



IQI Insights Volume 3, Number 2, Spring 2011
***Implementing Corrective Action(s) to Resolve Identified
Quality Issues***

A Note to the Reader:

IQI Insights is a series of brief informational pieces from the AAAHC Institute for Quality Improvement. Our focus is on enhancing quality and safety through educational activities. In this series, we hope to provide you with the opportunity to learn more about basic issues and concepts associated with quality improvement in ambulatory health care. These short documents are not meant to provide in depth or complete information; however, we hope that they will increase your comfort with these topics and perhaps, lead you to seek additional information. We welcome your feedback.

Sincerely,

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Introduction

A couple of important concepts can be associated with successful *development* and *implementation* of corrective actions (AAAHC Standard 5.II.B.7). Using information gathered throughout the QI process and thorough planning can increase the chances of success of corrective actions. As with the other editions of the *IQI Insights*, this one is designed to provide information on, and examples for, a couple of key topics and not intended to provide a high level of detail or full breadth of key concepts.

Considering Possible Causes of Quality Issues throughout the QI Process

What opportunities do you have to understand the causes of and formulate successful corrective actions for quality issues as you proceed through the QI process? Here are some examples.

Choosing a Topic for Your QI Activity (AAAHC Standard 5.II.B.1)

Expertise and experience of key staff members: have you used people in your organization to select your topic? If you involve people with an “intimate” knowledge of the topic, they can provide you with information about the factors that are likely to influence your performance with regard to the topic chosen. They can distinguish between those things you can change (such as staffing, type of anesthesia used, scheduling practices, etc.) and those that are out of your control (shortages of vaccines or out-of-pocket payment requirements for Medicare patients who could benefit from intra-ocular lenses [IOLs] that correct for presbyopia).

Develop a Performance Goal (Standard 5.II.B.2)

Information from clinical practice guidelines and processes used by “best performers” in benchmarking activities: when you set performance goals, you may be using clinical practice guidelines or benchmarking information to set these goals. Clinical practice guideline recommendations will often include information about exclusions and the literature may also provide information about others’ attempts to comply with clinical practice guidelines and the barriers they have faced. As you consider your performance, you need to consider and possibly measure to see when the clinical practice guidelines do not apply or the presence/extent of barriers to best performance. With benchmarking information, information about the processes of care employed by the “best performers” can be compared with the processes employed by your organization and new or different processes can be considered as possible corrective actions.

Planning Data Collection (5.II.B.3) and Providing Evidence of Data Collection (5.II.B.4)

Information that becomes available through data collection and analysis: as you decide which data are necessary to inform you about your performance (the frequency and severity of a quality issue), you need to include collection of data of those factors that can possibly influence your performance. You must collect data for a long enough period of time to sufficiently understand the QI issue. You need to include a large enough sample to feel that you have balanced the burden of data collection with the level to which the results represent the organization or providers. As you consider data sources, opt for those that are most likely to provide information about “why” performance is high or low. If a provider can’t meet a performance goal, what are the reasons and can you overcome these?

Processes used by “best performers” in benchmarking activities: if you have multiple providers who provide a certain type of care at your organization, you can internally benchmark (compare performance of these providers). If you are a part of a larger system (state university system, multi-center group practice, etc.) you could set up an opportunity to benchmark (compare) the care your organization provides with that of others. These benchmarks will allow you to compare the processes of care used and find out which ones are associated with the “best performers.”

Performing Data Analysis (5.II.B.5)

During data collection, you may find new, important factors that influence your results. As you analyze your data, try to quantify and summarize these. Here are examples:

- Wrong site surgery prevention: of 200 patients, 2% received anesthesia before the surgeon had the opportunity to confirm and mark the site of the surgery, with the patient's input. Each of the four surgeons had at least one case in which this happened. For 10% of cases, the nurse, not the surgeon, confirmed and marked the site with the patient. This occurred exclusively with one surgeon's cases. The performance goal was that in 100% of cases studied, surgeons would confirm and mark the site, with patient input.
- Immunizations: two providers did not administer immunizations to 20% of 100 patients who were due for these immunizations, because the information that indicated that the patients were due for routine immunizations was not readily available in the patients' charts. The proportion was very similar from one provider to the other. For 10% of patients (primarily from one provider), the patient had symptoms of acute illness and the provider did not have the patient schedule a return visit to receive immunizations. The immediate performance goal for immunizations was that more than 90% (per national benchmarks) of patients with immunizations due either received their immunizations or were scheduled for a follow up visit to receive immunizations due.

Comparing Your Performance versus Your Goal (5.II.B 6)

Comparing performance versus your goal provides information about the frequency and/or severity of an issue and your decision about whether you met your goal (or not). If you have not met your goal, this indicates the need for corrective action(s). However, the comparison of your performance and your goal does not, in itself, provide you with information about the factors leading to your performance—what factors you need to change to improve performance.

Systems factors: if comparing your performance to your goals indicates an issue worthy of corrective action, as those described in "Performing Data Analysis" above do, you may be able to use some of the data collected to develop and target interventions. Many of these interventions may be designed to address "system" factors (policy/procedure, facility layout, reward systems, staffing, standardization of equipment, how you schedule or move patients through your organization, etc).

- For the wrong site surgery prevention example: a small but preventable issue is shown by the 2% of cases where anesthesia is administered before the surgeon has had the opportunity to confirm and mark the site of the surgery, with the patient's input. New policy and reminder systems can be put in place so that no patient receives anesthesia if the surgeon hasn't confirmed and marked the surgery site with patient input. In a check off sheet for the anesthesia provider, the anesthesia provider must check off that the patient's surgery site has the surgeon's unique mark before providing any anesthesia to the patient. A more targeted intervention may be necessary for the one surgeon who appears to be delegating the tasks of confirming and marking the site to nurses. This may be associated with the surgeon arriving late, the shortness of time this surgeon has scheduled between cases, and/or the belief that this delegation is acceptable. Changes in scheduling and/or a clarification and reminder of policy with regard to the role of the surgeon in preventing wrong site surgery may be necessary.
- For the immunization example: if in one out of every five cases (20% of the time) both providers are not able to easily find information about when their patients were due for routine immunizations in the patients' charts, it is time to make a change. The change could be a special sticker or brightly colored form that is placed in the file and lists the specific immunizations that are due at the time of visit. Or this information could be part of a preventive care (including not only immunizations but also screening and counseling) check off list that staff prepares before each patient's visit. One provider seems to remember that when a patient comes in for an acute care visit that a follow up should be scheduled for immunizations that are due.

What is necessary to bring the other provider “up to speed?” In this case, it may be that some of the same type of reminder systems described above could work. Another alternative is for the receptionist to “catch” the patient prior to departure and ensure that a follow up appointment is made.

The Thorough Implementation Plan

Who is the target of the corrective action plan? Are there *multiple* targets (example: both providers and patients can be reminded to ensure that flu shots are received or that the surgeon marks the surgical site)?

What sort of intervention are you planning? Are you considering *multiple* means of intervening (example: posters and chart reminders)?

When (for how long) are you planning to implement your corrective action(s) before you re-measure to see whether you have experienced improvement? How long did it take you to collect the data to find out the severity/frequency of the issue? How serious is the issue and how frequently does the issue manifested itself? How far are you from your performance goal? The more serious the issue or the more ingrained (frequent and or long-term) the issue, the more time you should invest in giving the corrective action a chance to work. This may mean repeated work with the surgeon who has been delegating prevention of wrong-site surgery to nurses or the provider who has a difficult time remembering that there are opportunities at acute care visits to schedule visits for immunizations.

Where should the corrective action take place? Where is the problem? Example: what if the real issue with immunization rates is that patients are not aware that they are due for these and no visits are scheduled? Then you may need to go to the patients. In the wrong-site surgery example, are patients being taken to have anesthesia, before the surgeon has had the chance to confirm and mark the site with the patient, because the waiting room is too small and crowded? Then you may need to consider expanding your waiting area to accommodate your patient volume and/or perhaps changing your scheduling.

How can you make your corrective action as easy as possible to use or adopt? Change is something that most people resist. As described in the “Who, What, and Where” examples above, using multiple targets and multiple means of communication can increase the probability of success. The “When” section discusses the importance of repeating the messages and giving people sufficient time to incorporate them into their thinking and behaviors and is also associated with successful change.

Another way to have successful corrective actions is to make doing the right thing “easy” and make poor performance more difficult (or impossible). Some of the most successful interventions are ones that are hard to ignore and are “systems” changes. Just as “systems” can create barriers to doing the optimal performance (examples: a poor filing system leads to inability to easily find information about patients’ immunizations or facility lay out contributes to anesthesia administration prior to surgeons’ confirming and marking surgical sites), system changes (change your file system to make it easy to find immunization information or use facility changes to change patient flow) can facilitate performance improvement.

Additional References and Resources—*please note: references to web sites or products are not endorsements.*

1. Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange:

<http://www.innovations.ahrq.gov/>

2. Baily MA “Quality Improvement Methods in Health Care.” *From Birth to Death and Bench to Clinic: The Hastings Center Bioethics Briefing Book for Journalists, Policymakers, and Campaigns*, ed. Mary Crowley (Garrison, NY: The Hastings Center). 2008. 147-152

<http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2204>

3. van Bokhoven MA, Kok G, van der Weijden T. Designing a quality improvement intervention: a systematic approach. *Qual Saf Health Care*. 2003. 12:215-220:

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1743716/pdf/v012p00215.pdf>