The sample RCA, actions, interventions, best practices, and metrics illustrated here to address identified infection prevention areas of opportunity are solely intended as example guidance. Your team should perform an infection prevention gap analysis/risk assessment and build a customized action plan to best meet the needs of your specific organization and community.

**TOPIC AREA**

Antibiotic Stewardship  Infection Control Surveillance  Vaccination/Immunization

Environmental Hygiene  Staff Infection Exposure Prevention  Other

Hand Hygiene  Testing/Screening, Cohorting Residents

Isolation Precautions  Visitors Restriction Infection Prevention

**Conduct Root Cause Analyses for Each Identified Gap or Opportunity:**

* Determine contributing factors, events, system issues and processes involved.
* Utilize RCA tools as appropriate e.g. 5 Whys, Fishbone, Cause & Effect Diagram
* Conduct a Plan-Do-Study-Act (PDSA) to test intervention, review results and adjust actions needed.

**Identify Infection Prevention and Control Gaps & Areas of Opportunity:**

* CDC Infection Control Assessment for Long-term Care Facilities: <https://www.cdc.gov/infectioncontrol/pdf/icar/ltcf.pdf>
* Review previous survey findings, federal & state regulations, CDC updates for long term care facilities
* Check CMS QSO Memos: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions>

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| **Area of Opportunity:** |
| Antibiotics are being prescribed when criteria for antibiotic use not met, especially for UTI. |
| **Root Cause Analysis** **(specify each root cause and address each within the action plan):** |
| 1. Prescribers use different antibiotic prescribing criteria than what the facility uses. |
| 1. Antibiotic use criteria and SBARs not readily or conspicuously available to staff. |
| 1. Newly hired nurses not receiving training on antibiotic use criteria before working independently on units. |
| **S.M.A.R.T. Goal: (Specific, Measurable, Achievable, Relevant, Time-based)** |
| Achieve 95% compliance with facility-initiated antibiotic treatment courses that are guideline-concordant by SPECIFIC DATE |

| **Project Start Date** | **Specific Actions and Interventions**  **\*** *HQIN IP Intervention Resources (optional)* | **Projected**  **Completion**  **Date** | **Person/Team Responsible**  **\**To include QAPI Committee*** | **Ongoing Monitoring and Surveillance** | **Additional Comments** |
| --- | --- | --- | --- | --- | --- |
|  | Review Antibiotic Stewardship Policies and Procedures and update if needed. |  | Administrator, DON, IP, Medical Director | IP to check CDC & CMS guidance, State & local health department updates related to antibiotic stewardship quarterly | Ensure P&P’s are evidence-based (e.g. CDC Core Elements, AHRQ, APIC).  [CDC Core Elements of Antibiotic Stewardship](file:///C:\Users\aspangler\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\WA3XFH0Y\CDC%20Core%20Elements%20of%20Antibiotic%20Stewardship)  [AHRQ Nursing Home Antimicrobial Stewardship Guide](https://www.ahrq.gov/nhguide/index.html)  [Implementing an Antibiotic Stewardship Program: Guidelines by Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America](https://academic.oup.com/cid/article/62/10/e51/2462846?searchresult=1) |
|  | Develop tools to monitor, track/trend compliance and clinical outcomes |  | Administrator, DON, IP |  | Notify HQI QIA if auditing and monitoring tools are needed. |
|  | Audit compliance of facility-initiated antibiotic use meeting guideline criteria. |  | DON, IP | Monitor % of time antibiotic use met criteria and identify clinical staff NOT applying guidelines. Set thresholds for improvement. |  |
|  | Audit tracking of clinical outcomes related to antibiotic use (CDI/MDRO/Adverse Events) |  | DON, IP | Monitor % reduction in infections, outbreaks, ADEs – set thresholds for improvement |  |
|  | Determine baseline compliance rates for facility-initiated antibiotic use |  | QAPI Team |  |  |
|  | Educate clinicians about resistance and optimal prescribing related to antibiotic stewardship |  | DON, IP, Medical Director, Staff Development, Consultant Pharmacist | Ensure 100% clinical staff trained | [CDC Antibiotic Prescribing and Use](https://www.cdc.gov/antibiotic-use/healthcare/index.html) |
|  | Educate residents and families about antibiotic resistance and appropriate use of antibiotics |  | DON, IP, Medical Director, Staff Development | Monitor % residents & families provided education on admission and annually | [CDC Be Antibiotics Aware Campaign](https://www.cdc.gov/antibiotic-use/week/index.html) |
|  | Re-educate nursing staff formally and with 1:1 coaching regarding UTIs, McGeer’s Criteria, Info needed by prescriber to make informed decision, and how to use SBAR when communicating with prescribers and during resident transfers. Conduct competency training and testing annually. |  | DON, IP, Medical Director, Staff Development | Ensure 100% nursing staff trained annually | [AHRQ Suspected UTI SBAR](https://www.ahrq.gov/sites/default/files/wysiwyg/nhguide/4_TK1_T1-SBAR_UTI_Final.pdf)  [CDC Interfacility Transfer Form](https://www.cdc.gov/hai/pdfs/toolkits/Interfacility-IC-Transfer-Form-508.pdf)  [CDC & CMS The Nursing Home Infection Preventionist Training Course; Modules 14 & 15](https://www.train.org/cdctrain/training_plan/3814) |
|  | Utilize SBAR and review antibiotic orders and use for appropriateness, consult with physician/clinician and/or pharmacist as needed |  | DON, IP, Nursing Team, Consultant Pharmacist |  | [AHRQ Suspected UTI SBAR](https://www.ahrq.gov/sites/default/files/wysiwyg/nhguide/4_TK1_T1-SBAR_UTI_Final.pdf) |
|  | Develop antibiotic formulary based on facility antibiogram |  | DON, IP, Medical Director, Lab Rep, Consultant Pharmacist, Health Dept. |  | [AHRQ Nursing Home Antibiogram Toolkit](https://www.ahrq.gov/nhguide/toolkits/help-clinicians-choose-the-right-antibiotic/toolkit3-develop-implement-antibiogram-program.html) |
|  | Work with EHR Vendor to embed antibiotic prescribing criteria and SBARs |  | Administrator, DON, IP |  |  |
|  | Share Antibiotic Stewardship “progress to goal” metrics with nursing home staff |  | QAPI Team | Ongoing |  |
|  | Report findings and compliance at monthly/quarterly QAPI meeting. |  | QAPI Team |  |  |
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