Ohio | Department of Developmental Disabilities

RN QUALITY ASSESSMENT REVIEW AND FORM INSTRUCTIONS

(REFERFENCE Ohio Administrative Code 5123:2-6)

(the instructions and form are designed and should be printed in landscape format – not portrait format)

FORWARD

Before you begin to read about how to use the Registered Nurse Quality Assessment (QA) review form, please pause for a moment and think about your story. Why did you become a nurse? The reasons that people often give for pursuing a career in nursing include wanting to care for others, to repay a kindness, or to make a difference. Each of these goals can be met as you use this form in collaboration with managers, Direct Service Providers, and individuals with intellectual/developmental disabilities (IDD). The overarching goal of the QA review is to provide consultation and oversight to ensure a safe environment for the administration of medications and performance of Health-Related Activities in individual's homes and/or work settings.

Ida Jean Orlando's Nursing Process Theory includes assessment, diagnosis, planning, implementation, and evaluation. This process is entirely applicable in the use of this QA form. For each setting, you will complete an assessment of what is currently occurring, identify areas of concern, diagnose the core underlying contributing factors, collaborate with the provider to develop a plan of improvement, allow

the provider to implement the changes, and ensure a method is established for the provider to monitor the effectiveness of changes implemented.

The American Nurses Association Code of Ethics calls nurses to "create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect" (American Nurses Association [ANA], 2015, p. 4). All those participating in the care of individuals with IDD share a desire for everyone to have the freedom to live, work, and play where he/she wants by receiving safe, person-centered supports as needed. As the RN QA review is completed, it is essential that the perception of a punitive approach is avoided. Instead, focus on process driven outcomes and look for patterns that indicate areas of concern that need to be addressed to improve safety in the setting being evaluated. Together we can ensure the safest environment possible, with person-centered positive outcomes, while creating a culture of compassion and caring.

"So never lose an opportunity of urging a practical beginning, however small, for it is wonderful how often in such matters the mustard-seed germinates and roots itself." Florence Nightingale

American Nurses Association. (2015). *Code of ethics for nurses* [Website]. Retrieved from Nursing World website: http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html-

PREPARATION AND THE NURSING ASSESSMENT

- Keep in mind that this RN QA Form is an Assessment OUTCOME form. It is not the actual nursing assessment.
- The format and process each RN uses will be specific to the individuals and circumstances.
- The medication administration (MA) support settings are primarily people's homes (or daily places of work and recreation). It is essential that the QA RN keep that fact foremost in consideration when determining how and where the various aspects of the assessment process are completed. No individual should ever feel that their home is being intruded upon, or that a way of life they have chosen, the supports they receive, or the personnel who provide those supports are in anyway threatened. The QA RN must assure that utmost respect for the role of the RN as a guest in the home (or work place) is maintained and the spirit of the transaction is one of support for health and safety in a technical assistive manner.
- Person-centered and trauma informed approaches should be universally applied.
- The format and location of records reviews should be collaboratively determined by the QA RN and the Provider(s). The mutual convenience and expenditure of time and resources should be fairly negotiated.
- The only records that are required to be available in the home (or Work/Day Support location) are the current Medication Administration Records, the pharmacy labeled prescription medications (and copies of prescriptions for OTC or changed current medications), and the relevant Step-by-Step instructions for current medications and tasks. Any other records may be housed elsewhere. QA RNs should observe original records to the degree it is practical, and not make or request excessive or unnecessary copies. The use of electronic copies and transmissions of records and other communications must be HIPAA compliant.
- Interviews of pertinent personnel or other relevant parties do not need to be done in the home. Practicality and use of resources will be principle considerations in addition to the necessary affirmation of safe, effective medication administration.
- EXAMPLES included in these instructions for the form are NOT intended to indicate requirement. The QA RN must be knowledgeable about medication administration law and rule. The RN will need to use evidence and nursing judgement to

determine if there are patterns of outcomes that appear to indicate lack of rule compliance or safe medication administration practices.

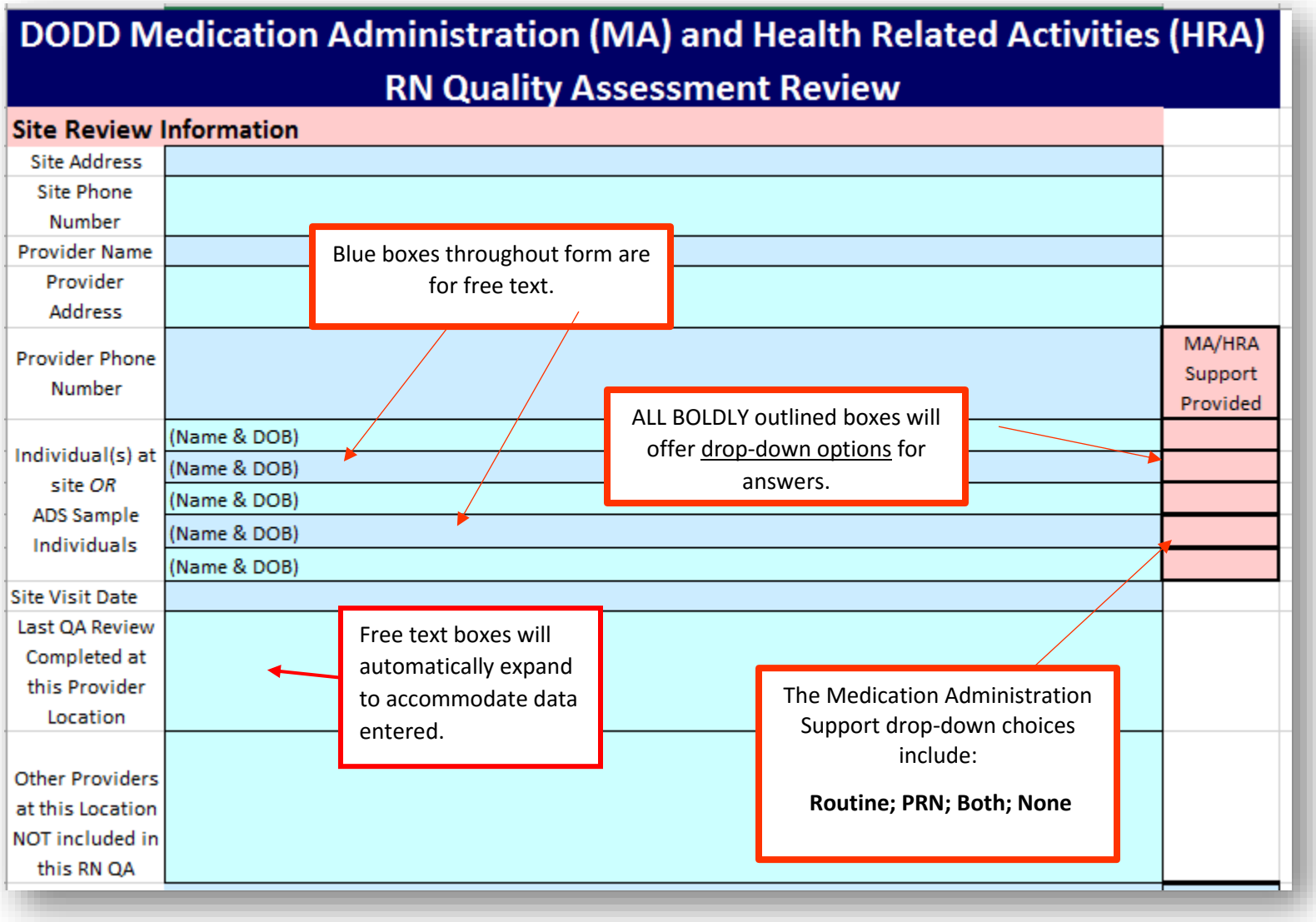
- Emergency Medications are not a singular topic; they should be considered in context of the processes related to PRN medication orders.
- A well written policy/procedure does not ensure quality care. For this reason, there will be areas in the form that ask if there is ***evidence*** that MA Personnel "know and follow the process". (What does the documentation reflect?) This will be followed by a question exploring the ***knowledge*** of interviewed staff. (Do they understand why they are doing the process and how it relates to safe outcomes?)
- Providers may have policy/procedure/guidelines in writing or a manager should be interviewed to determine agency process. Then, personnel should be interviewed to assess for knowledge and effectiveness of identified processes. Highly functional processes are those that can/will be able to be followed on-going regardless of personnel changes.
- The question to be answered: Is the process set up, established, or written down in such a manner that if there is staff turnover, the process will continue uninterrupted?
- At least 1 personnel should be interviewed and medication administration skill observed. The need for additional interviews or observations should be collaboratively determined by RN and Provider.
- Assess for *patterns* that indicate risk for poor outcomes – NOT isolated errors. Errors noted may need to be acted upon, but the POI should primarily focus on needed changes identified by root cause analysis.
- The rating system for each process will aid in the identification of core issues/concerns related to PROCESS. Root cause analysis may determine a singular root cause for multiple process weaknesses.

- QA RNs may find that some issues do not clearly land in one category or may be applicable in multiple categories. It will be within the nursing judgement of the QA RN to decide where to capture the evidence-based findings and where to address the root cause in the Outcome sections.
- The process of Root Cause Analysis should be applied in collaboration with the provider to guide plans of improvement that will mitigate risk and increase accuracy of medication administration and healthcare going forward. There are many good sources of training for effective Root Cause Analysis; QA RNs need to have a functional working knowledge of the principles and process of Root Cause Analysis (aka Systems Analysis) (https://psnet.ahrq.gov/primers/primer/10/root-cause-analysis).
- In questions related to agency supervision, the independent providers are responsible for the process of self-management and meeting medication administration rule requirements.
- Be sure to check your "print preview" before printing; if all columns (the width of the page) are not visible on a single page, make sure the print setting is for scale is set to "fit all columns on one page" (not the other default of "no scaling").
- Before sending copies to provider or others "save as" a PDF formatted file. This will prevent editing by others. The copy you save as excel will continue to be editable.
- This form is optimized for Microsoft® Excel 2016. Please note: use of IOS or other software may affect appearance and performance.

Form Appearance & Usability

Understanding the Format of Instructions Below:

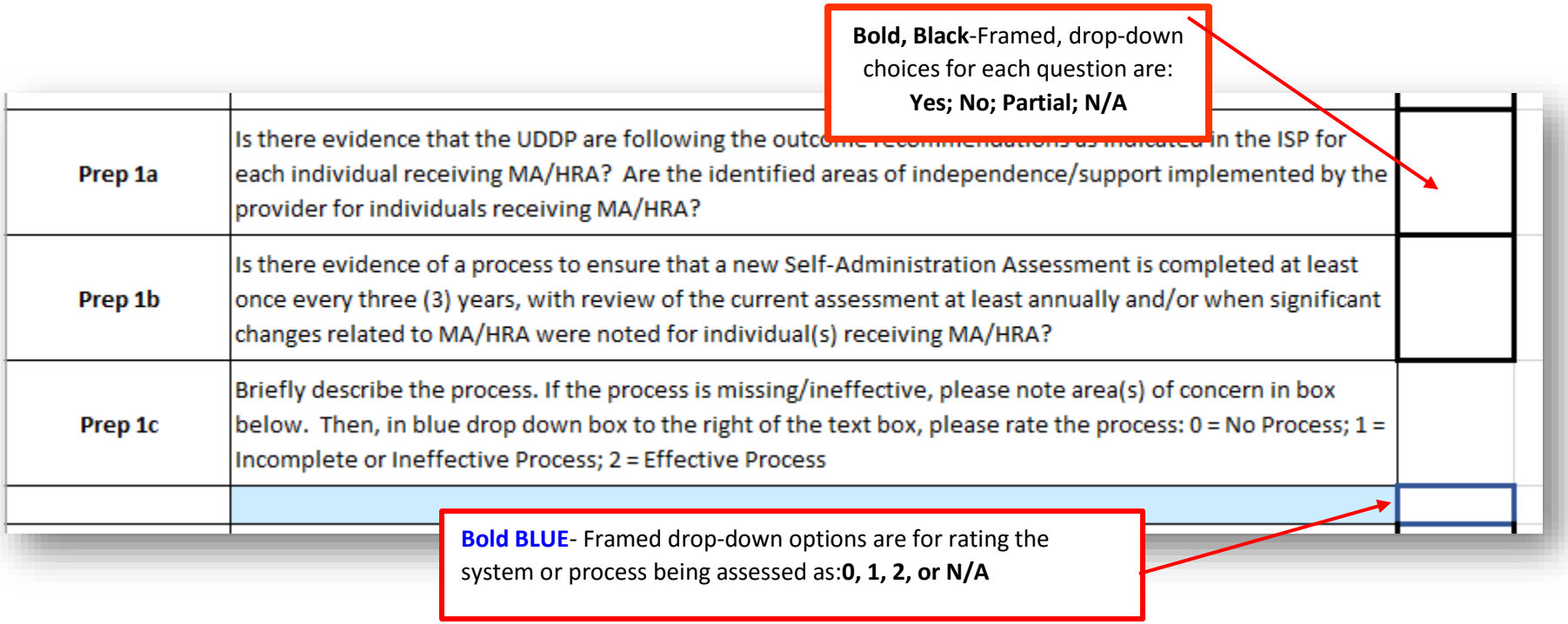
- **Instruction Pages begin with Screen Shots** of selected sections of the form, the pictures have text boxes inserted that describe the form's **FUNCTIONALITY**
- **Instruction Pages then include** line-by-line guidance for **INFORMATION** that will be entered in the form


DODD Medication Administration (MA) and Health Related Activities (HRA)
RN Quality Assessment Review
Site Review Information
Site Address
Site Phone Number
Provider Name
Provider Address
Provider Phone Number
Individual(s) at site OR ADS Sample Individuals
(Name & DOB)
(Name & DOB)
(Name & DOB)
(Name & DOB)
(Name & DOB)
Site Visit Date
Last QA Review Completed at this Provider Location
Other Providers at this Location NOT included in this RN QA
MA/HRA Support Provided
Blue boxes throughout form are for free text.
ALL BOLDLY outlined boxes will offer drop-down options for answers.
Free text boxes will automatically expand to accommodate data entered.
The Medication Administration Support drop-down choices include:
Routine; PRN; Both; None

Provider Name		
Provider Address		
Provider Phone Number		MA/HRA Support Provided
Individual(s) at site *OR* ADS Sample Individuals	(Name & DOB)	
	(Name & DOB)	
	(Name & DOB)	
	(Name & DOB)	
	(Name & DOB)	
Site Visit Date		
Last QA Review Completed at this Provider Location		
Other Providers at this Location NOT included in this RN QA	(Provider Name, contact name, and phone #)	
RN QA Reviewer	(Name & Credentials)	**DATE**
Personnel Observed and/or Interviewed	(Name & Title)	
	(Name & Title)	
	(Name & Title)	
	(Name & Title)	
	(Name & Title)	
	(Name & Title)	

Click in any bold framed box and the drop-down arrow will appear

Date Boxes must be populated using the **mm/dd/yyyy** format


Bold, Black-Framed, drop-down choices for each question are: **Yes; No; Partial; N/A**
Prep 1a
Is there evidence that the UDDP are following the outcome recommendations as indicated in the ISP for each individual receiving MA/HRA? Are the identified areas of independence/support implemented by the provider for individuals receiving MA/HRA?
Prep 1b
Is there evidence of a process to ensure that a new Self-Administration Assessment is completed at least once every three (3) years, with review of the current assessment at least annually and/or when significant changes related to MA/HRA were noted for individual(s) receiving MA/HRA?
Prep 1c
Briefly describe the process. If the process is missing/ineffective, please note area(s) of concern in box below. Then, in blue drop down box to the right of the text box, please rate the process: 0 = No Process; 1 = Incomplete or Ineffective Process; 2 = Effective Process
Bold BLUE- Framed drop-down options are for rating the system or process being assessed as:**0, 1, 2, or N/A**

CPS 3	Is there evidence of a process used by the agency/supervisor to track expiration dates to ensure MA certifications are current?	Yes
CPS 3a	Is there evidence that the process is effective?	No
CPS 3b	Briefly describe the process. If the process is missing/ineffective, please note area(s) of concern in box below. Then, in blue drop down box to the right of the text box, please rate the process: 0 = No Process; 1 = Incomplete or Ineffective Process; 2 = Effective Process	
		1

Answers that indicate an incomplete or ineffective process will result in the nurse giving a score of "1" for the process

CPS 3	Is there evidence of a process used by the agency/supervisor to track expiration dates to ensure MA certifications are current?	Yes
CPS 3a	Is there evidence that the process is effective?	Yes
CPS 3b	Briefly describe the process. If the process is missing/ineffective, please note area(s) of concern in box below. Then, in blue drop down box to the right of the text box, please rate the process: 0 = No Process; 1 = Incomplete or Ineffective Process; 2 = Effective Process	
		2

Answers that indicate a complete and effective process will result in the nurse giving a score of "2" for the process

CPS 3	Is there evidence of a process used by the agency/supervisor to track expiration dates to ensure MA certifications are current?	No
CPS 3a	Is there evidence that the process is effective?	No
CPS 3b	Briefly describe the process. If the process is missing/ineffective, please note area(s) of concern in box below. Then, in blue drop down box to the right of the text box, please rate the process: 0 = No Process; 1 = Incomplete or Ineffective Process; 2 = Effective Process	
		0

Answers that indicate a lack of a process will result in the nurse giving a score of "0" for the process

Each of the color-coded scores will populate into a summary at the bottom of the form. This will assist both the QA RN and the Provider in the identification of opportunities for improvement.

Qualitative data collection is complex and can be confusing. This rating system offers a more simplified explanation of process assessment that supports pattern recognition to identify opportunities for improvement.

These sample results indicate that:

Outcomes: 0 = No Process; 1 = Incomplete or Ineffective Process; 2 = Effective Process	
Certification and Provider Supervision	
MA Certification on DODD Website	1
Agency/Supervisor Tracking MA Certification Dates	0
Individual Specific Training	1
Maintain Annual Skills Checks	0
Provider Monitoring for Correct Technique and Documentation	0
Use of VNS, Epinephrine auto-injector, and/or OTC Topical Products Without Prescription	N/A
Preparation	
Self-Administration Assessment	2
Storage and Care of Medications	2
Controlled Substances	2
Standard and Universal Precautions	2
Orders for Medications and Health Related Activities from Ohio Authorized Prescriber	1
Observation	
Implementation of Proper Steps in Administration of Routine Medications	1
Implementation of Proper Steps in Administration of PRN Medications	1
Implementation of Proper Steps in the Completion of HRAs	1

Certification and Provider Supervision offers the greatest opportunity for improvement

Preparation category processes are fundamentally effective

Observation category offers some or moderate opportunity for improvement

EVALUATION of the "PROCESS":

Is the process set up, established, or written down in such a manner that if there is staff turnover, the process will continue uninterrupted?

<u>Root cause analysis</u> will help determine if the issues related to 1 or more processes may have the same or related root cause that can be improved simultaneously.

ADS – Adult Day Services

CBDD – County Board of Developmental Disabilities
DD – Developmental Disabilities
DODD – Department of Developmental Disabilities
HIPAA – Health Insurance Portability and Accountability Act
HRA – Health Related Activities
IDD – Intellectual/Developmental Disabilities
ISP – Individual Service Plan
IST – Individual Specific Training
MA – Medication Administration
MAR – Medication Administration Record
MUI – Major Unusual Incident
OTC – Over the Counter
PCP – Primary Care Physician
POA – Power of Attorney
POI – Plan of Improvement
PRN – As needed
QA – Quality Assessment
RN – Registered Nurse
RCA – Root Cause Analysis
TAR – Treatment Administration Record
UDDP – Unlicensed DD Personnel
UI/MUI – Unusual Incident/Major Unusual Incident
VNS – Vagus Nerve Stimulator

- **Line 3** – Site Address - the location where services are being provided and assessed (note: if individual lives alone or with family, and changes addresses, but does not change providers, the new address is not considered a new "site" that would need a new QA review. The individual's home equates to a "site")
- **Line 4** – Site Phone Number (If the residence has no phone – leave blank)
- **Line 5** – Agency or Independent Provider Name
- **Line 6** – Provider Address – enter if provider has an off-site business address
- **Line 7** – Provider Phone Number (Business Phone Number or Independent Provider Phone Number)
- **Lines 8 to 12** –Individual(s) living at the Site OR ADS Sample Individuals
- Name and DOB – Free Text
  - Names included on QA Form indicate the individual's living at the residential service location. Individuals who receive medication administration are part of the observation, interview, or documentation review. NOTE: As this is a review of the process – a concern identified will potentially impact all individuals receiving MA and should be corrected systematically rather than for a specific individual.
  - At ADS sites, the names of individuals reviewed is limited to 5. A 5-person sample of an ADS is 31% and should be sufficient for identifying problems. This is consistent with other QA processes in waiver settings.
  - At the ADS, the RN may request specific records, or be provided with the sample's names. The RN may do a cursory view of the MAR book to determine possible individuals for review sample.
  - "MA/HRA Support Provided" – Select from Drop Down Options – Click in box, drop-down button will appear. Choose from the options applicable: Routine (medications); PRN (medications); Both (routine and PRN); or None (able to self-administer or not using medication at the time of the review)

- **Line 13** – Site Visit Date
  - Date of Observation of MA and/or HRA at the provider location
  - The RN will generally have completed all phone interviews, and review of documentation that is not kept at the site, prior to the on-site visit. RNs need to apply person-centered and trauma-informed practices when planning visits to people's homes. In some cases, a mock-demonstration of medication administration will be necessary to avoid visits at disruptive times of the day and night. The RN and/or provider should ask the person(s) when would be a good time for the RN to visit the site.
  - After the on-site visit, the RN has 10 business days to complete and submit the report to the provider and County Board representatives. This will serve as the "date of the QA Review" for tracking purposes.
- **Line 14** – Last QA Review Completed at Provider Location
  - This may be N/A as the RN QA transitions from per individual to per service location (January 2018 forward).
  - Best Practice Recommendation – If an individual (living alone) gets a new provider, a "Technical Assistance RN QA review" should be done as soon as it is reasonable. A Technical Assist (TA) QA is not necessarily a full QA RN Assessment and form completion is optional (though it may be completed for convenience). A TA review is to generally evaluate the provider's processes for MA Rule compliance and to offer assistance/education, as needed, for providers who may not be clear on requirements or how to develop functional processes. This is a collaborative process and the QA form would not need to be completed nor a POI submitted.
- **Line 15** – Other Providers at this Location NOT Included in this RN QA (this information may be found in the ISP)
  - Independent Providers; Agencies; Family Members; Natural Support Person(s); Home Health Nursing; etc.
  - Provider name, Contact name, Phone Number – Free Text
  - Best Practice Recommendation - If more than one provider needs a RN QA at a single site, the RN should coordinate the review process so that the location review can be completed in one visit if possible.
- **Line 16** – QA RN Reviewer
  - The primary QA RN may have other nurses who collaborate on data gathering; those names should be kept in the QA file records; not listed on this form.

- The QA RN's status, as a QA RN, employed or contracted by the CBDD, must be registered in the MAIS as an "Add-on" to the RN's current RN Trainer Certification.
- Name – Free Text
- Credentials – Free Text

❖ **Lines 17 to 22** – Personnel Observed and/or Interviewed

- Name & Title – Free Text
- Date of Interview/Observation – Date in mm/dd/yyyy format
- All staff employed will not be listed on the form; only those observed and/or interviewed by QA RN
  - *Observations* are *in-person*
  - *Interviews* may be in-person (at the location or off-site), or by telecommunication. If more than 6 people are interviewed or observed the names should be kept as part of the RN's review records.
- People providing support for medical services who are not personnel of this provider being reviewed, should be listed on line 15 of the QA form. (Example: A parent is making medical appointments or a home health agency providing wound care; see line 15)
- Home managers are not required to be present at time of QA RN site observation. While the home manager will need to explain processes to the QA RN, it is up to the QA RN and manager to determine if this should be done by telecommunication or in person; at the service location, or at another mutually convenient location. The RN should attempt to interview managers and personnel prior to the site visit. The site visit will confirm that the processes reported and documented prior to the visit appear to be taking place at the site.

❖ **Line 24** – Date of Observational Visit

- Date of Observation of MA and/or HRA at the provider location

❖ **Line 25** – Report sent to Provider & Date

- Agency Contact or Independent Provider Name
- Date Sent

❖ **Line 26** – Report Sent to CBDD Representative & Date

- Name of CBDD Representative
- In most cases the QA RN will be providing the outcome report to a designated CBDD personnel who has responsibility for provider compliance – the RN should avoid being a singular entity at the CBDD aware of the assessment outcome. If no other CBDD designee is assigned, the RN should provide a copy of the report to individuals' SSAs.
- Date Sent

❖ **Line 27** – Date Report Response (Plan of Improvement) Received from Provider

- Date QA RN receives a response from the provider regarding the POI; if no POI required, then Provider's acknowledgment of receipt of the report will serve as this date

❖ **Line 28** – Date Plan of Improvement and initiation of implementation affirmed by QA RN as sufficient

- POI will be about changes to process; some processes will take time to be fully realized (such as something to do with each refill) – the RN should affirm when the process has been *sufficiently initiated*; not necessarily fully realized across all persons or personnel
- This is the date this QA RN review is finished. If the RN is unable to collaboratively resolve concerns, enter N/A and move to line 29.

❖ **Line 29** – **Optional:** Date QA Report and Insufficient POI initiation report sent to the County Board and DODD

- OAC 5123:2-6-07 (D) provides for the QA RN to move the RN QA process to Provider Compliance within the County and DODD if provider is not able to sufficiently address issues identified by the QA RN
- The RN should write a brief description of the insufficiency of POI (the reason plan is not being affirmed on line 28); indicate the name of the person the report is being forwarded to, and the date

Nursing Quality Assessment Review Categories:

- Certification & Provider Supervision
- Preparation
- Observation
- Documentation
- Coordination of Care/Communication
- Delegation of Nursing Task(s)
- Delegation of G-Tube, J-Tube Medications/Feedings
- Delegation of Insulin and/or Injectable Treatments for Metabolic Glycemic Disorders
- Outcomes
- RN Findings & Recommendations

CATEGORY REQUIREMENTS:

Certification & Provider Supervision

- **CPS 1** – personnel Certification Verification *by QA RN*
  - RN should not request copies of "certificates". The MAIS should be queried for the status of UDDP's certifications
    - Tip: RNs will want to use the Reports page in MAIS to query by DD Personnel > Employer and then "upload to Excel" for rapid review; then search individually for any personnel who did not appear on employer report.
  - RN should validate that all personnel currently assigned to administer medication have current certification; note that gaps in certification are visible by MAIS dates (start date of certification span does not bookend with previous certification).
  - If any person is identified as administering medication without current certification, enter a notation on their MAIS record. If not currently certified, employer needs to end MA/HRA duties until UDDP is certified

- **CPS 2** – Verification of certification for all MA personnel must be done *by agency/supervisor* prior to the start of MA/HRA duties
  - Evidence Examples:
    - Documentation on new hire paperwork verifying MA Certification was confirmed on DODD website (RN should advise agencies to use web – in real time - not unreliable paper copies of certificates)
    - Agency tracking sheets used on-going to record on-line verifications completed
  - RN should educate providers on running employer reports on public access view and/or MAIS reports page
- **CPS 3** - Maintenance of certification for all MA personnel
  - Evidence Example:
    - Record indicating tracking of certification dates for staff
- **CPS 4** – Individual Specific Training
  - What is the provider's system for ensuring that IST is completed prior to certified personnel administering medications for the first time to any given individual? Do the records of the most recently hired personnel verify the system is being effectively utilized?
  - IST – OAC 5123: 2-6-01 (U) – Does the IST conform to rule; does it include a method for assuring accurate identification of the individual who will receive MA/HRAs?
  - Evidence Examples:
    - MA personnel observed, and MA personnel interviewed, can provide information regarding healthcare and support plans of individuals receiving MA
    - Photo of individual is on the cover page of IST attached to the ISP

- **CPS 5** – Skills Check List
  - Evidence Example:
    - Record in personnel's MAIS application summaries, or provider files, indicating the skills checks completed by personnel correspond with skills being used
- **CPS 6** – Provider monitoring (oversight/supervision) technique for all MA Personnel
  - Evidence Examples:
    - Manager performing unannounced observations of MA by Personnel
    - Skill checks signed by manager/supervisor as done on a variety of dates for a variety of person
    - Personnel report drop-in visits by supervisors
- **CPS 7** – VNS, epinephrine auto-injector, OTC Topical Products without a Prescription
  - RN QAs are **only** completed in settings where personnel are administering **prescribed** medications/HRAs for individuals who are unable to do so for themselves. Verification of the authorizations for VNS, Epinephrine and topical OTCs are included in the RN QA review currently to evaluate the state-wide change implemented November 2017. Systemic issues/concerns identified by RNs or providers should be reported to DODD.
  - Evidence Examples:
    - Record indicates staff have received DODD training on use of VNS with IST for individual
    - Staff interviewed able to verbalize process and perform hypothetical return demonstration

Preparation

- **Prep 1** – Self-Administration Assessment
  - A self-administration assessment is only required for individuals who are receiving medication administration by DD personnel or other healthcare professionals. The assessment confirms the need to override the individual's inherent right to self-administer medications and treatments (per OAC 5123:2-6-02). People known to self-administer do not need an assessment unless there are specific reasons (other than IDD diagnosis) to warrant concerns about whether self-administration is being done safely and accurately.
  - Individuals who are not able to self-administer, or self-administer with assistance, should only be assisted by certified personnel on the specific steps of medication administration they are not able to do (OAC 5123:2-6-02).
  - Evidence Example:
    - The documentation in the ISP aligns with personnel demonstration and/or description of MA to individual
- **Prep 2** – Storage & Care of Medications
  - Medication storage should be secure, not necessarily locked. Person-centered planning concepts should be applied to the circumstances of each individual/setting to determine what constitutes appropriate security of medications in each setting.
  - Evidence Examples:
    - Manager description/expectation of medication storage aligns with what is observed and/or described by MA Personnel
    - Individual who self-administers has self-storage with lock, while roommate's medications are locked elsewhere
    - Individual living alone without children or visitors keeps medication in kitchen cupboard
- **Prep 3** – Controlled Substances
  - Evidence Examples:
    - Manager description/expectation of medication storage aligns with what is observed and/or described by MA Personnel

- System in place such that missing medication would be readily notable via accounting process
- Refill schedule is monitored to align with reported usage

❖ **Prep 4** – Universal Precautions

➢ Evidence Examples:

- Manager description/expectation of use of Universal Precautions aligns with what is observed and/or described by MA Personnel
- Appropriate personal protective equipment and spill clean-up supplies are visualized as readily available in the setting
- Personnel can readily verbalize how to address spills/exposure incidents

❖ **Prep 5** – Evidence of orders for Medications and/or HRA from healthcare professional with prescribing authority

➢ The current proof of prescription for most medications will be the pharmacy label. For medication changes, PRNs and prescribed OTC drugs, there will need to be written directives in lieu of the pharmacy prescription label

➢ Evidence of orders may be a pharmacy labeled container

- Best Practice – pharmacy refill documentation is kept as part of medical records

➢ If orders or MAS are unclear, RN may need to contact pharmacy for current, correct prescriptions and possibly validate with healthcare professional

➢ Evidence Examples:

- Prescription containers correspond with MAR; if not, there are written directives that affirm MAR entries for prescribed medications (including OTC)
- Personnel interviewed offer consistent response regarding process for changes to orders

Observation – the RN should try to put everyone at ease during the visit/observation of MA/HRA activities; remind personnel to just do what they normally do day-to-day

- **Obs 1** – Routine MA
  - Evidence Examples:
    - MA Certified personnel followed step-by-step directions as indicated in DODD MA training including (but not limited to) use of universal precautions, hand washing, identification of individual, and triple check of medications with MAR prior to administration
    - If one personnel observed has performance issues, the RN will likely want to observe demonstration by a second person to establish if it represents an individual's issue or pattern of performance issues by multiple staff
- **Obs 2** – PRN MA
  - Evidence Examples:
    - When no PRN medications were administered during observation visit MA personnel could state parameters for PRN medications and frequency the medication can be administered
    - Personnel are aware of reporting process if medication is ineffective
    - Personnel can readily explain how to get care for common illnesses if no PRNs are ordered/available
- **Obs 3** – HRA
  - Evidence Examples:
    - Personnel observed performed blood sugar check following step-by-step directions and IST. The process included use of Universal Precautions and proper disposal of sharps.
    - The supplies and equipment for prescribed HRA are available and personnel can describe steps for use.

Documentation

- **Doc 1** – Transcription
  - Evidence Examples:
    - Records reviewed prior to the visit indicate accurate transcriptions and order changes
    - Drug orders on MARs are legible and complete
    - Personnel describes copying medication instructions to MAR from bottle received from pharmacy, dating and initialing the transcription
    - Personnel state that at shift change, other MA personnel verifies accuracy and dates/signs beside original transcriber
    - Additional MA personnel interviewed describe same steps
- **Doc 2** – Documentation of MA
  - Evidence Examples:
    - No blanks on MARs; medications missed are indicated by circled initials with explanations on the back of MAR
    - MA personnel utilized Medication Administration Record to document medications administered immediately after giving medications
    - MA personnel indicates that each time he/she prepares to administer medications or treatments he/she reviews previous documentation and immediately reports any blanks to home manager
    - MA personnel can explain how to know if a missed medication should be administered late or skipped
- **Doc 3** – Documentation of HRA
  - Evidence Examples:
    - MA personnel utilized Treatment Administration Record to document time blood sugar check was completed, which location was stuck, and results of testing

- MA personnel indicated that each time he/she prepared to do HRA he/she reviews previous documentation and immediately reports any blanks noted to home manager

❖ **Doc 4** - Identification of Initials/Signatures

- Signatures must be legible OR must have corresponding legible printed name
- Evidence Examples:
  - Personnel place initials and corresponding LEGIBLE signature on a master log of signatures
  - The MAR and/or TAR for every month includes legend of signatures/initials

Coordination of Care/Communication

❖ **CC 1** – Reporting of Situations/Symptoms

- Evidence Examples:
  - MA personnel state that the frequency and duration of individual's seizures are documented on a log; and recent seizures are reported in a shift-to-shift communication. They are aware to call 911 for seizures lasting more than 2 minutes for this individual, and are to report to PCP if individual has more than 3 seizures in 5 days. Documentation in log aligns with what personnel reports and with IST documentation.
  - Manager reports process personnel are to follow if/when individual's behavior indicates a possible health change; personnel interviewed describe that process

❖ **CC 2** – Reporting Medication Errors and/or Unsafe MA/HRA practice as UI/MUI

- Evidence Examples:
  - UIs are completed for any medication administration that does not adhere to the 6 rights of administration
  - Personnel can verbalize what would be considered a medication error

- Personnel report need to contact home manager immediately for any noted errors
- Personnel explain how/when to contact healthcare professional for medication errors

❖ **CC 3** – Outings or Family Visits

➢ Evidence Examples:

- Requirements for packaging medications (published by OBN in Winter 2011 Momentum) are evidenced in agency process
- Personnel interviewed can explain process
- The packets needing to be prepared by personnel to adhere to OBN specifications are available at the site

❖ **CC 4** – Back-up Plan for Times When Scheduled MA Personnel is Unavailable

➢ Evidence Examples:

- Provider maintains a schedule that indicates who is scheduled and who is on stand-by for emergencies
- Stand-by staff and/or managers are MA certified
- Contact phone numbers are readily available and personnel know who to contact
- Independent provider can identify certified personnel who can cover MA if provider has an emergency

❖ **CC 5** – Emergency/Urgent Situations

➢ Evidence Examples:

- Emergency numbers and healthcare provider contact information is readily available to personnel
- The address of the home is posted for personnel to have in case of emergency
- Interviewed personnel state examples of when to call 911 vs. a call to the PCP or other healthcare provider

- **CC 6** – Locating Emergency Contacts
  - Evidence Example:
    - Interviewed personnel indicate where to locate list of emergency contacts (Parents, POA, Guardian, etc.) for each person; site visit verifies location is accurate
    - Interviewed personnel identify the proper order of calls to be made in an emergency (911 first, then notifications to agency and guardian/family)
- **CC 7** - Scheduling of Healthcare Appointments – Routine & As Needed
  - Evidence Example:
    - Manager identifies process used to schedule routine, follow-up and as-needed healthcare appointments
    - Process is documented for personnel to follow
    - Personnel can describe process (or where it is written if needed)
    - Healthcare records indicate recommended and as-needed appointments are made and kept
    - Information needed to be communicated to healthcare providers at appointments is written for whomever will accompany the individual to the appointment
- **CC 8** – New and/or Changed Orders for MA and/or HRA
  - Healthcare records, MARs and/or other communication logs indicate post-appointment or post-discharge information is communicated to all personnel and/or other persons/providers who support the individual's healthcare {see line 15}
  - Examples of changes that may impact an individual's health may include, but is not limited to medications, dressing changes, diet, exercise, mobility limitations, fluid intake, etc.

- Evidence Examples:
  - Following a hospital visit the discharge medication list was compared to the MAR. Appropriate changes were made and verified by 2 staff members per transcription process.
  - Diet or other restrictions related to pre-testing and bloodwork, or post-discharge appointments are communicated in a manner that assures all personnel will know and follow indicated instructions

❖ **CC 9** - Obtaining New Medications and/or Refills

- Evidence Example:
  - Manager identifies process used to obtain new or refilled medications
  - Process is documented for personnel to follow
  - Interviewed personnel can explain the process
  - Medications are available at the site
  - MAR indicates no medications missed due to absence of supply
  - New medications are initiated within 24 hours of original order

Delegation of Nursing Tasks

❖ **D1 through INJ 11**

- Any nursing tasks that are not specifically authorized for personnel with Cat 1 (as one of the Health-Related Activities) require nursing delegation
- The QA RN is not assessing the nurse's decision to delegate; just the presence of the elements in rule that are required for the delegation

- RN Assessment
- Statement of delegation – what is being delegated to whom and for whom
- Step-by-step instructions
- Training and/or certification as applicable
- Parameters or indications of when/why and how to contact nurse

➢ Hours of availability of Delegating Nurse is determined by the task, situation, and setting. Use nursing judgement regarding the safety of the process established

➢ The personnel must be aware of having been delegated on a task and know how to contact the delegating nurse DIRECTLY

Outcomes

❖ The ratings of processes entered in each section will pre-populate into the outcome section at the bottom.

❖ The RN can look at the overall outcomes for each section to evaluate the general strength or weaknesses of the processes assessed related to that subject/category.

❖ The RN will use **Root Cause Analysis** to look at systems in an aggregate manner so that issues with similar or related root causes can be addressed simultaneously. Please see information below on the use of root cause analysis for healthcare system improvement.

❖ Although some specific findings will require immediate action to address issues of imminent health and safety risk, the outcomes should direct the RN and provider to address long-term quality improvement through systems/process improvements

➢ From the *Agency for Healthcare Research and Quality* – a Division of the United States Department of Health and Human Services: "Initially developed to analyze industrial accidents, RCA is now widely deployed as an error analysis tool in health care. **A central tenet of RCA is to identify underlying problems that increase the likelihood of errors while avoiding the trap of focusing on mistakes by individuals**."

"RCA thus uses the systems approach to identify both active errors (errors occurring at the point of interface between humans and a complex system) and latent errors (the hidden problems within health care systems that contribute to adverse events). It is one of the most widely used retrospective methods for detecting safety hazards."
"RCAs should generally follow a prespecified protocol that begins with data collection and reconstruction of the event in question through record review and participant interviews."
11-1-2017 https://psnet.ahrq.gov/primers/primer/10/root-cause-analysis

RN Findings and Recommendations

- **Processes and Performance areas of strength:**
  - Using the outcome ratings and observations, the RN will identify systems and processes that are functioning well to ensure safety and compliance with law/rule/curriculum expectations.
- **Immediate Action Required:**
  - Issues that require immediate action for assurance of health and safety need to be initiated at the time of the review. This section will reflect the findings and actions that were taken immediately during the interviews, data review and/or visit. Root causes of these issues will be addressed in the related sections below.
- **Concerns and Root Causes Identified by RN Assessment and RN Recommendations**
  - The RN will communicate with the provider about the systems and processes the nurse believes need improvement and why.
  - The RN will consult with the provider during the review process (and prior to submitting the report) to collaboratively determine the suspected root cause of any evidenced deficiencies.
  - The RN and provider will use root cause analysis of the evidence, to determine what processes or systems are missing, incomplete or ineffective.

- The RN and provider will collaborate on possible systems and processes that can be put in place to address and avoid future occurrences.
- In the space provided on the form the RN will indicate the evidence that supports the finding of any missing, incomplete or ineffective processes, and the suggested development or enhancement of systems and processes discussed previously with the provider.
- When submitting the Plan of Improvement, the provider will describe the processes and systems being implemented that address the root causes identified.
- The provider may implement processes or systems that are different than the ones initially discussed with the RN or suggested in the report. The RN will evaluate the POI and accept the systems/process changes based on determination of:
  - **Reasonable Standards** for rule compliance
  - **A Community-Typical approach** that reflects appropriate standards for services that are home and community based
  - **Person-centered planning** that reflects consideration of the preferences and interests of the individuals living at or attending the service location
- The RN will continue to collaborate with the provider about any concerns that the systems/processes do not address the root cause of identified issues. If the RN and provider cannot respectfully agree upon implementation of changes to systems and processes the RN will complete line 29 and forward the report and POI to provider compliance division of the County Board or DODD.