2019 Plan of Correction Update

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Laguna Honda Hospital

In 2019, a robust investigation was completed at Laguna Honda Hospital (LHH) of particular staff due to incidents of abuse.

On June 28, 2019, Mayor London Breed, President of the Board of Supervisors Norman Yee and Health Director Dr. Grant Colfax reported directly to the community about patient abuse issues involving residents of LHH.

The incidents of misconduct do not represent the values of LHH, the San Francisco Health Network (SFHN), or the Department of Public Health (DPH).

The staff members directly involved are no longer employed by the city.

Plan of Correction

This presentation serves as an update to the corrective actions that were put in place in response to the Immediate Jeopardy placed on LHH in July 2019.

LHH was found to be in full compliance with all corrective actions in October 2019 by CDPH.

The CMS 2567 Statement of Deficiencies cited the following f-tags:

- F583 Privacy and Confidentiality
- F600 Freedom from Abuse, Neglect, and Exploitation
- F605 Right to be Free from Chemical Restraints
- F607 Develop/Implement Abuse/Neglect Policies
- F689 Free of Accident Hazards/Supervision/Devices

Plan of Correction – Progress Report

Corrective Action:

Annual Staff Education Compliance

1. *Mandated Reporter*
2. *Abuse, Restraints, Privacy, and Accident Prevention*
3. *DPH Annual Compliance & Privacy*
4. *Memo & Employee Attestation for Physical and Chemical Restraints*

Monitoring: Compliance for the in-service education is tracked using the electronic learning system. Compliance with all in-service and education will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of September 2019 for items #1, 2, and 4. **Goal Not Met** for item #3. This corrective action has been closed.

Next Steps: LHH staff receive the education annually and completion is mandatory. Department managers receive monthly compliance reports and follow up with staff who are noted as not having completed their assigned learnings.

Plan of Correction – Progress Report

Corrective Action:

Case Presentations

Case Presentations for staff on all shifts in each neighborhood, to emphasize, using a scenario-based approach, and the role of mandated reporter.

Monitoring: Executive partners reported to the Executive Committee after the completion of each presentation and shared feedback from staff.

Status: **Goal Met** as of September 2019. This corrective action has been closed.

Plan of Correction – Progress Report

Corrective Action:

Bar Code Medication Administration (BCMA)

Bar code medication administration (BCMA) will be implemented hospital-wide at LHH as part of the EPIC electronic health record (EHR) implementation.

Monitoring: Reports will be generated from EPIC for medication scanning and patient ID scanning. The compliance will be reported to the Pharmacy and Therapeutics Committee to ensure 95% compliance or greater. Overall data regarding compliance with this corrective action will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of May 2021.

Next Steps: The BCMA compliance reports continue to be reviewed during the Pharmacy and Therapeutics Committee monthly. The reports are brought to PIPS Committee quarterly.

Plan of Correction – Progress Report

Corrective Action:

Drug Diversion Committee

A monthly multidisciplinary diversion prevention committee was convened in April 2019 to create a LHH policy and a standardized algorithm for monitoring and investigating potential employee medication diversion.

Monitoring: This committee proactively addresses concerns, reviews data, provides a process for diversion detection and reviews events or circumstances where there is suspicion of diversion. The committee reports to the Pharmacy and Therapeutics Committee monthly. The Pharmacy and Therapeutics Committee reports to PIPS Committee quarterly.

Status: **Goal Met** as of May 2021.

Next Steps: The Drug Diversion Committee will continue to convene monthly. All investigations are to be completed within one month and presented to the committee for review.

Plan of Correction – Progress Report

Corrective Action:

Medication Administration

The Nursing Department implemented a random audit that includes medication administration, narcotic waste, cycle count, and medication administration documentation for all 13 neighborhoods across all 3 shifts.

Monitoring: Four medication passes, one cycle count and two narcotic wastages are audited per shift/per unit. Compliance with be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of May 2021 for Narcotic Waste.
Goal Not Met as of May 2021 for Cycle Count.
Goal Not Met as of May 2021 for Medication Administration Spot Check.

Next Steps: Each licensed nurse shall be observed one time per month. The data will be tracked and reported to the Nursing Quality Improvement Committee. Narcotic waste and cycle count are monitored through the Drug Diversion Committee, which reports to PIPS quarterly.

Plan of Correction – Progress Report

Corrective Action:

Medication Simplification

LHH Physicians are undertaking a medication simplification process that will reduce polypharmacy risks for residents.

Monitoring: Four medication passes, one cycle count and two narcotic wastages are audited per shift/per unit. Compliance with be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Not Met** as of May 2021.

Next Steps: This action has a new physician champion who will partner with Pharmacy to develop an action plan to move toward meeting the goal of 15% reduction in doses administered per day and TID/QID orders. Compliance reports are reviewed during the Pharmacy and Therapeutics Committee monthly. The reports are brought to PIPS Committee.

Plan of Correction – Progress Report

Corrective Action:

Great Room Zone Manager

New protocol has been developed regarding appropriate supervision of resident visiting one-another from different neighborhoods. These visits will occur in the Great Room of each neighborhood and not in residents' room.

Monitoring: Great Room Zone Managers will sign-in for their shift. The sign-in sheets will be audited to ensure compliance of 95% or greater. Compliance will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of March 2020. This corrective action has been closed.

Next Steps: A Great Room Zone Manager continues to be present. The monitoring is no longer reported since 3-months of compliance was achieved.

Plan of Correction – Progress Report

Corrective Action:

N1 Door Monitor

A door monitor was implemented on North 1 requiring all visitors and staff to sign in. This is to increase safety and monitoring of visitors on North 1.

Monitoring: The log sheets were collected on a weekly basis to ensure that the log is completed. Random observations of the door monitor were performed to ensure that the staff undertaking the role are fulfilling the specified duties. Compliance will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of April 2020. This corrective action has been closed.

Next Steps: All units have a sign-in process for visitors on the unit, which was developed through COVID contact tracing needs.

Plan of Correction – Progress Report

Corrective Action:

Out on Pass Resident Screening

New protocol to be implemented regarding the screening residents when returning from a pass to identify if a clinical search is necessary to prevent the bringing of illicit substance(s) or non-prescribed medication(s) to the facility.

Monitoring: The log sheets were collected on a weekly basis to ensure that the log is completed. Random observations of the door monitor were performed to ensure that the staff undertaking the role are fulfilling the specified duties. Compliance will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Not Met** as of March 2020.

This monitoring process was placed on hold due to COVID. Residents were not permitted to go out on pass from April 2020 to May 2021.

Next Steps: Monitoring for 3-months of 95% compliance or greater will be reported again in August 2021. Overall compliance will be reported to the JCC.

Plan of Correction – Progress Report

Corrective Action:

Weekly Resident Check-Ins

Nurse Managers for all Neighborhoods undertook check-ins with all residents to conduct interviews and evaluations regarding breach, abuse or neglect. These interactions also allowed each resident a safe and secure venue to voice any concerns.

Monitoring: Check-in responses will be evaluated. The questions and frequency of the check-in will be adjusted based on data outcomes. Any issues identified during resident interviews are immediately escalated according to the abuse protocol. Compliance will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of March 2021.

Next Steps: This will be an ongoing expectation of staff to check-in with residents. Any patient safety concerns will be escalated to Quality Management, the PIPS Committee, and the JCC.

Plan of Correction – Progress Report

Corrective Action:

Culture of Safety

LHH plans to begin measuring the Culture of Safety on a biennial basis moving forward. Following analysis of these results, in collaboration with managers, supervisors and frontline staff, action plans will be formulated.

Monitoring: LHH-wide data has shown improvement on nine of the ten Culture of Safety measures. Factors that may have influenced these improvements include individualized improvement plans developed by departments, and heightened urgency and action towards patient safety, collaboration, and trust-building in the context of the COVID-19 response at LHH.

Status: **Goal Met** as of February 2021.

Next Steps: A new pulse survey will be conducted in July 2021. This data will be shared with the PIPS Committee and the JCC. Beginning 2022, LHH will work to implement the industry standard survey developed through Agency for Healthcare Research and Quality (AHRQ).

Plan of Correction – Progress Report

Corrective Action:

Nursing Staff 1:1 Check-Ins

Nurse Managers for all Neighborhoods initiated a standardized tool and process to conduct employee supervision and check in with all nursing staff members. This process gives staff an opportunity to raise concerns privately and allows the Nurse Manager to observe staff performance.

Monitoring: Individual staff members will receive feedback as part of the process. Staff with opportunities to improve their practice will be coached and counselled in real time by the nurse manager. Compliance will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Met** as of March 2021.

Next Steps: This will be an ongoing expectation of staff to check-in with residents. Any patient safety concerns will be escalated to Quality Management, the PIPS Committee, and the JCC.

Plan of Correction – Progress Report

Corrective Action:

Quality Management Reorganization

The Quality Management Department at LHH is currently being assessed and potentially reorganized to create standard work regarding the investigation, assessment and reporting of adverse events, abuse, and other unusual occurrences to state and federal agencies.

Monitoring: Changes in the structure and departmental functions will be reported to the PIPS Committee and the JCC.

Status: **Goal Met** as of February 2021. This corrective action has been closed.

Next Steps: Quality Management is working to fill its eleven vacancies. A presentation sharing an update on the reorganization will be provided to the JCC in September.

Plan of Correction – Progress Report

Corrective Action:

Allegations of Abuse Timely Reporting

Quality Management Nurses will be assigned to conduct a monthly review of the facility reported incidents of allegations of abuse to track facility Compliance and timely reporting.

Monitoring: Results of the monthly audits will be aggregated and reported to the Resident Safety and Abuse Prevention Performance Improvement Team to identify opportunities for improvement. Compliance will be reported to NQIC, PIPS and MEC, these committees reporting overall compliance to the JCC.

Status: **Goal Not Met** as of May 2021.

Next Steps: Quality Management will review each missed opportunity and conduct 1:1 education with the staff or department that is unclear with the 2-hour reporting timeframe. The 1:1 session is an opportunity to understand gaps and implement improvements to support staff in timely reporting to CDPH.

Questions.
Comments.

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