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

[x]  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 and state regulations and CDC updates for long-term care facilities
* Check [CMS Quality Safety & Oversight memos](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions)

|  |
| --- |
| **Area of Opportunity:**  |
| Proper hand hygiene is not being performed consistently by direct care staff and other employees |
| **Root Cause Analysis** **(specify each root cause and address each within the action plan):** |
| 1. All staff do not receive the same frequency of hand hygiene education
 |
| 1. All staff are not audited on hand hygiene
 |
| 1. Hand hygiene stations not conveniently located on the units
 |
|  |
|  |
| **S.M.A.R.T. Goal: (Specific, Measurable, Achievable, Relevant, Time-based)** |
| Achieve 95% compliance with hand hygiene 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 hand hygiene policy and update if needed
 |  | Administrator, DON, IP | Annually and as needed | **Ensure P&Ps are evidence-based (e.g., APIC, CDC, WHO guidelines)*** [Hand Hygiene Infection Prevention](https://apic.org/resources/topic-specific-infection-prevention/hand-hygiene/) (APIC)
* [Hand Hygiene in Healthcare Settings (CDC)](https://www.cdc.gov/handhygiene/index.html)
* [Your 5 Moments for Hand Hygiene Poster (WHO)](https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf)
 |
|  | * Develop tools to monitor and track/trend compliance
 |  | Administrator, DON, IP |  | * Notify a Health Quality Innovators (HQI) Quality Improvement Advisor (QIA) if auditing and monitoring tools are needed
* [Measuring Hand Hygiene Adherence: Overcoming the Challenges (JCAHO)](https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hh_monographpdf.pdf?db=web&hash=7F1A70731D44DC2D183B1038CE34EC46)
* [Hand Hygiene Self-Assessment Framework](https://www.who.int/gpsc/country_work/hhsa_framework_October_2010.pdf?ua=1) (WHO)
 |
|  | * Establish facility baseline compliance
 |  | Administrator, DON, IP, QAPI Team |  |  |
|  | * Educate ALL staff on proper hand hygiene– how and when
* Use multiple modalities (posters, video, live training) to increase attention and keep hand hygiene at top of mind
 |  | Administrator, IP, DON, Staff Development, Department Managers | Provide training at orientation, quarterly and as needed based on audit compliance rates and infection control concerns | * [Handwashing: Clean Hands Save Lives Posters (CDC)](https://www.cdc.gov/handwashing/posters.html)
* [Put Your Hands Together Video](https://www.youtube.com/watch?v=SyRtMl4a1FE) (CDC)
* [Targeted COVID-19 Training for](https://qsep.cms.gov/welcome.aspx) Nursing Homes [Note: This training requires logging in to the Quality, Safety & Education Portal (QSEP)]
 |
|  | * Follow up staff education with hand hygiene competency validation
 |  | IP, Staff Development |  | * [Hand Hygiene Competency Validation (SPICE)](https://hqin.org/wp-content/uploads/2020/05/Hand-Hygiene-Competency-Validation_SPICE_4-9-20.pdf)
 |
|  | * Institute scheduled hand hygiene audits as part of facility’s infection prevention and control program (ICPC)
 |  | Administrator, IP, DON | At least quarterly |  |
|  | * Give feedback and on-the-spot education if individual hand hygiene performance does not follow guidelines
* Encourage accountability, questions and a culture of safety that is not punitive
 |  | Administrator, IP, Department Managers |  | * [COVID-19: Team and Human Factors to Improve Safety (AHRQ)](https://psnet.ahrq.gov/primer/covid-19-team-and-human-factors-improve-safety)
* [TeamSTEPPS® in LTC: Communication Strategies to Promote Quality and Safety (QIO Program)](https://qioprogram.org/teamstepps%C2%AE-ltc-communication-strategies-promote-quality-and-safety)
 |
|  | * Report findings and compliance at monthly/quarterly QAPI meeting
 |  | QAPI Team |  | * [QAPI At a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home](https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf)
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