

# Applied QAPI: Statewide ASC Quality Improvement Initiative

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Per 42 CFR 416.43 (Q80), ASCs are required to have a robust QAPI program designed to improve care being furnished to its patients. The same concepts can be applied on a statewide level to help improve care being furnished to ASC patients through a better understanding and application of the ASC regulatory requirements.

## Learning Goals

At the conclusion of this training you will be able to:

- Identify how the components of the ASC QAPI regulations (quality indicator data, program activities, program data, and PI projects) can be applied on a statewide level in an effort to improve patient care through increased regulatory compliance.
- List the current problem prone areas & the statewide PI project.

This training is designed to demonstrate how components of the ASC QAPI regulations can be applied to improve statewide ASC regulatory compliance.

## QAPI Scope & Program Activities

- QAPI Plans:
  - Identification of areas in need of improvement based on data analysis.
  - Specifies performance improvement goals and plans to reach those goals.
  - Includes quality indicator data, data sources, and the frequency of data collection.
  - Includes time frames for analysis and action.

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Last year we started comprehensive monitoring and training for ASCs following the QAPI principles outlined in the regulatory requirements, by implementing a comprehensive QAPI plan as outlined on the slide.

For additional information on last year's data and training, please refer to the PowerPoint presentations posted to the BFS website.

## QAPI Scope & Program Activities

- Comprehensive Monitoring: what is it you need and want to know?
  - Regulatory understanding.
  - Regulatory application.

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For the state-wide plan, we wanted to ensure ASC staff understood and could consistently apply the Federal regulatory requirements.

## QAPI Scope & Program Activities

- Data Collection: How will you know it?
  - All regulations.
  - All provider questions.
  - All complaints.

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This year we once again analyzed the data from quality indicators, including outcome indicators (e.g. regulatory compliance), process of care indicators (e.g. provider questions) and perception indicators (e.g. complaints). Please note, as with last year, complaints included in this data are only those which included an allegation of regulatory non-compliance. Complaints that did not have a regulatory component (e.g. billing issues) were not included.

## QAPI Scope & Program Activities

	2009	2010	2011	2012	2013	2014
Complaints	1	2	1	0	2	0
Questions	17	23	19	31	28	15
Citations	43	122	107	70	99	69

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2014 showed a decrease in complaints, questions and citations. However, as with the data ASC providers collect, the statewide data can provide some good first impressions, but it does not paint the entire picture. In order to make the data usable, it must be analyzed.

## QAPI Scope & Program Activities

- Data Analysis: How will you know on which areas to focus?
  - High-risk, high-volume, problem-prone areas.
  - Incidence, prevalence, and severity.
  - Areas which affect health outcomes, patient safety, and quality of care.

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From all the data being gathered, we again focused on those main areas which must be kept in mind as a way to monitor quality and identify opportunities that could lead to improvement per 42 CFR 416.43(b), 42 CFR 416.43(c)(2) and 42 CFR 416.43(c)(3) or Q82.

## QAPI Scope & Program Activities

- Data Analysis:
  - Incidence: What is the rate or frequency it is occurring?
  - Prevalence: How widespread is it?
  - Severity: How serious is it?

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When reviewing the data, we look for patterns and trends over time from all data sources and ask multiple questions, keeping in mind our focus areas.

## QAPI Scope & Program Activities

	2009	2010	2011	2012	2013	2014
Complaints	1	2	1	0	2	0
Facility	ASC A	ASC B	ASC D		ASC E	
		ASC C			ASC F	
Regulation	Pt. Rights & Medical Records	Surgical Services & Discharge Patient Rights	Patient Rights		ER supplies Transfer agreements	

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For complaints, we have no data to analyze. Therefore we will continue to monitor, but no interventions will be developed related to complaints at this time.

## QAPI Scope & Program Activities

	2009	2010	2011	2012	2013	2014
Questions	17	23	19	31	28	15
Process	11	14	12	24	20	7
Regulation	6	9	7	7	8	8
	- Q002	- Q002	- Q002 x2	- Q002	- Q042	- Q002
	- Q063	- Q041	- Q041	- Q043	- Q105	- Q041
	- Q181	- Q162	- Q101 x2	- Q162	- Q122	- Q100
	- Q221	- Q180	- Q122	- Q181	- Q181 x4	- Q105
	- Q222	- Q181	- Q202	- Q200	- Q202	- Q141
	- Q224	- Q202		- Q202		- Q180 x2
		- Q222		- Q241		- Q181
		- Q241				
		- Q261				

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As with last year, 2014 data includes documented questions. The data does not reflect questions which may have been asked during the survey process. The documented questions were analyzed for possible areas of improvement.

We did continue to receive process questions. However, these were primarily from people seeking initial certification in the ASC program, who were not familiar with the information located on the BFS website.

Questions regarding how to apply and meet the regulatory requirements were also analyzed for patterns and trends. For 2014, it was determined questions asked regarding length of stay (Q02) and contracts (Q41) were already addressed on the ASC FAQs posted on the BFS website. Six questions related to Q100, Q105, Q141, Q180 and Q181 were new. Therefore, we did add these questions to the FAQs posted on the BFS website and we will continue to monitor, update the FAQs, and develop training as concerns arise.

## QAPI Quality Indicator Data

	2009	2010	2011	2012	2013	2014
Citations	42	122	107	70	99	69
Deficiency free:	0	1	0	0	1	2
Severity:	1 IJ 6 CFCs 2 ASCs	2 IJs 23 CFCs 8 ASCs	1 IJ 22 CFCs 4 ASCs	1 IJ 10 CFCs 2 ASCs	1 IJ 25 CFCs 6 ASCs	0 IJ 14 CFCs 4 ASCs

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As we did in 2013, this year we also analyzed all citation data, keeping in mind the three main focus areas of incidence, prevalence and severity.

For incidence, we ask what is the rate or frequency it is occurring? First impressions include seeing the number of citations trending upward, from 2009. However, the revised regulations did not become effective until 5/18/09, so 2009 data is skewed. Beginning in 2010, all providers were surveyed under the revised regulations. Since that time we can see an overall downward trend in the total number of citations, with a slight spike in 2013.

We also analyzed the prevalence and asked how wide spread is the problem? The majority of ASCs do have some citations. However, the facilities with CFC level findings accounted for the majority of total citations. Additionally, we did have 2 facilities that were deficiency free.

# QAPI Quality Indicator Data

## Immediate Jeopardy:

- Immediacy,
- Serious Harm, Impairment or Death
- Culpability

## Condition-level

- Severe and/or Systemic

	2009	2010	2011	2012	2013	2014
Severity	1 IJ	2 IJs	1 IJ	1 IJ	1 IJ	0 IJ
	6 CFCs	23 CFCs	22 CFCs	10 CFCs	25 CFCs	14 CFCs

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This year we also wanted to take a closer look at severity. Immediate jeopardy findings are the most severe of all deficient practices as it means patients are currently in danger of experiencing serious harm, impairment or death and the facility knew and did not take corrective action or they should have known, but failed to identify the problem. Immediate jeopardy findings will always result in Condition-level findings. Second to immediate jeopardy findings, condition-level of CFC level findings are also severe. CFC level findings typically indicate deficient practice related to facility systems that impact multiple patients.

We also analyzed the severity of the citations. For this we reviewed for Immediate Jeopardy findings and Condition level non-compliance. Again, we saw a slight spike in 2013, but the overall number of immediate jeopardy, Conditional level findings and the number of facilities involved have decreased since 2010, with no Immediate Jeopardy findings in 2014.

## QAPI Quality Indicator Data

	2009	2010	2011	2012	2013	2014	Totals
Compliance with State Law	0	0	0	0	0	0	0
Lab./Rad.	0	1	0	0	0	0	1
Medical Staff	0	1	0	0	1	0	2
Environment	0	1	1	0	1	0	3
Pharm. Services	1	1	1	0	1	0	4
Patient Admission, Assessment & Discharge	0	3	2	0	1	0	6
Nursing Service	1	1	1	2	1	0	6

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When CFC data was further analyzed, there were trends that emerged over time. Of the 13 CFCs, Compliance with State Licensure Law has never been cited and the CFC for Laboratory and Radiologic Services has only been cited once. While cited more frequently since 2009, the 5 CFCs for Medical Staff, Environment, Pharmaceutical Services, Patient Admission, Assessment & Discharge, and Nursing Services were not cited in 2014.

## QAPI Quality Indicator Data

	2009	2010	2011	2012	2013	2014	Totals
Medical Records	0	1	3	0	2	1	7
Patient Rights	0	2	3	1	2	1	9
Surgical Services	0	3	1	1	2	2	9
Infection Control	1	3	2	2	4	2	14
Governing Body	2	3	3	2	5	4	19
Quality Assessment Performance Improvement (QAPI)	1	3	5	2	5	4	20

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The remaining 6 CFCs have been the most problematic over time and were also cited in 2014. Currently, the most common Condition-level findings occur at the CFC for QAPI.

## QAPI Scope & Program Activities

	2009	2010	2011	2012	2013	2014
Citations	42	122	107	70	99	69
Q81 – QAPI – Priority 4 in 2013.	8.3% - Ranked number 3	13.6% - Ranked number 5	40% - Ranked number 3	13.3% - Ranked number 5	60% - Ranked number 1	44.4% - Ranked number 2
Q84 – QAPI Priority 4 in 2013.	8.3% - Ranked number 3	18.2% - Ranked number 4	20% - Ranked number 5	13.3% - Ranked number 5	50% - Ranked number 2	44.4% - Ranked number 2
Q162 – Form & Content of Records Not addressed in 2013	25% - Ranked number 1	18.2% - Ranked number 4	60% - Ranked number 1	40% - Ranked number 1	50% - Ranked number 2	44.4% - Ranked number 2

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Additionally, in 2013, all 68 current regulations are monitored for compliance through the survey process. All citation data was analyzed for patterns and trends over time. Through that review, it was determined that 9 regulations are consistently rated in the top 5 deficiencies cited year after year. 2014 was not different in this respect. The same 9 deficiencies remain in the top 5. However, for all but 3 areas, there has been improvement in the percentage of surveys which resulted in those citations. This means, citations are still occurring, but less frequently.

On the slides, the percentage represent the percentage of all surveys which resulted in that citation and the rank number represents where the citation was in that year's top 5 deficiencies. The priority number is related to the performance improvement training projects which were initiated last year.

## QAPI Scope & Program Activities

	2009	2010	2011	2012	2013	2014
Citations	42	122	107	70	99	69
Q181 – Medication Administration <b>Priority 1 in 2013</b>	25% - Ranked number 1	40.9% - Ranked number 2	50% - Ranked number 2	26.7% - Ranked number 3	60% - Ranked number 1	44.4% - Ranked number 2
Q220/Q219 – Patient Rights <b>Priority 3 in 2013</b>	16.7% - Ranked number 2	18.2% - Ranked number 4	40% - Ranked number 3	13.3% - Ranked number 5	20% - Ranked number 5	11.1% - Ranked number 4
Q225 – Patient Grievances <b>Priority 3 in 2013</b>	25% - Ranked number 1	27.3% - Ranked number 3	30% - Ranked number 4	26.7% - Ranked number 3	30% - Ranked number 4	11.1% - Ranked number 4

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Again, it should be noted ASC facilities showed measurable improvement in 6 of the problem areas identified last year.

## Performance Improvement Projects

	2009	2010	2011	2012	2013	2014	Totals
Expired medications	0	8	4	2	3	0	17
<b>Multi-dose vials not labeled with open date</b>	<b>0</b>	<b>5</b>	<b>2</b>	<b>0</b>	<b>3</b>	<b>2</b>	<b>12</b>
<b>Improper labeling of pre-drawn syringes</b>	<b>2</b>	<b>3</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>9</b>
Single use vials used for multiple patients	0	0	1	1	4	0	6
No read back and verify of verbal orders	2	2	1	0	0	0	5
<b>No orders for medications given</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>1</b>	<b>2</b>	<b>6</b>
Medications not secure	1	0	1	0	2	0	4
No control count for narcotics	0	1	0	1	2	0	4
No log for receipt and disposition of meds.	1	1	0	1	0	0	3
<b>Incomplete orders (dose not identified)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>1</b>	<b>2</b>
Medications improperly stored	0	0	0	0	1	0	1
<b>Medications given which fell on the floor</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>1</b>

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Further, for 2013's number 1 priority related to Medication Administration, not only did we see a decrease in the overall number of citations, we also saw an overall decrease in the specific areas of those citations.

2014 data showed potential for improvement in only 5 areas (down from 11 identified in 2013). It should also be noted 4 of those areas are related to labeling and medication orders. The final area of medications administered after they had fallen on the floor appears to be an anomaly. We will continue to monitor this area, but do not anticipate this will become a prevalent area of concern.

Please continue to monitor your medication administration systems, paying particular attention to labeling of open multi-dose vials and pre-drawn syringes and ensuring physicians' orders are present and complete for all medications administered.

## QAPI Scope & Program Activities

	2009	2010	2011	2012	2013	2014
Citations	42	122	107	70	99	69
Q82 – QAPI <b>Priority 4 in 2013</b>	8.3% - Ranked number 3	18.2% - Ranked number 4	50% - Ranked number 2	20% - Ranked number 4	40% - Ranked number 3	44.4% - Ranked number 2
Q241 – Sanitary Environment <b>Priority 2 in 2013</b>	8.3% - Ranked number 3	27.3% - Ranked number 3	20% - Ranked number 5	26.7% - Ranked number 3	40% - Ranked number 3	55.6% - Ranked number 1
Q242 – Infection Control <b>Priority 2 in 2013</b>	25% - Ranked number 1	13.6% - Ranked number 5	20% - Ranked number 5	33.3% - Ranked number 2	40% - Ranked number 3	55.6% - Ranked number 1

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Getting back to total citation data, these are the 3 areas which did not show improvement in 2014.

## Performance Improvement Projects

- Frequent citations which did not show improvement from 2013 to 2014:
  - Q082: QAPI program data,
  - Q241 & Q242: Infection control
- CFC: QAPI

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Once data is gathered and analyzed, the ASC must undertake one or more specific quality improvement projects each year per 42 CFR 414.43(d) or Q83.

Based on 2014 data, the standards at Q82, Q241 and Q242 were the 3 targeted areas which did not show improvement between 2013 and 2014. Further, QAPI is the most commonly cited CFC over time.

## Performance Improvement Projects

Priority 1: Infection Control (Q241 & Q242).

Data source: Citations.

Incidence, prevalence, problem-prone & high-risk potential to affect health outcomes.

Priority 2: QAPI (Q080 & Q082).

Data source: CFC and citations.

Severity, incidence, prevalence, problem prone & potential to affect quality of care.

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As with last year, the identified areas in need of improvement were then prioritized based on the 3 main focus areas:

- High risk, high volume, and problem-prone areas.
- Incidence, prevalence, and severity.
- Areas which affect health outcomes, patient safety, and quality of care.

This year, Infection Control was identified as priority 1 due to the potential immediate impacts on patients. QAPI was assigned priority 2 as infection control and all other areas of compliance should be addressed through the facility's QAPI program.

## Performance Improvement Projects

- How do you know what to change in order to achieve improvement?
- Priority 1: Infection Control (Q241 & Q242):
  - Q241: “The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.”
  - Q242: “The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.”

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As stated in the interpretive guidance of Q83, related to Performance Improvement Projects, once the ASCs analysis of its data has identified opportunities for improvement, the ASC must develop specific changes to accomplish improvements in the identified areas of weakness. Changes may include changes to policies, procedures, equipment, the environment, staff training, etc. Knowing what to change is often data driven.

For example, in the Infection Control project, we first look at the regulation. As we saw last year with the Q181 Medication Administration project, the regulations can be wide reaching and include multiple components. The regulations at Q241 and Q242 are similar as each regulations contains multiple components.

Additionally these regulations are very closely related and infection control problems can often lead to citations at both regulations. For example, if observations are conducted and staff do not wash their hands at appropriate times, Q241 may be cited for a lack of adhering to professionally acceptable standards of practice. If surveyors then review facility policies and there is no documentation to support nationally recognized infection control guidelines have been considered, selected, and followed, then Q242 would also be cited.

## Performance Improvement Projects

Q241 & Q242	2009	2010	2011	2012	2013	2014	Totals
Non-sterile implants used	0	1	0	0	0	0	1
No infection control training	0	1	1	0	0	0	2
Reuse of single use devices & supplies	0	1	0	1	0	0	2
Inappropriate biohazard waste disposal	0	1	1	1	0	0	3
No infection control program	1	2	2	0	0	0	5

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Therefore, like we did with drug preparation and administration last year, we needed to further analyze the data to determine which specific areas of Q241 and Q242 were problematic. Data for both Q241 and Q242 was analyzed holistically and showed there are 9 specific areas that have been cited. Additionally, 5 of these areas have not been cited since 2012 (as indicated on the slide).

## Performance Improvement Projects

Q241 & Q242	2009	2010	2011	2012	2013	2014	Totals
No evidence of National Guidelines being adopted and implemented	0	1	1	0	2	2	6
Lack of comprehensive ongoing program (includes lack of infection control training, lack of surveillance for adherence hand hygiene, cleaning standards, and post op. infection policies, lack of biological and chemical indicators or sterilization logs, etc.)	0	4	2	7	2	3	18
Lack of appropriate environmental cleaning (wrong chemicals, wrong contact time, expired chemicals, laundry not cleaned properly, unsanitary equipment and rooms)	1	1	2	6	2	7	23
Lack of appropriate hand hygiene	2	5	3	9	2	4	25

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That leaves only 4 areas of Q241 & Q242 which continue to be problematic. Further, 3 specific areas (lack of comprehensive surveillance, lack of appropriate environmental cleaning and lack of appropriate hand hygiene) comprise 78% of all Q241 and Q242 citations.

## Performance Improvement Projects

- Development of changes
  - Web-based provider training developed to address frequently cited areas within Q241 and Q242, with emphasis placed on the **CMS ASC Infection Control Surveyor Worksheet** and the **ASC's QAPI program**.

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Once the data has been analyzed, specific strategies can be developed to improve performance (Q82). Based on the statewide data, web-based trainings have been developed to help ASCs better understand the regulatory requirements. To address priority 1, web-based trainings related to Q241 and Q242 have been developed and QAPI components have been incorporated into the infection control training to address priority 2.

## Performance Improvement Projects

- Implementation of changes:

# Training

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Once and ASC has developed a Performance Improvement Plan with specific changes, the specific changes must be implemented. For the State Agency, this involves training. Updated FAQs and the new infection control training will be posted on the BFS web site for all ASC providers to access.

## Training

# Welcome Qualis!

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This year, we also have an extra bonus. This year, we are fortunate enough to have Qualis with us. At this time I am very pleased to introduce Martha and Deanna.

Today Martha is going to talk about the infection control problem prone areas that have been identified.

## Primary Lessons About Health Care

- No one intends to harm patients
  
- Errors and unplanned adverse events occur because of:
  - Human factor – nobody is perfect
  
  - Flaws in systems

Throughout the rest of today's training, please keep in mind the primary lessons about health care. When we talked last year, we talked about people really wanting to do a good job and provide the highest quality of care to individuals. When a negative event occurs, it is typically not intentional. It is typically due to unintentional human error and/or systems flaws.

## Primary Lessons About Health Care

- Systems are developed and implemented to reduce the potential for human error:
  - Systems to ensure patient rights are upheld
  - Medication administration systems
  - Record keeping systems
  - Facility preventative maintenance and repair systems
  - Infection Control systems.

Facilities develop systems to provide clear, consistent direction to staff, which helps reduce the potential for human error. However, human error will still occur.

## Human Factor: We All Make Mistakes

- 3 classes of human fallibility (behaviors)
  - Inadvertent behavior: inadvertently doing other than what should have been done; slip, lapse, mistake.
  - At-risk behavior: behavioral choice that increases risk where risk is not recognized or is mistakenly believed to be justified.
  - Reckless behavior: behavioral choice to consciously disregard a substantial and unjustifiable risk.

There are 3 basic classes of human error. The first class is simply making a mistake. Think about typos. We type, we know how to spell, we still make mistakes. This is an inadvertent behavior. Now if we have systems in place to have 2 people review a report prior to publishing it, we choose not to follow that procedure and only have one person review it, that is at-risk behavior. We have made a choice to deviate from a procedure that reduces the risk of errors being made. We may believe that a one person review is okay, because the person reviewing it has really good editing skills, so it's justified, but it still increases the risk for error. Reckless behavior is a blatant disregard of systems, such as not reviewing a report at all.

## At-Risk Behavior

- Patient care is most frequently impacted by at-risk behavior
  - Comfort with a system will cause people to deviate from what they were taught to do with the belief they are acting safely.
  - “Cutting corners to get the job done.” (David Marx, J.D.)

Patient care is most frequently impacted by at-risk behavior. At-risk behavior occurs when people get comfortable and they think they know what they are doing but they really don't and/or start taking short cuts. At-risk behavior is not malicious or ill-intended, but it does have negative impacts on the patients.

## Some At-Risk Behaviors in ASCs

- Not implementing time outs prior to initiating surgery.
  - **It saves time.**
- Not properly labeling medications with a 28 day expiration date.
  - **We have a lot of patients and will use the whole bottle in a week. We will never come close to the 28 day expiration date.**
- Not obtaining a physician's order for medications.
  - **We know the physicians' very well; this is what they always order.**
- Omitting hand hygiene after glove removal.
  - **The gloves were clean.**
- Not implementing emergency drills for anything but fires.
  - **No other potential hazards (earthquakes, floods, etc.) have been identified.**

In ASCs, staff will deviate from established procedures in a number of ways. Again, it is not ill-intended and there is typically a reason why staff are deviating from established procedures. When Martha is talking about infection control today, please think about your facilities and if staff are engaging in at-risk behaviors. If staff are engaging in at-risk behaviors, how does the facility handle it?

## The Traditional “Blame/Shame” Culture of Health Care

- Staff at-risk behavior is rarely reported. Nothing “bad” happened so there is nothing to report.
- When an error occurs, the person(s) responsible is sought out, blamed and punished.
- Fear of punishment and peer pressure causes people to remain silent.
- Errors, events and “near misses” are under reported.

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Traditionally, staff at-risk behavior is rarely reported. This happens because staff do not always recognize patients are being placed at risk until it is too late and/or staff do not want to get into trouble.

The health care industry has traditionally been a blame/shame culture. When an error occurs, the person responsible is sought out, blamed and punished up to and including termination. No one really likes being in trouble and staff need their jobs. Fear of punishment causes staff to remain silent. Beyond that, staff work together a lot. People do not want to be labeled as a “rat” or a “snitch,” which also contributes to a culture of silence. Again, these staff are not ill-intended, but they do allow for patients to be put at risk.

## The Traditional “Blame/Shame” Culture of Health Care

- We cannot fix something if we do not know it is broken.
- Fear prevents meaningful investigation into WHY something happened or almost happened.

Unfortunately, staff silence often results in problems not being identified, investigated and resolved until someone gets hurt. No one wants that, so what's the solution?

## A Facility-Wide “Culture of Safety” Will Protect Patients

- Open, non-judgmental communication between **ALL** people who share the same goal of providing quality care for patients (not blame/shame)
- Everyone has a “voice” and is listened to:
  - Patients
  - Guardians, POAs, family and friends
  - All levels of staff: scrub techs, maintenance staff, housekeeping staff, RNs, Administrators, Physicians, etc.
  - Other providers: The state and national associations, etc.
  - Outside advocates: APIC, AORN, CDC, Qualis
  - Surveyors

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One of the most important things that can be done to minimize risks to patients is establishing a “culture of safety.” Changing culture is one of the most difficult things to do, but the effort is definitely worth it. When a culture of safety is established, it gives everyone a voice. People are less afraid to speak up and make suggestions because they are actively engaged in the process.

Again, while Martha is talking today, please think about your facility’s culture. If a staff member is not consistently washing their hands, do other staff members feel free to speak up? When people do speak up, does everyone listen? Or does the facility wait for a patient infection occur?

## A Facility-Wide “Culture of Safety” Will Protect Patients

- Reporting after someone has been harmed is too late.
- Comprehensive system for reporting, investigating and addressing causal factors of ALL abnormal events.

Again, no one wants to harm patients. So if a patient infection does occur, it's too late. We need to ensure staff know what to report. Incident and adverse event reports are good and they are necessary, but they are typically generated after someone has already experienced a negative event.

## Identification and Reporting

- Everyone knows what to report
  - Any unplanned event
  - “Near misses” and “close calls”
  - Variance from procedure
  - Environmental hazards
  - Concerns about patients
  
- Everyone feels FREE to report
  - No fear of reprisal

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If everyone, reports close calls, near misses and the at-risk behaviors which occur, then investigation and corrective action can take place before anyone experiences a negative event. Again, this is not an easy point to get to and everyone needs to feel free to report without fear of reprisal (culture of safety, not blame/shame).

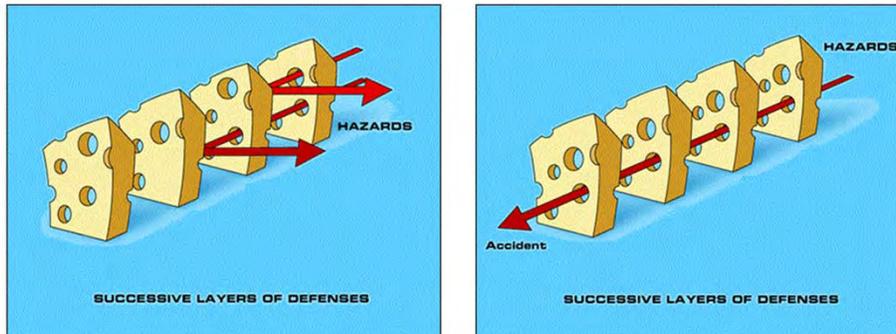
Again, during today's infection control discussions, please think about what systems your facility has for reporting prior to an adverse event occurring and whether your patients and staff know what to report and feel free to report.

## Primary Lessons About Health Care

- Not WHO did it, but WHAT and WHY did it happen?
- Understanding WHY and HOW bad things happen is key to preventing them.
  - Consider human factors.
  - Consider system flaws.

Those near miss investigations can then focus not on who did it, but what happened and why it happened. During this process people often use “Root Cause Analysis” and look both at human and system factors.

# Systems



Errors/adverse events occur because protective barriers needed to prevent them have not been constructed or have failed.

Swiss Cheese Model of Error:

[http://patientsafetypeduhs.duke.edu/module\\_e/swiss\\_cheese.html](http://patientsafetypeduhs.duke.edu/module_e/swiss_cheese.html)

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We all know human errors will occur. Facility systems are designed to minimize the potential for human error. Prior to implementing interventions for improvement, please ensure facility systems are analyzed in order to get to the “root cause” of the problem. Without such systems analysis, the facility may be able to correct a symptom of a problem, but it will not be able to correct the true underlying problem, allowing for negative events to continue.

## The Importance of Inclusion

- “Everyone is an expert in a highly specialized field...his or her own job. Odds are, each individual knows better than anyone how to improve it.” (Wolfe Schmitt, CEO of Rubbermaid)
- “The real experts about your organization are your own people, and the management challenge lies in tapping into this wealth of knowledge. The ideas people will support most are the ones they come up with themselves. Asking people for their input encourages both creativity and buy-in.” (Ed Oakley and Doug Krug, “Enlightened Leadership”)

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It is also important to remember in that “Everyone is an expert” in their own job and they will “knows better than anyone how to improve it.” Think about the staff who starts deviating from procedures and engaging in at-risk behavior. They are not trying to do a bad job. If you talk to that staff, the solution may be as simple as moving the hand sanitizer dispenser.

## Inclusive Investigation and Problem-Solving/Addressing

- Any and all persons involved with an error/occurrence/event should be included in the investigation and **resolution**
  - Their point of view of WHY, HOW and WHAT will work to address and resolve
  - Not just investigator “impressions”
  - Staff who are involved in plans for correcting problems are more likely to adhere to them
- This concept is well-documented.

Therefore, when you are working through to find the root of problems, we all know thorough investigation requires talking to everyone involved about the incident. However, how often is everyone included in the corrective action? Please keep in mind staff who are involved in plans for correcting problems are more likely to adhere to them.

## The Importance of Inclusion

**“Tell me and I’ll forget; show me and I may remember; involve me and I’ll understand.”**

- Chinese Proverb

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Again, staff are experts at their own jobs and they know how to improve it better than anyone. The more people you involve in the corrective action the more likely it will be effective. Talk to people. Ask everyone “how can we resolve this problem? How can we improve?”

Again, while Martha is talking today, please think about your facility. Has the facility conducted investigations into the infection control issues identified? Were all staff involved in both the investigation and the resolution?

## Evaluating the Strength of Corrective Actions

- **Weak:** dependent on staff, such as staff training, re-training, etc.
- **Intermediate:** somewhat dependent on staff but includes tools to help staff and modifies existing processes, such as peer review, checklists, etc.
- **Strong:** forced function actions that do not depend on staff, such as electronic systems which lock staff out, disallowing them from moving forward until documentation is completed, etc.

Veterans' Health Administration National Center for Patient Safety (VA/NCPS)  
<http://www.patientsafety.gov/SafetyTopics.html>

Beyond involving everyone in the resolution of a problem, the facility can also look at the strength of the action. The Veterans Affairs National Center for Patient Safety Hierarchy of Action, classifies corrective actions into 3 categories as stated on the slide. When developing corrective actions, please evaluate the strength of the corrective actions.

## Addressing Occurrences for Future Prevention

- Taking immediate action
  - Correcting hazards
- Implementing corrective action
- Monitor
- Re-assess the actions
  - Changing strategies if ineffective

Once corrective actions are identified, they need to be implemented, just like you would implement an other performance improvement action. The action is implemented, monitored, re-assessed and adjusted as needed, again based on everyone's input.

Again, while Martha is talking today, please think about your facility. Has the facility evaluated the strength of corrective actions? Has the monitoring of the infection control corrections being include in the facility's infection control surveillance methods?

## Putting It All Together

- A facility-wide culture of safety improves individual safety and quality of life. **This is not reliant on one person. Systems must be strong enough to be sustainable despite changes in personnel and turnover.**
- The elemental components of a culture of safety are:
  - Open, non-judgmental, non-punitive communication between **all** people involved in patient care.
  - Clear expectations.
  - Comprehensive system of error/occurrence/near miss reporting.
  - Comprehensive investigation to get to the “root” of the problem.
  - Input regarding corrective actions sought from all involved people.
  - Continued monitoring and adjustments to ensure systems and corrective actions are effective.

In summation, a facility-wide culture of safety improves patient safety and quality of care. It is based on designing systems to minimize the risk of human error by giving everyone a voice and following the other elements listed on the slide. Please note, culture of safety is not dependent on one person. The culture and facility systems must be strong enough to be sustainable even when key staff leave.

## Putting It All Together

- The elemental components of a culture of safety are aligned with the elements of QAPI:
  - Open, non-judgmental, non-punitive communication between **all** people involved in patient care (Q 81 – monitor all aspects of care).
  - Clear expectations and a comprehensive system of error/occurrence/near miss reporting. (Q 81 and Q 82 – quality indicator data based on patients and staff knowing what to report).

While the primary goal of implementing a culture of safety is to keep patients safe and improve care, the other benefit is that it will help facilities maintain regulatory compliance as an integral part of QAPI.

## Putting It All Together

- The elemental components of a culture of safety are aligned with the elements of QAPI:
  - Comprehensive investigation to get to the “root” of the problem. (Q 82 – Data analysis).
  - Input regarding corrective actions sought from all involved people (Q 83 – Performance Improvement projects).
  - Continued monitoring and adjustments to ensure systems and corrective actions are effective (Q 80 – ongoing, data driven program).

## Performance Improvement Projects

- Monitoring (more data):
  - Performance Improvement Project Monitoring.
  - Monitoring of all other areas.

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For the State, the number of citations will continued to be documented and the citations will be analyzed to determine the specific area of the citation. Data collection and analysis will take place after each survey. Should the data indicate continued non-compliance, adjustments to the training will be made. However, if the project is successful and improvements are made, the State Agency will continue to collect data regarding frequency of Q241 and 242 citations, necessary to document sustained improvements over time and another Performance Improvement Project will be implemented focusing on specific regulations indicated by 2015 quality indicator data.

The regulations also require the entire QAPI program to be on-going (CfC Q80). Therefore, data collection (via questions, complaints and citations) will continue for all ASC regulations.

## Promoting Culture of Safety

- Ensure **open communication** with **all** people involved in patient care.
- Educate and encourage everyone to **freely report** errors/occurrences/variances and "near misses/close calls" without fear of retribution.
- Encourage everyone to **freely voice** suggestions, concerns and complaints without fear of retaliation.
- **Encourage everyone to voice** concerns about, or ideas for, improvements.
- **Engage everyone** in improvement activities.

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Beyond that data monitoring, we also look forward to promoting a “culture of safety” in all ASCs by ensuring all ASC staff and our new partners at Qualis feel free to voice concerns and suggestions and are actively engaged in improving patient safety and service quality.

## For More Information on Culture of Safety...

- Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network  
<http://www.psnet.ahrq.gov>
- Veterans' Health Administration National Center for Patient Safety (VA/NCPS)  
<http://www.patientsafety.gov/SafetyTopics.html>
- Institute for Healthcare Improvement (IHI)  
<http://www.ihl.org>
- Health Research and Educational Trust (HRET)  
<http://www.hret.org/quality/projects/patient-safety-leadership-walkrounds.shtml>
- The Joint Commission (TJC)  
[http://www.jointcommission.org/topics/patient\\_safety.aspx](http://www.jointcommission.org/topics/patient_safety.aspx)
- Duke University Medical Center  
[http://patientsafetied.duhs.duke.edu/module\\_e/swiss\\_cheese.html](http://patientsafetied.duhs.duke.edu/module_e/swiss_cheese.html)

## QAPI Scope & Program Activities

Please submit your questions, comments or suggestions to [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

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Should you have questions, comments or suggestions regarding this or other aspects of the ASC survey process, please submit them to the Facility Standards email.

Thank you for your time and attention during this training.