Performance Improvement Boot Camp
For Assisted Living

QUALITY OPERATIONALIZED!
Is your facility prepared?

Presented by:
Barb Jezorski, RN, MSN
&
Brian R. Purtell
WiCAL Executive Director
Objectives

• Describe the core elements of quality program.
• Understand how to complete a root cause analysis.
• Verbalize operational strategies to incorporate quality assurance activities in everyday activities.
• State benefits to implementing a quality program.
Definition

Degree of excellence

Meeting or exceeding customer expectations
Definition

Planned interventions in order to improve the quality of the care and services delivered to assisted living residents

A comprehensive, structured, and ongoing transformational approach to assess and improve the quality of care and services
Quality

- Problem solving
- Improvement
- Data driven
- Structured process
- Measurement
- Interventions & Plans
- Evaluation
Involve all members of an organization to continuously identify opportunities for improvement and address gaps in systems.
The Problem-Solving Model

Implement quality program to develop an effective way of planning, working, & problem-solving.

Not just about compliance, about inventing better ways of providing care & service.
Quality Program Components

• Early problem identification
• Examination of root causes
• Use of data & feedback from multiple sources
• Understanding how systems of care might affect quality outcomes
• Systemic action
• Involvement of all staff in the quality mission
Leadership & Accountability

• Executive leadership, including the board of directors and owners

• Corporate leadership personnel set a climate and provide resources to help leadership flourish in each home.
Benefits of Quality

• Process to solve quality problems and prevent further occurrences
• To improve the processes
• Employee satisfaction when goals are achieved
• Better Care & Quality of life for residents
“Not all change is improvement, but all improvement is change.”

Donald Berwick, MD
Statements of Quality

• Opportunities to improve
• Investigate problems and try to prevent recurrence
• Track and report adverse events
• Compare quality of your facility to others
• Receive and investigate complaints
• Strive to achieve improvement with identified processes or systems
• Commitment to culture of safety
Culture Change

- Person-centered care
- Increased resident choice
- Eden Alternative
- Pioneer Network
- Neighborhoods
- Green Houses
How to get started

- Clinical or nonclinical
- High Volume of issues in certain process or area
- Problem-prone area
- High Risk area
Quality Cycle

1. Problem
2. Collect Data
3. Analyze
4. Action Plan
5. Evaluate
6. Problem
Quality Monitoring

• Utilize multiple sources
• Set priorities & targets
• Give everyone an opportunity to participate
Benchmarking

Process of Comparison
Benchmarking in Healthcare

Performance
Clinical
Competitive
Root Cause Analysis (RCA)

- A systematic method to analyze and evaluate a problem to get to the true “root cause”.
- Focus on “systems” not people.
- Ask “why” 5 times.
## Differences

<table>
<thead>
<tr>
<th>Symptom Approach</th>
<th>Root Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Errors” cause of staff carelessness</td>
<td>“Errors” result of defect in the system. Employees are only part of the process.</td>
</tr>
<tr>
<td>Staff need more training or education to be more careful.</td>
<td>We need to find out why this is happening, and implement mistake proofs so this won’t happen again.</td>
</tr>
<tr>
<td>We don’t have time or resources to really get to the bottom of the problem.</td>
<td>This is critical. We need to fix it for good or it will keep happening.</td>
</tr>
</tbody>
</table>
Steps to RCA

1) Gather Facts/Data
2) Understand what happened
3) Identify root causes
4) Develop a plan to prevent or reduce risk
5) Evaluate
Team

- Interdisciplinary
- All employees directly involved
- Experts
- Administrative Support
Ground Rules

• Facilitator
• Professional & Equal
• Start on Time
• Minute Taker
• Parking Lot
• Everyone Participate
• Confidentiality
Step 1
Collect the Facts/Data

- Review medical record, incident report
- Interview
- Observe “typical” process
- Review policies
- Literature Review
Step 2
Understand What Happened

- Timeline
- Compare
- Begin to identify opportunities
Step 3
Determine Root Cause

- ASK WHY
- Human Factors
- Environmental
- Equipment
- Polices
- Information Technology
- Culture
Step 4

Risk Reduction/Action Plan

• For each contributing or root cause
• Create timelines
• Assign accountability
• Pilot Testing
• Measure Methods
Step 5

Evaluation

• Evaluation Cycle/Dates
• Evaluate if actions taken prevented or reduced risk
• Revise plan as needed
• Report activities and outcomes to organization’s leaders and/or Board
Tools

• Brainstorming
• Charts
  – Flowcharts
  – Control Charts
• Diagrams
  – Fishbone
  – Scatter
  – Tree
Flow Chart
Factors and/or categories of factors
Fishbone Diagram (cause and effect)

- 3rd Largest Cause
- Least Influence
- 2nd Largest Influence
- Largest Influence

Factors and/or categories of factors
CAUSES OF LOW CUSTOMER SATISFACTION

LOW QUALITY PRODUCT

- Minimal Activities
- No follow through
- Incompetent Employees

HIGH PRICING

- Ineffective Marketing
- Fee Structure

LOW CUSTOMER SATISFACTION

POOR SUPPORT

- Minimal Staff
- Long Wait Times
- Staff Rude
Example – Noise Complaints

- PA Announcements
- Noisy on PM shift
- Noisy at meals
- Dishes clattering in dining room were noisy

- PA Announcements discontinued
- Lights turned down in the evening
- Quieter residents were seated together
- Dishes were scraped in the kitchen
Steps to Implement Quality

1) Establish leadership & Accountability
2) Develop team
3) Develop a strategy for collection and using data
4) Choose Tools to use for Quality
5) Identify your quality problems
6) Prioritize Problems
7) Plan, Conduct, and Document
8) Perform Root Cause Analysis
9) Evaluate
Summary

• Just get started
• Celebrate successes
• Remember to document
RESOURCES

- Agency for healthcare research and quality: http://www.qualitymeasures.ahrq.gov
- Institute for Clinical System Improvement: https://www.icsi.org
- An Introduction to Root Cause Analysis in Healthcare http://www.dcs.gla.ac.uk/~johnson/papers/Pascale_book/incident_analysis.PDF
- Joint Commission Framework for conducting a RCA: www.jointcommission.org/Framework_for_Conducting_a_Root_Cau...
- Techniques for root cause analysis PATRICIA M. WILLIAMS, BS, MT(ASCPSBB
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1292997/ Health Care Benchmarking Dr Jan FL Kay The Hong Kong Medical Diary Vol 12 No 2 Feb, 2007 pg 22-27
Resources

Quality Improvement Organizations (QIOs)
www.ihi.org/knowledgewebsite/Pages/HowtoImprove/default.aspx

Advancing Excellence in America’s Nursing Homes
http://www.nhqualitycampaign.org/

Stratis Health
www.stratishealth.org/events/recorded/html

Oklahoma Foundation for Medical Quality
www.ofmg.com