

CIVIL MONEY PENALTY (CMP) FUNDED PROJECT

FINAL REPORT

Grantee

Wisconsin Center for Performance Excellence (WCPE)
2909 Landmark Place, Ste.
Madison, WI

Project Title

Assist nursing homes learn, apply quality tools for their QA program

Award Amount

\$35,800

Grant Period

May 2013 - October 2014

Additional Information and Resources



Department of Health Services / Division of Quality Assurance
Quality Assurance and Improvement Committee

This project report has been prepared by the author under a research grant from the Department of Health Services (DHS) Quality Assurance and Improvement Committee. The views expressed in the report/training are personal to the author and do not necessarily reflect the view of the Department of Health Services or any of its staff and do not bind the Department in any manner.

F-01593 (08/2015)



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Nursing Home Quality Assurance Project Final Report

The Wisconsin Center for Performance Excellence piloted a program to assist 24 Wisconsin nursing homes in learning about and applying quality tools, in support of the development of their own quality assurance program. The pilot was funded by the State of Wisconsin Department of Health Services, Division of Quality Assurance (DQA) and ran between October 1, 2013 and September 30, 2014.

Program Goal: The Grantee will provide a pilot program that will assist twenty-four (24) Wisconsin nursing homes to learn and develop their own quality assurance program.

II. Scope of Work Accomplishments

10 Wisconsin nursing homes were successfully recruited for **Cohort 1**, and 14 were recruited for **Cohort 2**. The nursing homes in our target group represent high and lower performing facilities located in both urban and rural settings across Wisconsin. Project kick off meetings with nursing homes and coaches were held on January 31, 2014 and May 29, 2014 at MetaStar in Madison, WI.

13 volunteer mentor/coaches were recruited and trained to support the participating nursing homes. All had significant quality background, and five had past experience in a nursing home setting, including one as a nursing home administrator. Most were familiar with the Baldrige Framework for Performance Excellences. Several coaches worked with two nursing homes during a cohort. Five coaches participated in both cohorts. Coaches expressed much satisfaction with their involvement with the project.

Laptops were acquired, processed and distributed to the delight of participants. A SharePoint site was loaded with project information and quality resources (gap analysis, root cause, Quality 101, sustaining high performance topics), and participants were trained on how to access the SharePoint site. We opted for SharePoint as resources can be updated and added easily efficiently. Laptops were also used to create 5 x 5 presentations that served as the nursing homes' "final project". Participants and coaches completed an evaluation of the quality resources loaded on our SharePoint site to determine which tools were most popular, and to learn about additional resources needed. We determined that participating facilities will continue to want access to the SharePoint site after the project period.

MetaStar staff and coaches assisted the participating nursing homes in identifying goals that are related either to a recently identified care deficiency or to an adverse event. Individual

facility goals also had to support the project goal of protecting or improving nursing home services for residents.

During the kick off session, volunteer mentor/coaches helped their assigned facilities complete a QAPI Assessment and Goal Setting Worksheet. WCPE linked coaches and facilities by geography, or by a particular skill set or need of a coach or participant. We were able to group several nursing homes and coaches geographically, which facilitated best practice sharing. Before leaving the kick off meetings, coaches and mentees signed agreements, future contacts were scheduled, and next steps were identified. MetaStar staff served as expert resources.

PDSA cycles were used to improve processes for Cohort 2 mentors and participants. The QAPI Assessment was completed as the pre-project baseline. A survey for coaches and participants was conducted for both cohorts. Coach/NH teams completed a 5X5 presentation as their final project. The program summary activity occurred at the MetaStar Quality Symposium on November 4, 2014. All nursing home participants were invited to send two people to the conference at no charge. A poster conference of selected 5 x 5 presentations was displayed. Several of those presentations are attached to this report.

IV. Deliverables

- A. Completed a minimum of three e-learning modules or face-to-face training on core quality/improvement tools with each of the 24 participating nursing homes.
- B. Demonstrated that each of the 24 participating nursing homes were able to:
 - Effectively apply at least one core quality/improvement tool to a current situation in the facility.
 - Demonstrate increased confidence in using RCA, PDSA or other quality tools to improve quality of care.
 - Cite pre- and post-program data that indicates favorable improvement in their selected focus area.
 - Identify another performance improvement project to implement with the tools and methods learned through this pilot program.
- C. The final face-to-face trainings on core quality/improvement tools with Cohort 1 & 2 (24 Nursing Homes) was completed for all participating nursing homes. All but one participating facility has completed at least one improvement project with assistance from their coach/mentors. One facility started but was not able to complete the project due to a change in leadership. The NH representative and mentor were able to meet twice.

Participant Feedback

Coach/mentor feedback

This was very beneficial for me to work with the DON's of both facilities and get to know how quickly they need information and how I needed to not disrupt their work environment but try to ride alongside with their pace to get them what they needed to have a good experience with quality.

Thanks for the opportunity and I would like to help more facilities that want to get started with this journey.

Nursing Home Feedback:

All 2nd cohort survey respondents indicated they moved from no/little confidence to very confident in using the (PDSA, RCA, FISHBONE) tool AFTER the coaching

Excerpt of email from participating nursing home dated April 11, 2014:

I am so excited to have the results from the survey (nursing home survey on patient safety culture from AHRQ.gov) and to have our coach's help, it is really great.

He came here today (this morning) to review the results and set up a tentative plan.

1. We will have a Presentation for the staff summarizing the results.
2. Ask staff for input to solve the identified problems
3. Develop 2 to 3 teams to work toward solving the identified problems.
 - a. One to Two teams to work on communication between Administration and the front line, and between departments. So everyone is on the same page. Perhaps one team would work specifically with management on solving problems and developing systems to make sure that the solution is tried and evaluated and if it doesn't work that we continue to work on a solution until we have found the answer. The goal would be to be to have staff work with administration on solving problems and that administration will follow up on suggestions and changes. We need a lot of work on that topic. The other team would work on communication specifically like new admissions information and care plan changes, how to get that information assimilated.
 - b. One team to develop systems that will make the work load easier (i.e. moving laundry)
4. I will also obtain the turnover rate from Corporate, and investigate how many days/shifs we have had to mandate and pay bonus money to get people to work extra shifts.

The teams will be made up of C.N.A.'s and management depending on the duty or goal of the team.

Then we would re-do the survey next quarter (Maybe August, September). This would show us any results of the team effort.

Excerpt from phone conversation with a participant April 8, 2014:

A participant indicated: "The mentor was exactly what I needed. I was a bit lost after viewing the tools. Having someone here real time is making all the difference"

Sample 5 X 5 presentations served as the final project" and were displayed as part of a poster conference at the 2014 MetaStar Quality Symposium.

Based on Core Competencies

Physicians keep their certification active by maintaining the following competencies which form the foundation of the ABMS Programs for Maintenance of Certification (ABMS MOC®). The ABMS Program for MOC activities are the ways which physicians demonstrate their ability to provide high-quality care for the diagnosis and treatment of disease, promotion of health and prevention of disease, and the physical and emotional support of patients and families. The competencies were first adopted in 1999 by the Accreditation Council for Graduate Medical Education (ACGME) and ABMS.

- **Practice-based Learning and Improvement:** Show an ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the practice of medicine.
- **Patient Care and Procedural Skills:** Provide care that is compassionate, appropriate, and effective treatment for health problems and to promote health.
- **Systems-based Practice:** Demonstrate awareness of and responsibility to the larger context and systems of health care. Be able to call on system resources to provide optimal care (e.g. coordinating care across sites or serving as the primary case manager when care involves multiple specialties, professions or sites).
- **Medical Knowledge:** Demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and their application in patient care.
- **Interpersonal and Communication Skills:** Demonstrate skills that result in effective information exchange and teaming with patients, their families and professional associates (e.g. fostering a therapeutic relationship that is ethically sound, uses effective listening skills with non-verbal and verbal communication; working as both a team member and at times as a leader).
- **Professionalism:** Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to diverse patient populations.

Project: Improve New Employee Orientation

Site: St Francis Home
Project lead: Jenna Floberg, NHA

DO: Four PDSA Cycles of Improvement were Implemented June 1 – October 1, 2014

- Location Change:
 - Implemented June 5th
 - New location eliminates non-orientation staff walking into the kitchen causing interruptions to the learning process.
 - Transition was easy as equipment to show videos existed.
 - New associates score learning environment positive
 - New location better as it is close to vending machines and bathrooms

AIM: Zero Avoidable Certified Nursing Assistant (CNA) Turnover in the first 90 days of employment

- 35 CNAs left St. Francis Home from June 2013 to May 2014
 - 26 resigned
 - 9 transferred
 - 4 out of the 26 quit within 90 days; 15.4% turnover rate
- The root cause is related to the nursing secretary facilitating the orientation and the location of the program in the kitchenette.
- Some CNAs join the organization to get their "foot in the door" with the intent of transferring to the sponsoring acute care hospital soon after employment.
- Turnover results in a disruption in continuity of care for residents and an unnecessary expense to the business.

DO: Four PDSA Cycles of Improvement were Implemented June 1 – October 1, 2014

- Subject Matter Experts (SMEs) as Instructors:
 - 6-9 disciplines or SMEs replaced the secretary as instructors for orientation
 - SMEs are able to answer questions on the spot
 - The schedule and allotted time had to be worked out and has been adequate
 - Due to the nature of one presentation, staff missed lunch which has now been remedied by the organization providing lunch.
 - Evaluations positive. "I really enjoyed meeting different people".

PLAN: Revise New Employee Orientation for CNAs

- Change the instructor from the secretary to subject matter experts
- Change the location of the program from the kitchenette to the basement classroom
- Improve the employee evaluation feedback form to capture data on satisfaction with orientation
- Add a new question to the interview format for new CNAs regarding their intended employment goal

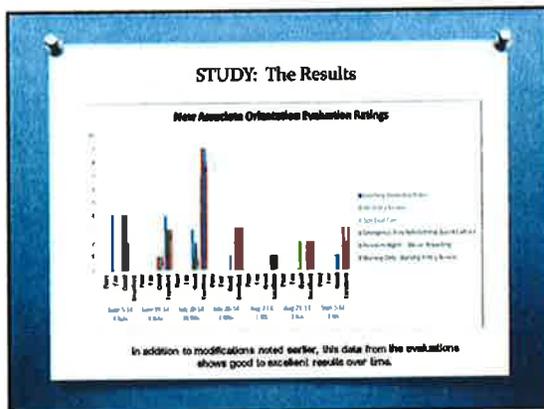
DO: Four PDSA Cycles of Improvement were Implemented June 1 – October 1, 2014

- New Evaluation Feedback Form:
 - A new form (no previous tool existed) was designed to test the orientation process changes and to collect ongoing feedback from new staff
 - Feedback tool lends to collecting, aggregating and analyzing data.
 - Based upon feedback, a change in a video shown did not receive the anticipated reaction and was replaced with a different one
 - Comment: "The way things are broken up are nice"

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DO: Four PDSA Cycles of Improvement were Implemented June 1 – October 1, 2014

- o **New Interview Question:**
 - o Started In June.
 - o Director of Nursing now asks applicants what their 6-12 month goal is to gauge whether they plan to transfer to the hospital after hire.
 - o Applicants goal is sometimes to work at hospital to get foot in the door.



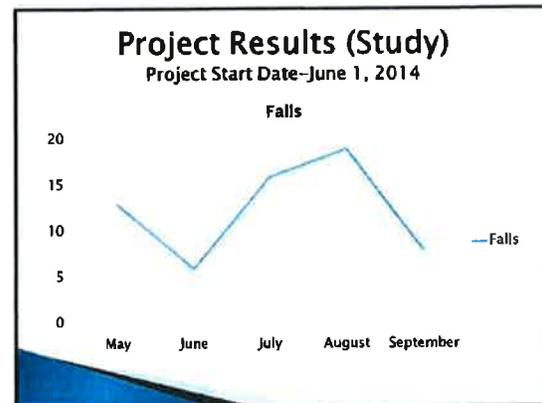
ACT: Next Steps

- o **Lessons Learned**
 - o Do one PDSA at a time
 - o Have baseline data to compare
 - o Rapid cycle test changes
- o **Continue**
 - o New location, subject matter experts, use of evaluation feedback tool and Interview question
- o **Future Steps**
 - o Create a new CNA mentor program
 - o Revise new associate overall onboarding process

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Falls Reduction Project

Wisconsin Veterans Home-Union Grove



- ### Project Aim (Plan)
- ▶ Reduce falls from an average of 15 per month to 7 per month.
 - ▶ This is a 50% improvement goal.
 - ▶ Location is the 2East unit of the Wisconsin Veterans Home-Union Grove
 - ▶ Length of the change project is June-September 2014.

- ### Project Results (cont.)
- ▶ Number of falls initially decreased 50%, but then spiked again due to a few speed bumps in the project (staff turnover, state and federal inspections, increase in admissions) but did level out again to 50% decrease by end of project.
 - ▶ Biggest result was that a few frequent fallers went from 5-10 falls per month to zero due to focused attention.

- ### Project Change (Do)
- ▶ Changes we made:
 1. Established QA/Root Cause Analysis Report for each fall.
 2. Focused attention (med review, labs in some cases, review with doctors) on frequent fallers.
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- ### Next Steps (Act)
- ▶ Continue QA/Root Cause Analysis of each fall in facility
 - ▶ Continue focused review of frequent fallers
 - ▶ Implement new procedure of having each new admission on hourly checks for 24-72 hours. This came up towards the end of the project.
 - ▶ Expand project throughout facility.

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Impact (Lessons Learned)

- ▶ Focused attention on frequent fallers initially costs more time, but payoff is less time spent on falls (assessments, charting, first aid, transfer to hospital, paperwork).
- ▶ Reducing falls improves QM scores, which can lead to more referrals.
- ▶ Reducing falls increases customer satisfaction with both residents and families.

Project Members

- ▶ 2East nursing staff (RNs, LPNs, CNAs)
- ▶ 2East Supervisors–Marie Maguire, Sue Dupor
- ▶ QI RN–Deb Deschler
- ▶ DON–Laurel Knudson
- ▶ Deputy Commandant–Susan Seibert
- ▶ Medical Director–Dr. Gerald Demers



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Project: Eliminate the Use of Resident Alarm Devices

Site: Harbor Haven Health & Rehabilitation
 Project lead: Mark Radmer, Administrator
 Project Team: Kerry Schumacher, Director of Nursing
 Heather Vavra, Staff Development
 Coordinator

AIM: Zero resident alarms in use throughout the facility within 6 months without a concurrent increase in the number of resident falls.

- o Harbor Haven nursing staff have been using safety devices designed to sound an alarm to alert nursing staff to a resident's need for assistance.
- o In July 2014 the facility has a total of 58 alarm devices in use which was broken down by "Harbor":
 - o Island – 1
 - o Meadow – 12
 - o Snug – 9
 - o Sunset – 21
 - o Sunrise – 15

Additional Background

- o The use of the devices has not helped to reduce the number of resident falls.
- o In some cases alarm devices may have contributed to falls.
- o There is perceived staff over reliance on the presence of alarms to guide their work.
- o Use of alarms is a resident dignity concern as they are loud, can be frightening, and do not promote a home-like environment.
- o Best practice in comparable settings is to shift away from the use of alarm devices.

PLAN: Develop a Zero Tolerance Level for Alarm Devices while creating a culture of resident safety

- o Staff training on vision and Advancing Excellence national strategy for quality.
- o Staff training on use of frequent staff-resident interactions as a technique to safely eliminate the use of alarm devices.
- o Harbor Huddles to obtain staff feedback and identify residents at risk.
- o Staff rounding observing for staff-resident interactions.
- o Leadership review of rounding data.
- o Dry Erase Boards to provide visual cues to staff & competition between Harbors.
- o Falls IDT care plan updates.

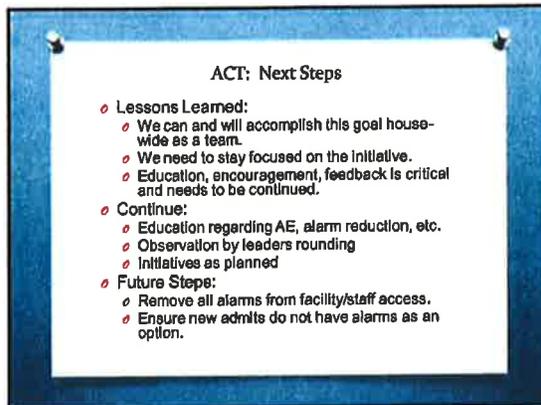
DO: Pilot initiated August 27th in all Harbors.

- o Since this initiative is part of a larger cultural shift to resident-centered care, it was decided to implement the changes in all Harbors at the onset. Sharing resulting data might also drive some competition in the organization.
- o An Advancing Excellence house-wide educational meeting was conducted.
- o Resident and families/guardians to be updated on the implementation of this initiative via care-planning conferences.
- o The Admission Handbook will be updated.

STUDY: The Results

- o As of 8-11-14 there are 17 alarm devices & restraints in use which is a 29.31% reduction since the beginning of the project
- o Harbor specific data on reductions is as follows:
 - o Island – 1; now 0
 - o Meadow – 12; now 3
 - o Snug – 9; now 2
 - o Sunset – 21; now 11
 - o Sunrise – 15; now 7
- o The number of falls has stayed about the same; however, a some falls have occurred on non-alarmed residents.
- o Staff feedback: Have expressed some hesitancy; leaders listening and encouraging
- o Seems to be a quieter resident environment both in terms of literal noise but also in resident agitation
- o Huddles initiated 9-11-14 so effectiveness yet to be evaluated.
- o Family and guardian acceptance: beginning to address during CP.
- o Working with staff upon seeing some alarms being re-introduced.

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Improve Ventilator Resident Safety

Aim (PLAN – what process you plan to make better)

- Reduce the number of episodes of when a resident is found without their oxygen being administered as per the MD order.

Changes Made (DO – what changes you made to improve)

- Developed a assessment tool to address resident's self management of respiratory equipment, including oxygen tubing and sources.
- Created a system notifying staff that a resident self manages their respiratory equipment to create awareness and intervention

Results (Check – add before and after info or data about what you learned)

- Before changes the Quarterly Occurrence Percentage (per resident day) was 1.01
- After changes the Quarterly Occurrence Percentage (per resident day) was 1.13

Next Steps (ACT – what changes you will keep, expand and/or sustain)

- Performance Improvement Project team is begin a new PDSA cycle.
- Initial steps include
 - New Root Causes Analysis
 - Inclusion of new team member for anticipated different perspective on the problem

Impact (ACT – Improved Outcome, Efficiency, Lessons Learned, Etc.)

- The outcome did not improve however other positive results
 - More thorough assessment of resident
 - Enhance resident independence with ADLs
 - Education for residents regarding safety and disease management

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