Quality Assurance Performance Improvement (QAPI) Case Study

Case History:

Mr. Smith is an 80-year-old male who was living in an assisted living facility (ALF) prior to falling and ending up in the hospital. After a qualifying hospital stay, where an open reduction, internal fixation (ORIF) was performed, he was discharged to a skilled nursing facility (SNF) two weeks ago with the following diagnoses:

- Congestive heart failure
- History of urinary tract infections (UTIs)
- Hypertension
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Anxiety
- Dementia (diagnosed one year ago)
- Anemia
- Recent left hip fracture related to fall; s/p ORIF

Medication List Sent to SNF by Hospital:

- Hydrocodone 5 mg: every four hours, as needed
- Acetometophine 650 mg: every four hours, scheduled
- Trazadone 150 mg: every night, scheduled
- Ferrous Sulfate 300 mg: daily
- Metoprolol 12.5 mg: daily
- Furosemide 80 mg: daily
- Spironolactone 50 mg: daily
- Albuterol 2.5 mg/3 ml: every four hours, as needed
- Zoloft 25 mg: daily
- Seroquel 100 mg: twice daily
- Potassium 30 meq: daily
- Lorazepam 2 mg: every four hours, as needed

Past Medical History:

Mr. Smith was hospitalized in 2005, 2007, and 2011 for CHF exacerbations, all with discharges back home where he lived with his wife. He had a cerebral vascular accident in 2011 with a discharge to a SNF for six weeks and then a move to an ALF following the SNF stay.

Background Information Since SNF Admission (two weeks ago):

Upon admission to the SNF, his wife (who is also elderly but currently the responsible party) signed a full-code status with the admissions nurse. No other advance care planning was conducted. It was made clear to her and the rest of the family at the hospital that Mr. Smith will most likely not be able to return to his prior living environment. This was based on questioning by caregivers who suggested the need for alternative placement prior to the fall for decreased safety awareness and some episodes of wandering in the evening. In addition, over the last month, ALF staff members reported to the manager that Mr. Smith became aggressive with the relief caregiver when she attempted to assist him with bathing. She was a new staff member who had previously not cared for him before.

Change in Condition:

It has been two weeks since his admission to the sub-acute unit of the SNF for therapy services. After working with physical therapy and occupational therapy for more than a week, it is noted that Mr. Smith is becoming increasingly confused and uncooperative with caregivers. He is trying to get up from the bed on his own at least once an hour, even though he has been instructed repeatedly by nursing staff members and the therapy department on the safety issues related to this behavior. His wife reports to the nurse that she has “never seen him this confused” and is concerned for his safety in the SNF. She also complains that it is “always a different caregiver” who is taking care of him when she visits, and she has to “tell them how to take care of him” when she arrives each time. She feels he is “much better off just going back to the hospital to find out what is wrong.” Subsequently, Mr. Smith has fallen three times in the past week.

The nurse contacts the doctor about Mr. Smith’s increased confusion and his wife’s concerns. He orders a urinalysis to screen for a possible UTI and states that, if it is negative, he may need to be referred for a psychiatric evaluation to look at a Seroquel increase or a medication change.

When the nurse informs Mrs. Smith of the doctor’s orders, she becomes increasingly upset and states that she would like the SNF to put up bed rails for his safety since he had them at the hospital. When the nurse explains that this is not possible, Mrs. Smith calls her son for assistance with the matter. Mr. Smith’s son becomes very upset to see that his mother’s concerns are not being addressed and calls the nurse on the unit demanding that his father be sent back to the hospital.

The nurse explains that she will speak with the doctor again about this. When she contacts him, he agrees to the transfer order to the hospital for Altered Mental Status. The Director of Nursing is informed about the transfer and instructs the nurse to make sure she documents that the family insisted on the transfer.

Outcome:

When Mr. Smith arrives at the hospital, he is evaluated and held in observation for 12 hours. Hospital nursing staff members, as part of their assessment process, note that Mr. Smith has a Stage II pressure ulcer on his coccyx. Lab results also indicate that Mr. Smith has a UTI. The family is upset with the SNF and states, "we do not want him to go back there."

Guiding Principles:

1. There is no other information available on this patient. This is the information that was given to the SNF at the time of transfer.

2. Think about the interactions between the different levels of care, including the ALF, SNF, and hospital.

3. Consider the level of engagement and education with the family across the care settings.

Process Improvement Questions (group discussion):

1. Using the "5 Whys" of Root Cause Analysis (RCA), what questions do you have regarding Mr. Smith's conditions or medications? *How and from whom* would you obtain this information?
2. What processes, tools, or interventions can be used to improve the outcome of this situation?
3. How would you use the QAPI Performance Improvement Project (PIP) process to assign tasks/responsibilities?
4. How would you use the Plan, Do, Study, Act (PDSA) model to test and measure your proposed changes?
5. How would you spread the best practice once tested?

This material was prepared by Health Services Advisory Group, Inc., the Medicare Quality Improvement for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U. S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. CA-10SOW-7.2-050213-01