why a problem exists
Prioritize Your Cause

- The cause is most certainly a system issue, not a person issue.
- If it is an individual – you don’t need to do a root cause!
- Be careful – it is usually a system issue!

Brainstorming

- What would solve the problem?
- What strategy could resolve the root cause?
- What solutions have already been thought of?
- What approaches have not been thought of?
- What different methods might work?
- What "off-the-wall" (unusual) ideas might help?

Consider Using a Flow Chart

- Promotes systems thinking
- Helps the team understand how the process works
  - Provides visualization of complexity, rework, and problem areas
  - Helps identify gaps in the process
Develop Corrective Action and Follow-up

- Determine workable solutions for the root causes
- Re-visit any “quick fix” solutions that were put in place
- Use other performance improvement tools to assist

Compliance/Non-Compliance Root Cause Analysis

- Don’t know
  - Never knew
  - Forgot
  - Tasks implied - Not done due to inexperience
- Can’t comply
  - Scarce resources
  - Don’t know how
  - Impossibility
- Won’t comply
  - No reward / No penalty
  - Disagree or think is impractical

Document Your RCA Process and Results

- Date
- Team Members
- Fishbone/ Five whys/bullet points of discussion
- Corrective action(s) and follow up
  - PDSA
  - Action Plan
Team's Role

- Team designs a plan (Plan)
- Team creates time-lined actions (Do)
- Team/assigned individuals measure (Study)
- Team acts on the outcome of measurements (Act)

The PDSA Cycle

Why Test?

Act Plan
Study Do

PDSA – Small Tests of Change

“It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something.”

- Franklin D. Roosevelt
Why Test?

- Possible Objectives of PDSA Cycles for Testing
  - Increase your belief that the change will result in improvement
  - Opportunity for learning from “failures” without impacting performance
  - Document how much improvement can be expected from the change
  - Learn how to adapt the change to conditions in the local environment
  - Evaluate costs and side-effects of the change
  - Minimize resistance upon implementation

PDSA – Small Tests of Change

Learn from the mistakes of others

You can't live long enough to make them all yourself

Author unknown
Successful Cycles to Test and Adapt Changes

- Plan multiple cycles to test and adapt change
- Think a couple of cycles ahead
- Scale down size of test (# of products, locations)
- Test with volunteers
- Do not try to get buy-in or consensus for the test
- Be innovative to make testing feasible
- Collect useful data during each test
- Eventually, test over a wide range of conditions
PDSA – Small Tests of Change

“PDSA is the growth of knowledge through making changes... and then reflecting on the consequences of those changes.”
- Don Berwick

Putting it all Together

• Identify the problem from data (QMs, staff, residents). Initiate a Performance Improvement Project
• QAPI Committee charters team
• Team meets, sets goal and time, gathers data
• Root Cause Analysis
• Brainstorming
• PDSAs – frequent small tests of change
• Decide to spread new interventions

Blessed are the flexible for they will not be bent out of shape

Courtney H. Lyder, N.D., GNP, FAAN 2007
Questions?

Contact us:

• Charlene Kawchak-Belitsky, R.N., BSN, NHA  ckbelitsky@mpro.org  
  248-465-1038
• Yvette McKenzie, R.N., BSN  ymckenzie@mpro.org  
  248-465-7327
• Audrey Stob, R.N., CPHQ  astob@mpro.org  
  248-465-7321

This material was prepared by MPRO, the Medicare Quality Improvement Organization for Michigan, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOW-MI-C.7-14-181