# Laguna Honda Hospital & Rehabilitation Center (LHH)

# Quality Improvement Expert (QIE) Action Plan Summary and Final Recommendations

Health Services Advisory Group, Inc. (HSAG)

**Action Plan Final Summary Report**
**November 9, 2023**

# LHH Action Plan Analysis

In October 2022, Laguna Honda Hospital and Rehabilitation Center (LHH) contracted with Health Services Advisory Group, Inc. (HSAG) to serve as the Quality Improvement Expert (QIE) in response to its Settlement and Systems Improvement Agreement with the Centers for Medicare & Medicaid Services (CMS). The QIE conducted nine root cause analyses (RCA) to address CMS monitoring survey findings at a scope and severity of D or higher.

LHH, in consultation with the QIE, created an Action Plan with 960 milestones to address the 13 RCA category findings and implement the recommendations and necessary improvements. Milestone deliverables included, but were not limited to, new policies and procedures, staff training and competency checks, EMR updates, ongoing audits, feedback, and quality reporting. LHH submitted 960 (100 percent) of the milestones by November 3, 2023.

During the implementation of LHH's Action Plan, QIE staff members (1) participated in on-site visits; (2) rounded LHH nursing units and attended huddles and resident meetings; (3) met one-on-one with leadership and provided coaching around skilled nursing facility regulations; and (4) regularly attended LHH's staff education and training. The QIE also held twice weekly virtual office hours to assist LHH staff members with questions regarding Action Plan items, deliverables, and deadlines.

The QIE reviewed deliverables to ensure they met the intent of the milestones described in LHH's Action Plan. Overall, 31% of deliverables required revisions following QIE content review, guidance, and coaching (Table 1).

**Table 1. Percentage of LHH Action Plan Deliverables Requiring Resubmission**

| # | RCA Category | # Milestones Developed and Submitted | # Requiring QIE Revisions | Revision Percentage |
|---|---|---|---|---|
| 1 | Quality Assurance & Performance Improvement | 33 | 9 | 27% |
| 2 | Infection Prevention and Control | 51 | 10 | 20% |
| 3 | Behavioral Health and Substance Abuse | 72 | 29 | 40% |
| 4 | Medication Management and Administration | 26 | 7 | 27% |
| 5 | Resident Rights and Freedom from Harm | 222 | 63 | 28% |
| 6 | Comprehensive Care Plans and Quality of Care | 107 | 49 | 46% |
| 7 | Competent Staff, Training, and Quality of Care | 36 | 8 | 22% |
| 8 | Emergency Preparedness Program | 71 | 20 | 28% |
| 9 | Fire and Life Safety | 40 | 9 | 23% |
| 10 | Resident Quality of Care | 157 | 65 | 41% |
| 11 | Food and Nutrition Services | 43 | 11 | 26% |
| 12 | Homelike Environment | 41 | 11 | 27% |
| 13 | Abuse and Neglect | 61 | 7 | 11% |
| | **Total** | **960** | **298** | **31%** |

Implementing nearly 1,000 milestones created an organizational structure more aligned with traditional skilled nursing facility operations, including the hiring of licensed nursing home administrators and experienced directors of nursing (DON). Action plan implementation also increased awareness and action around high-risk resident issues, including comprehensive care plans, physical restraints, wounds, abuse and neglect, and falls. LHH also established more robust unit-based meetings, including huddles with huddle boards and unit-based QAPI meetings to address high-risk, problem-prone issues that impact resident care. LHH also implemented enhanced education techniques, including Situation-Background-Assessment-Recommendation (SBAR) and teach-back. LHH improved the daily environment of care rounding to ensure basic standards of care are met. The Action Plan also fostered greater accountability between management and direct-care staff to ensure standards are being met daily. Consistent strong leadership and management will be vital to sustain improvements made during the Action Plan.

## Sustainability Vulnerabilities

The QIE identified three ongoing issues that will impact the sustainability of gains made during the Action Plan, including (1) audit integrity, (2) data integrity, and (3) continuous quality improvement (CQI) at the unit level.

**Audit Integrity:** An analysis of Action Plan deliverables revealed that many audits (1) have very low sample sizes and (2) often have 100% compliance (Table 2). A low sample size limits the generalizability of findings and can affect analysis for quality improvement. It is rare in complex health systems for any process to be perfect. Consistent 100% compliance indicates a lack of objectivity and potential bias among auditors.

**Data Integrity:** Another vulnerability is the lack of alignment between resident care plans, the Kardex, and MDS coding. Resident data must be aligned across these items to ensure all staff members accurately communicate resident interventions, goals, and conditions. Alignment ensures quality measure data integrity to support ongoing quality improvement and sustainability.

**CQI at the Unit Level**: Data presented at QAPI indicates that LHH is not sustaining metrics related to Action Plan deliverables. The most recent report shows that 1/22 (4.5%) metrics have maintained goals for three consecutive months (Figure 1). Many of the unit-based interventions listed on the report are duplicative, such as “discussed during IDT stand up and unit-based email.” This indicates that intervention development is not being discussed during QAPI. In addition, despite coaching, unit-based interventions are not adequately monitored or strengthened using continuous quality improvement techniques, such as plan-do-study-act (PDSA cycles) or practical performance improvement projects (PIPS). A lack of a robust PDSA process, targeted interventions, and feedback loop at the unit level is a potential root cause of this lack of sustainment.

These issues negatively impact LHH’s ability to analyze and provide comprehensive, in-depth evaluations of its processes and practices. They also limit LHH’s ability to detect emerging trends, identify risks, and develop strong interventions before significant issues arise.

## Sustainability Recommendations

LHH can sustain Action Plan progress and maintain strong resident care by addressing its sustainability vulnerabilities. The QIE recommends the following actions to strengthen a culture of sustainability and continuous quality improvement.

- LHH must continue the transition to normal operations to the nursing home administrator (NHA), assistant NHAs, and directors of nursing. Leadership must also strengthen the facilitation of the Quality Assurance and Performance Improvement (QAPI) program to create strong feedback, data systems, and monitoring to drive systemic analysis and action. Leadership must also continue to improve LHH's monthly QAPI meeting facilitation to support systemic improvements through robust discussion. This includes maintaining strong, interdisciplinary stand-up meetings to maintain awareness of issues and ensure accountability for follow-up actions.
- To support the stabilization of Action Plan improvements, LHH must continue its Consistent Care at the Bedside Monitor (CCBM) Program to help DONs and nurse managers and ensure with an objective perspective that strong processes are effectively implemented at the unit level.
- To support strong data monitoring, LHH must develop audit education and train LHH staff with competencies, such as audit tool development, creating data definitions, selection of reliable data sources, choosing sufficient sample sizes, and observation techniques. This will help ensure the organization can accurately assess processes and practices for compliance and have confidence in the results.
- To help sustain Action Plan improvements, LHH must continue collecting and reporting data, at a minimum, for the 13 milestones in Table 2. This will support sustained compliance for these vulnerable areas and provide opportunities to monitor staff performance for competencies (e.g., audits, care plan reviews). Before data collection is continued for those milestones, the data collection tool should be reviewed to validate the tool is sufficient and collecting the correct information and staff auditors should be trained to ensure inter-rater reliability.
- To monitor sustainability outcomes effectively, LHH must revise its management plan to continuously monitor key metrics and outcomes (e.g., executive dashboard, unit-based QAPI) that also includes a regular review of the effectiveness of unit-based interventions.
- LHH must support continuous quality improvement using regular PDSA cycles at the facility and unit levels. This includes re-training unit staff on QAPI techniques, such as PDSA, to ensure that interventions are tailored to individuals at the unit level. Leadership must also set expectations for regular PDSA cycles to support improvement efforts.
- LHH must continue participation with critical external stakeholder groups to become part of the post-acute care community. This participation will allow LHH to be knowledgeable of leading-edge best practices and to connect to a talent network to support LHH's continued growth in developing long-term care expertise to support long-term sustainability.

## Table 2. Recommended Deliverables to Continue to Support Sustainability

| # | RCA Category | Milestone Description | Analysis |
|---|---|---|---|
| 1 | Behavioral Health and Substance Abuse | **Root Cause 7, Milestone 2:** Validate sustained knowledge among staff with competency validation. Implement competency assessment in a phased approach; first prioritizing units with residents who have expressed suicidal ideation. Ongoing assessments will be completed on units where new suicidal ideations are identified. | Competency assessments identify that staff are 100% competent with no gaps or issues in knowledge. Perfect compliance is rare with thorough assessments. Additionally, the competency tool used for PCAs was specific to the Columbia Suicide Severity Rating Scale C-SSRS, a task they do not perform. Continued assessments with unbiased validators and appropriate competency tool for the tasks that each job position performs are needed. |
| 2 | Behavioral Health and Substance Abuse | **Root Cause 7, Milestone 3:** Partner with a care plan SME to perform a monthly chart and care plan review with a focused on ensuring clinical recommendations from LHH psychiatry providers are clearly documented in care plans for residents who have expressed suicidal ideation. Implement audits with a phased approach; first prioritizing units with residents who have expressed suicidal ideations. | Deliverables submitted identify that recommendations have been documented. Subsequent consultant care plan validations show ongoing discrepancies. |
| 3 | Behavioral Health and Substance Abuse | **Root Cause 8, Milestone 3:** For residents with expressed suicidal ideation, nurse directors must perform twice-weekly documentation audits utilizing the standard work for SI to ensure medical record accuracy and implementation of required interventions. These audits will occur for at least six weeks based on results. | The sample size was one resident and the duration was only 3 weeks instead of 6 weeks due to the deliverable pause in September. Given the severe nature of this metric, additional monitoring needs to occur and for a longer duration of time. Additionally, initial audit showed 100% compliance which did not align with subsequent consultant validations, which show ongoing discrepancies. |
| 4 | Resident Rights and Freedom from Harm | **Root Cause 9, Milestone 4:** An audit will be performed to validate appropriate coding. | Ongoing consultant MDS coding reviews have identified gaps in accurate coding. MDS requires additional monitoring to ensure continuing accuracy and reliability. |

| # | RCA Category | Milestone Description | Analysis |
|---|---|---|---|
| 5 | Comprehensive Care Plans and Quality of Care | **Root Cause 4, Milestone 12:** Nurse managers, in collaboration with the CCBM, will ensure care plans are updated timely and appropriately through their daily clinical review for residents with recent falls. | Submitted data identify high compliance; however, resident falls continue. Additional reviews and focus will be required to ensure documented fall interventions are effective. |
| 6 | Comprehensive Care Plans and Quality of Care | **Root Cause 5: Milestone 3:** Develop a metric, using its Daily Clinical Form, to measure and monitor care plan updates for residents who return to LHH from a higher level of care. Data will be stratified by nursing unit and shared with nurse directors and nurse managers so that unit specific solutions can be developed and implemented. | While this milestone is specific to the metric, please note that there continues to be an ongoing vulnerability specific to care plans for those residents who recently returned from acute care. Independent audits from consultants continue to show lack of individualization and timeliness. |
| 7 | Resident Quality of Care | **Root Cause 1, Milestone 4:** Nurse managers and charge nurses will perform daily visual rounds on the units and complete observations to ensure daily supplies and care is being provided as documented and ordered, such as oxygen titration and tracheostomy care is as ordered by the physician. Daily rounds will include speaking with frontline staff to assess how the worklist is being utilized, which is reviewed by nurse managers in Milestone 2. | Audit results indicate high performing results, however audits and observations from other departments that focus on the environment of care continue to show gaps in compliance. |
| 8 | Resident Quality of Care | **Root Cause 5, Milestone 9:** Nurse Directors will monitor and audit change of shift handoff processes to ensure adherence to the new standard work and policy. Audits will be on a weekly basis, a minimum of 3 observations per unit, and must include a weekend change of shift or 11:00 -11:30 pm change of shift observation. | Change of shift hand-off is a critical element for reliable and safe care. The observations occurred for only one week and the average sample size per unit was 8 observations. Given the critical nature of this task it is important to increase the observations and duration of time for a strong assessment of the process. |
| 9 | Resident Quality of Care | **Root Cause 6, Milestone 4:** Nurse manager will compare worklist to current physician orders, treatments, care plan, and Kardex to ensure that worklist is current and up to date. Ten residents per unit weekly will be audited for accuracy of the worklist by comparing to current physicians orders, treatments, care plans, and Kardex. | Audit results indicate high performing results, however chart reviews and observations from other sources indicate there are many gaps. Continued assessments with unbiased validators are needed. |

| # | RCA Category | Milestone Description | Analysis |
|---|---|---|---|
| 10 | Resident Quality of Care | **Root Cause 10, Milestone 2:** Nurse managers in conjunction with their unit-based wound champions and assigned CCBMs will complete three weekly wound care competencies to include all three shifts. Weekly wound care competencies currently include assessment of pain, review of the wound, and verification of orders. | Competencies showed a 100% pass rate and few staff required coaching. These results are rare with thorough assessments. Continued assessments with unbiased validators or WOCN (or similar certification) are needed. |
| 11 | Resident Quality of Care | **Root Cause 11, Milestone 2:** Nurse Managers will complete daily rounds to ensure dot placement, a resident alert process which indicates precautions requiring additional observational and potential attention, is accurate and updated per current individualized plan of care. New precautions will be captured and monitored per daily clinical review. | Consultant observations and meeting participation indicate the dot-based resident alert process remains a vulnerable issue due to staff's low understanding of the dot system. Data from the audits showed near perfect results and 100% compliance with the kardex and care plan. |
| 12 | Homelike Environment | **Root Cause 3, Milestone 3:** The results from Milestone 2 will be presented to facility-wide QAPI/QAA for evaluation of trends and patterns and opportunities for improvement with a target of achieving substantial compliance at the facility threshold of 95%. Ongoing issues regarding compliance will be addressed as necessary as part of the QAPI plan at the PIPS committee. | The compliance rate dropped in the last month to 87%, below the 95% threshold to ensure resident privacy and safety during medication administration. |
| 13 | Homelike Environment | **Root Cause 5, Milestone 4:** In collaboration with CCBMs, nurse managers will perform homelike environment rounds every week to identify instances of improper equipment storage in resident rooms, necessary belongings not within reach of the resident, any damage to resident equipment including wheelchairs, using the LHH business language, and any other concerns related to creating a homelike environment for Residents. | The number of rounds (representing the metric denominator) was low. In addition, the reported compliance rate was very high. |

## Figure 1. QAPI-Reported Monitoring 1&2 Survey Metrics Not Meeting Goal

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### Monitoring 1 & 2 Survey Metrics Not Meeting Goal

Resident Rights_RC12_Milestone 1 & Resident Rights_RC12_Milestone 5

**MS3_Resident Rights_RC12_Milestone 2:** All QAPI metrics where data has not met the compliance goal and that are related to deficiencies from Monitoring surveys (see Resident Rights, Root Cause 12, Milestone 1) will be discussed monthly at the facility wide QAPI meeting (known as PIPS) until the goal has been reached and maintained for three consecutive months before transitioning to quarterly review at the QAPI meeting. Note the committee needs to discuss and agree before moving to quarterly monitoring even if the target has been met for three consecutive months.

Each metrics needs unit based interventions in their report to committees.
Metrics that have been met specific to the milestone has been removed from this scorecard. These metrics may still be reported to PIPS.

11/9/23 Please note that the QM department was updating this deliverable at the time this report submission occurred so some data values may change.

| Action Item | Topic and Metric | Owner | Target | Jun | Jul | Aug | Sep | Status of ≥95% for three consecutive months (or % specified by target) | Unit-based interventions will be incorporated into the Committee Report |
|---|---|---|---|---|---|---|---|---|---|
| **Care Plans** | | | | | | | | | |
| Care Plans_RC2_Milestone 8 | PASRR Level II CEP | I. Blanco | 100% Compliant | 85% | 79% | 81% | 100% | Goal not met | Unit based interventions are still needed |
| Care Plans_RC1_Milestone 11 | Resident Care Conference Team Attendance | I. Blanco | 95% RCC key members will attend the RCC | 64% | 67% | 68% | 78% | Goal not met | Unit-based interventions in place |
| **Emergency - EOP** | | | | | | | | | |
| EOP_RC2_Milestone 2<br>EOP_RC3_Milestone 4 | After Action Response (AAR) Findings | G. Chase and T. Rivera | 100% compliance for corrective action completed | 76% | 81% | 81% | 81% | Goal not met | Individualized intervention in process for complex issues |
| **Fire Life Safety** | | | | | | | | | |
| FLS_RC2_Milestone 8 | Work Order Completion | G. Chase | 90% assigned within 30 days | 92% | 85% | 82% | 89% | Goal not met | Individualized intervention in process |
| FLS_RC4_Milestone 7 | Preventative Maintenance Completion | G. Chase | 95% of PM assigned within 30 days | 88% | 82% | 82% | 95% | Goal not met | Individualized intervention in process |
| **Med Mngmt** | | | | | | | | | |
| Med. Mngmt_RC2_Milestone 8 | Medication Self-Administration | D. Smith and M. Fouts | 95% residents with self-admin assessments | 77% | 31% | 93% | 100% | Goal not met | Pharmacy and Nursing leadership working with specific units |
| **Quality of Care** | | | | | | | | | |
| QOC_RC4_Milestone 7 | Pain Assessment - Pre-Scheduled Med | K. MacKerrow | 95% compliance | 86% | 88% | 95% | 96% | Goal not met | Staff who are non compliant receive coaching |
| QOC_RC4_Milestone 7 | Pain Assessment - PRE-PRN | K. MacKerrow | 95% compliance | 95% | 96% | 99% | 99% | Goal Met | Staff who are non compliant receive coaching |
| QOC_RC4_Milestone 7 | Pain Assessment - Post PRN | K. MacKerrow | 95% compliance | 71% | 74% | 86% | 91% | Goal not met | Staff who are non compliant receive coaching |
| **Resident Rights** | | | | | | | | | |
| Resident Rights_RC2_Milestone 7 | Timely Reporting | G. Mariano | 100% reported | 88% | 100% | 84% | 90% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | Documentation on Reporting | G. Mariano | 100% documentation | 85% | 89% | 94% | 100% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | Individualized Care Plan Review | G. Mariano | 100% of abuse care plans reviewed | 90% | 93% | 100% | 100% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | Physician Documentation | G. Mariano | 100% documentation | 90% | 96% | 94% | 100% | Goal not met | Discussed during IDT stand up and unit based email |

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# Monitoring 1 & 2 Survey Metrics Not Meeting Goal

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| Action Item | Topic and Metric | Owner | Target | Jun | Jul | Aug | Sep | Status of ≥95% for three consecutive months (or % specified by target) | Unit-based interventions will be incorporated into the Committee Report |
|---|---|---|---|---|---|---|---|---|---|
| Resident Rights_RC2_Milestone 7 | Surrogate Decision Maker Notification | G. Mariano | 100% of SDM are notified | 90% | 100% | 97% | 100% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | Social Work Documentation | G. Mariano | 100% documentation | 96% | 93% | 94% | 100% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | 24th hour Nursing Documentation | G. Mariano | 100% documentation | 65% | 81% | 10% | 60% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | 48th hour Nursing Documentation | G. Mariano | 100% documentation | 88% | 75% | 77% | 90% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | 72nd hour Nursing Documentation | G. Mariano | 100% documentation | 50% | 85% | 97% | 56% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC2_Milestone 7 | Special RCT Meeting | G. Mariano | 100% residents had RCT meeting | 100% | 85% | 77% | 89% | Goal not met | Discussed during IDT stand up and unit based email |
| Resident Rights_RC4_Milestone 6 | Grievances reviewed on time* | J. Carton-Wade | 100% of grievances reviewed by facility | 93% | 96% | 100% | 100% | Goal not met | Unit-based interventions in place |
| Resident Rights_RC7_Milestone 6 | Resident Council Participation | J. Carton-Wade | 90% participation | 86% | 78% | 88% | 82% | Goal not met | Unit-based interventions in place |
| Staff Training | | | | | | | | | |
| Resident Rights_RC1_Milestone 9<br>Staff Training_RC2_Milestone 7 | Leadership Rounding | L. Angel | 90% of units rounded | 72% | 90% | 83% | 100% | Goal not met | Rounding expectations and questions have changed |

Notes on Specific Metrics

**Grievances**: *Metric will continue to be reviewed monthly as indicated. On 8/15/23, final resolution was updated from 30 days to 10 days.

**Tube feeding:** metrics specific to the milestone was removed from this scorecard as they met the goals for three months. The tube feeding metrics not meeting goals (Free water) was not tied to a specific milestone. These are still be report to PIPS and has unit based interventions.
**Pain assessment**: metric (assessment pre-PRN) was removed from this score card as it has met the goal for three months.