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QAPI Program

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Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life

QAPI at a Glance:

A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

UNIVERSITY OF MINNESOTA

StratisHealth

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Introduction: Why This Guide?

As you use this guide, please take note of the following:

- The term "Caregiver" refers to individuals who provide care in nursing homes.
- The tool icon: indicates that there is a QAPI tool associated with that concept in Appendix A of this guide. Click the tool icon to access the corresponding QAPI tool.
- Words underlined in **bold blue** are defined in Appendix B. Click the underlined word icon to be automatically linked to the definitions listed in Appendix B.

Effective Quality Assurance and Performance Improvement (QAPI) is critical to our national goals to improve care for individuals and improve health for populations, while reducing per capita costs in our healthcare delivery system. We have the opportunity to accomplish these goals in each local nursing home with the aid of QAPI tools and the establishment of an effective QAPI foundation. Nursing homes are in the best position to assess, evaluate, and improve their care and services because each home has first-hand knowledge of their own organizational systems, culture, and history. Effective QAPI leverages this knowledge to maximize the return on investments made in care improvement. This *QAPI at a Glance* guide is a resource for nursing homes striving to embed QAPI principles into their day to day work of providing quality care and services.

Nursing homes in the United States will soon be required to develop QAPI plans. QAPI will take many nursing homes into a new realm in quality—a systematic, comprehensive, data-driven, proactive approach to performance management and improvement. This guide provides detailed information about the "nuts and bolts" of QAPI. We hope that *QAPI at a Glance* conveys a true sense of QAPI's exciting possibilities. Once launched, an effective QAPI plan creates a self-sustaining approach to improving safety and quality while involving all nursing home caregivers in practical and creative problem solving. Your QAPI results are generated from your own experiences, priority-setting, and team spirit.

The Affordable Care Act of 2010 requires nursing homes to have an acceptable QAPI plan within a year of the promulgation of a QAPI regulation. However, a more basic reason to build care systems based on a QAPI philosophy is to ensure a systematic, comprehensive, data-driven approach to care. When nursing home leaders promote such an approach, the results may prevent adverse events, promote safety and quality, and reduce risks to residents and caregivers. This effort is not only about meeting minimum standards—it is about continually aiming higher. Many nursing homes are already demonstrating leadership in developing and implementing effective QAPI plans.

We encourage nursing home leaders to use *QAPI at a Glance* as a reference as they examine their own activities in the context of the goals and expectations for QAPI and sustainable improvement. You can also visit the QAPI website at http://go.cms.gov/Nhqapi, which we will update regularly as new materials and resources become available.

WHAT IS QAPI?

QAPI is the merger of two complementary approaches to quality management, Quality Assurance **(QA)** and Performance Improvement **(PI)**. Both involve using information, but differ in key ways:

- QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.
- PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

The chart below was adapted from the Health Resources and Services Administration (HRSA)[1] and shows some key differences between QA and PI efforts.

	QUALITY ASSURANCE	PERFORMANCE IMPROVEMENT
Motivation	Measuring compliance with standards	Continuously improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers: *"bad apples"* Individuals	Processes or Systems
Scope	Medical provider	Resident care
Responsibility	Few	All

QA + PI = QAPI

QA and PI combine to form QAPI, a comprehensive approach to ensuring high quality care.

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration. Quality Improvement adapted from http://www.hrsa.gov/healthit/toolbox/HealthITAdoptiontoolbox/QualityImprovement/whatarediffbtwqinqa.html

WHY QAPI IS IMPORTANT

Once QAPI is launched and sustained, many people report that it is a rewarding and even an enjoyable way of working. The rewards of QAPI include:

- Competencies that equip you to solve quality problems and prevent their recurrence;
- Competencies that allow you to seize opportunities to achieve new goals;
- Fulfillment for caregivers, as they become active partners in performance improvement; and
- Above all, better care and better quality of life for your residents.

Being new at QAPI is like being a new driver…

A new driver must coordinate so many actions and pay attention to so many cues that driving feels awkward, confusing, and almost impossible at first. Yet when it suddenly comes together, it becomes automatic and ushers in new horizons for that driver. In the same way, once you get some QAPI experience, it will come together, seem automatic, and will take you to new places in your quality management.

In the following pages, we discuss QAPI and its inter-related components (QA and PI), and emphasize how it can readily fit into your nursing home. Launching QAPI is not necessarily easy or quick, but it has a compelling logic and it is feasible for all nursing homes, beginning wherever your nursing home is right now.

QAPI Builds on QA&A

QAPI is not entirely new. It uses the existing QA&A, or Quality Assessment and Assurance regulation and guidance as a foundation. Maybe you recognize some of the statements below as things you are already doing:

- You create systems to provide care and achieve compliance with nursing home regulations.
- You track, investigate, and try to prevent recurrence of adverse events.
- You compare the quality of your home to that of other homes in your state or company.
- You receive and investigate complaints.
- You seek feedback from residents and front-line caregivers.
- You set targets for quality.
- You strive to achieve improvement in specific goals related to pressure ulcers, falls, restraints, or permanent caregiver assignment; or other areas; (for example by joining the Advancing Excellence Campaign).
- You are committed to balancing a safe environment with resident choice.
- You strive for deficiency-free surveys.
- You assess residents' strengths and needs to design, implement, and modify person-centered, measurable and interdisciplinary care plans.

You are already partly there. All of this is part of QAPI.

QAPI Features

> *"Not all change is improvement, but all improvement is change."*
>
> *Donald Berwick, MD*
> *Former CMS Administrator*

QAPI includes components that may be new for many nursing homes. It emphasizes improvements that can not only elevate the care and experience of all residents, but also improve the work environment for caregivers. With QAPI, your organization will use a systems approach to actively pursue quality, not just respond to external requirements. Look at the following list of QAPI features. How many are you already using?

- Using data to not only identify your quality problems, but to also identify other opportunities for improvement, and then setting priorities for action
- Building on residents' own goals for health, quality of life, and daily activities
- Bringing meaningful resident and family voices into setting goals and evaluating progress
- Incorporating caregivers broadly in a shared QAPI mission
- Developing Performance Improvement Project **(PIP)** teams with specific "charters"
- Performing a **Root Cause Analysis** to get to the heart of the reason for a problem
- Undertaking systemic change to eliminate problems at the source
- Developing a feedback and monitoring system to sustain continuous improvement

Illustrating QAPI in Action

The scenario below illustrates how a QAA committee might develop a plan of correction in response to deficiencies identified during an annual survey. The example shows how facilities often react to regulatory non-compliance with a "band-aid" approach. The activities described are representative of the types of plans of corrections that are often submitted to Survey Agencies and accepted. It addresses the immediate problem, and then takes steps assumed to prevent recurrence of the problem.

Scenario 1

The Issue: Your nursing home, Whistling Pines, received deficiencies during their annual survey because residents had unexplained weight loss, and weights and food intake were not accurately and consistently documented.

What Whistling Pines did: The QA Committee developed a Plan of Correction, which contained the following components: Re-weighing all residents, and updating the weight records for the affected residents; in-servicing the Nursing Department on obtaining and documenting weights and intake. They stated they would conduct 3 monthly audits of weight and intake records, with results reported to the QA committee.

This plan of correction was accepted by the State Survey Agency.

The next case study shows a facility with effective QAPI systems in place to identify issues proactively, before trends become serious problems. A nursing home chooses a limited number of PIP projects in "high-risk, high volume, problem-prone" areas.

Scenario 2

The Issue: During the monthly QAPI meeting at Whistling Pines, staff discovered a trend of unexplained weight loss among several residents over the last two months. During the discussion, a representative from dining services noted that there had been an increase in the amount of food left on plates, as well as an increase in the amount of supplements being ordered. Although other issues and opportunities for improvement were identified at the meeting, the QAPI Steering Committee decided to launch a Performance Improvement Project (PIP) on the weight loss trend because unexplained weight loss posed a high-risk problem for residents.

What Whistling Pines did: The QAPI Steering Committee chartered a PIP team composed of a certified nursing assistant (CNA), charge nurse, social worker, dietary worker, registered dietitian, and a nurse practitioner. The team studied the issue, and then performed a root cause analysis (RCA) to help direct a plan of action. The RCA revealed several underlying factors, which included:

- No process existed for identifying and addressing risks for weight loss such as dental condition, diagnosis, or use of appetite suppressing medications;
- No system existed to ensure resident preferences are honored;
- Staff lacked an understanding of how to document food intake percentages; and
- Residents reported the food was not appetizing.

Based on the identified underlying causes, the PIP team recommended the following interventions:

- Development of a protocol for identifying residents at risk for weight loss to be done on admission and with each care plan. This protocol included a review of medications (appetite suppressants), new diagnoses, and resident assessments, including dental issues;
- Development of standing orders for residents identified as "at risk" for weight loss. These would include bi-weekly weights, referral to attending physician and dietitian for assessment, and documentation of meal percentages;
- Development of a new program for CNAs to be "Food Plan Leads" for at risk residents. The program would include identification of food preferences and accurate documentation of meals - laminated badge cards with pictures of meal percentages were distributed to all CNAs; and
- Revision of the menu to focus on favorite foods, adding finger foods and increasing choices outside of mealtimes.

The interventions were implemented in one area of the building that was home to 25 residents. The PIP team collected data from dietary (food wasted and supplement use), CNAs (observation of resident satisfaction and meal percentages), residents (satisfaction surveys), and weights.

After 3 months, they found that 5 residents gained weight, 15 remained stable, and 5 lost weight, but the weight loss was not unexpected and consistent with their clinical condition. Food costs did not increase and supplement costs decreased by 12%.

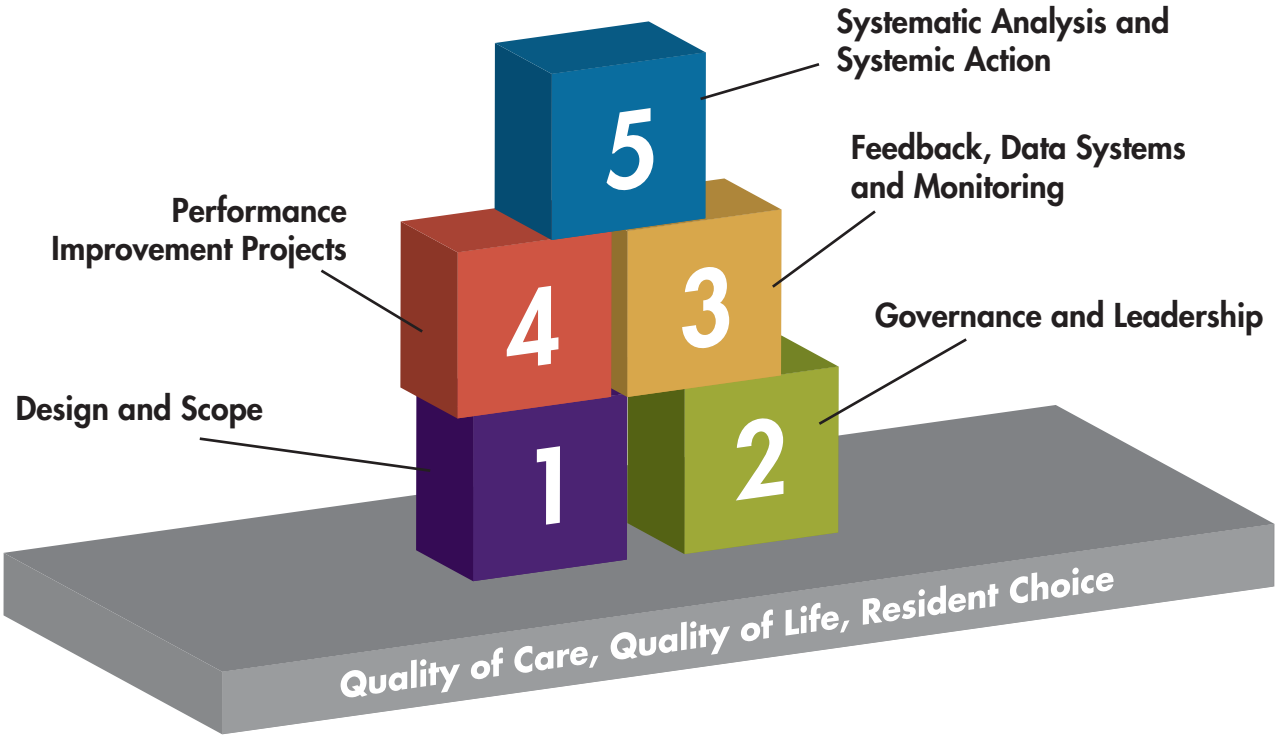
Whistling Pines decided to adopt and expand the changes to other areas of the facility. They received no deficiencies in the areas of nutrition on their annual survey. Using QAPI allowed them to identify and correct developing issues before they escalated to larger problems.

Many of the QAPI action steps discussed in this guide are found in the second scenario. Here are some of the key highlights:

- The facility had a structured Steering Committee for directing the QAPI activities (Step 1).
- The facility established performance measures and was conducting routine monitoring (Step 6).
- The facility used data to identify gaps or opportunities for improvement (Step 8).
- The QAPI Steering Committee used prioritization to decide when to conduct PIPs (Step 9).
- The QAPI Steering Committee created an interdisciplinary team, and as seen in this example, each discipline in the team brought a unique perspective that contributed to a balanced and comprehensive analysis (Step 2).
- The QAPI Steering Committee gave each team member real responsibility to study the issue, analyze the data, and recommend corrective actions (Step 2).
- The PIP team explored the issue, and designed interventions using a Plan-Do-Study-Act (PDSA) model (Steps 9 and 10).
- The PIP team's investigation revealed several underlying systemic issues and made recommendations that addressed those systems, rather than focusing on individual behavior (Step 12).

Five Elements for Framing QAPI in Nursing Homes

CMS has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.



The 5 elements are your strategic framework for developing, implementing, and sustaining QAPI. In doing so, keep the following in mind:

- Your QAPI plan should address all five elements.
- The elements are all closely related. You are likely to be working on them all at once—they may all need attention at the same time because they will all apply to the improvement initiatives you choose.
- Your plan is based on your own center's programs and services, the needs of your particular residents, and your assessment of your current quality challenges and opportunities.

THE FIVE ELEMENTS ARE:

Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

Element 2: Governance and Leadership

The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The Governing Body should foster a culture where QAPI is a priority by ensuring policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff are comfortable identifying and reporting quality problems as well as opportunities for improvement.

Element 3: Feedback, Data Systems and Monitoring

The facility puts in place systems to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Element 4: Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

Element 5: Systematic Analysis and Systemic Action

The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

Action Steps to QAPI

The next few sections detail action steps that may help you on your road to implementing QAPI. They do not need to be achieved sequentially, but each step builds on other QAPI principles.

The most important aspect of QAPI is effective implementation. Learning and understanding the principles is just the first step.

STEP 1: Leadership Responsibility and Accountability

Creating a culture to support QAPI efforts begins with leadership. Support from the top is essential, and that support should foster the active participation of every caregiver. The administrator and senior leaders must create an environment that promotes QAPI and involves all caregivers.

Executive leadership sets the tone and provides resources. Their challenge is to help leadership flourish in each home.

Put a Personal Face on Quality Issues

Leadership should:

- give residents, family and staff the opportunity to meet board members and executive leaders to generate support for QAPI.
- tour the organization regularly, meeting with residents and caregivers where they live and work.
- choose the person or persons who will be the QAPI lead in conjunction with top management—QAPI needs champions.

Here are some ways leadership can take action:

- Develop a steering committee, a team that will provide QAPI leadership:
  - The steering committee has overall responsibility to develop and modify the plan, review information, and set priorities for PIPs. The steering committee charters teams to work on particular problems. It reviews results and determines the next steps. The steering committee must learn and use systems thinking—a nursing home has many competing interests and needs. Top leadership such as the Administrator and the Director of Nursing must be part of this structure.
  - It is also important to have a medical director who is actively engaged in QAPI. It is possible to adapt your Quality Assurance committee to become your "Steering committee" to oversee QAPI. For this to work, the QA Committee may need to meet more often, include more people, and establish permanent and time-limited workgroups that report to it.
- Provide resources for QAPI—including equipment and training:
  - Caregivers may need time to attend team meetings during working hours, requiring others to cover their clinical duties for a period of time.
  - Equipment might include anything from additional computers, to low-cost supplies like posters to create story boards, or multiple copies of resource books or CDs.
  - Leadership may want to consider sending one or more team members to a specialized training.

- Establish a climate of open communication and respect. Leadership may wish to consider:
  - Having an open-door policy to communicate with staff and caregivers.
  - Emphasizing communication across shifts and between department heads.
  - Creating an environment where caregivers feel free to bring quality concerns forward without fear of punishment.
  - Understand your home's current culture and how it will promote performance improvement:
  - Create the expectation that everyone in your nursing home is working on improving care and services.
  - Establish an environment where caregivers, residents, and families feel free to speak up to identify areas that need improvement.
  - Expect and build effective teamwork among departments and caregivers.

STEP 2: Develop a Deliberate Approach to Teamwork

Teamwork is a core component of QAPI and too often it is taken for granted. You will hear and read that you should discuss a situation with "your team," or that the opinion of "everyone on the team" is valued. The word "teamwork" may have different meanings. Many people work together without being a designated or formal "team."

Characteristics of an effective team include the following:

- Having a clear purpose
- Having defined roles for each team member to play
- Having commitment to active engagement from each member

The roles of team workers may grow out of their original discipline (e.g., nurse, social worker, physical therapist) or their defined job responsibilities.

QAPI relies on teamwork in several ways:

- Task-oriented teams may be specially formed to look into a particular problem and their work may be limited and focused.
- PIP teams are formed for longer-term work on an issue.
- When chartering a PIP, careful consideration must be given to the purpose of the PIP and type of members needed to achieve that purpose. Here are some examples:
  - A PIP team with the goal of helping residents go outside more often decided that grounds personnel needed to be on that team so that procedures for snow removal, sun protection, and outdoor seating could be considered.
  - Another PIP team working at simplifying medication regimens included a pharmacist, even though the time needed to be added to the consultant contract.
  - After a PIP team began working on the problem of anxiety among residents, the members realized that many of the affected residents reported reassurance from the pastor and asked the QA committee to add him to the team that was planning the approach.
  - A PIP team working on reducing falls asked that the housekeeping department be involved as it considered root causes of falls and realized that equipment in the corridors and clutter in the bathrooms contributed.

Note: Generally, each team should be composed of interdisciplinary members. For example, a concern with medication administration should include nursing and pharmacy team members. However, even other disciplines or family members may bring a different perspective to understanding this issue and should be considered for this type of team.

- Family members and residents may be team members, though for confidentiality reasons, they may not review certain data or information that identifies individuals.
- PIP teams need to plan for sufficient communication—including face-to-face meetings to get to know each other and plan the work. The team should also plan for the way each team member will review information that emerges from the PIP.
- Leadership needs to convey that being on a PIP team is an important part of the job—not something to put aside if other things come up. They must also support this idea through action and resources to enable staff to complete daily assignments, provide clinical care and also participate on QAPI teams.

STEP 3: Take your QAPI "Pulse" with a Self-Assessment

In order to establish QAPI in your organization, it is helpful to conduct a self-assessment in your organization. As you continue implementing the action steps outlined in this guide, you should periodically evaluate QAPI in your organization – see how far you've come.

To get you started, we've developed a self-assessment tool to take your QAPI "pulse." It will assist you in evaluating the extent to which components of QAPI are in place within your organization and identifying areas requiring further development. It will help you determine how you really know whether QAPI is taking hold.

You may use the self-assessment tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress. You should complete the tool with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization.

Click here to go to the QAPI Self-Assessment Tool in Appendix A

STEP 4: Identify Your Organization's Guiding Principles

It is important to lay a foundation that will help you think about what principles will guide your decision making and help you set priorities.

Nursing homes are complex organizations, with numerous departments performing different functions that interact with and depend on each other. Establishing a purpose and guiding principles will unify the facility by tying the work being done to a fundamental purpose or philosophy. These principles will help guide your facility in determining programmatic priorities.

Use the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI to establish the principles that will give your organization direction. The team completing this assignment should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan.

Click here to go to the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI in Appendix A

STEP 5: Develop Your QAPI Plan

Your plan will assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI. This is a living document that you may revisit as your facility evolves.

A written QAPI plan guides the nursing home's quality efforts and serves as the main document to support implementation of QAPI. The plan describes guiding principles that will be used in QAPI as well as the scope QAPI will have based on the unique characteristics and services of the nursing home. The QAPI plan should be something that is actually used and not viewed as a task that must be completed. You should continually review and refine your QAPI plan.

- Tailor the plan to fit your nursing home including all units, programs, and resident groups (for example, your sub-acute care unit, your dementia care unit, or your palliative care program). Think also of the range of residents. Do you have some younger residents? You may need to consciously develop a distinct plan to create quality of life for those residents.
- Some large organizations or corporations may choose to develop a general plan for all nursing homes in the group—in fact many multi-home organizations already have a corporate quality plan. Flexibility must be built in because individual nursing homes must have a plan that works for them. Leaders at the facility level need flexibility to develop plans for the priorities that fit their needs.

You may use the Guide for Developing a QAPI Plan to help you create a comprehensive plan that addresses the full range and scope of care and services provided by your organization.

Click here to go to the Guide for Developing a QAPI Plan in Appendix A

STEP 6: Conduct a QAPI Awareness Campaign

COMMUNICATE WITH ALL CAREGIVERS

- Let everyone know about your QAPI plan—often and in multiple ways.
- Plan ongoing caregiver education beyond single exposures—the goal is widespread awareness of QAPI initiatives.
- Train through dialogue, examples, and exercises. Transform the material in this guide into smaller pieces and easily understood ideas. Use your home's own experiences with certain caregivers or residents as part of the learning materials.
- Convey the message that QAPI is about systems of care, management practices, and business practices—systems should support quality and/or acceptable business practices, or they must change. Use examples to get the message across, and ask caregivers to think of examples of their own.
- Be sure consultants, contractors, and collaborating agencies are also aware of your QAPI approach. Maybe you have several hospice organizations coming in and out of your home. You may work with a podiatrist who visits regularly. They each have a role in your system.
- Convey the message that any and every caregiver is expected to raise quality concerns, that it is safe to do so, and that everyone is encouraged to think about systems.

- Discuss the hard questions—what is meant by a culture of safety here in our nursing home? How does the nursing home try to balance issues of safety and resident choice/autonomy? These types of questions often do not have easy answers but QAPI opens up these types of issues for discussion and deeper thinking.

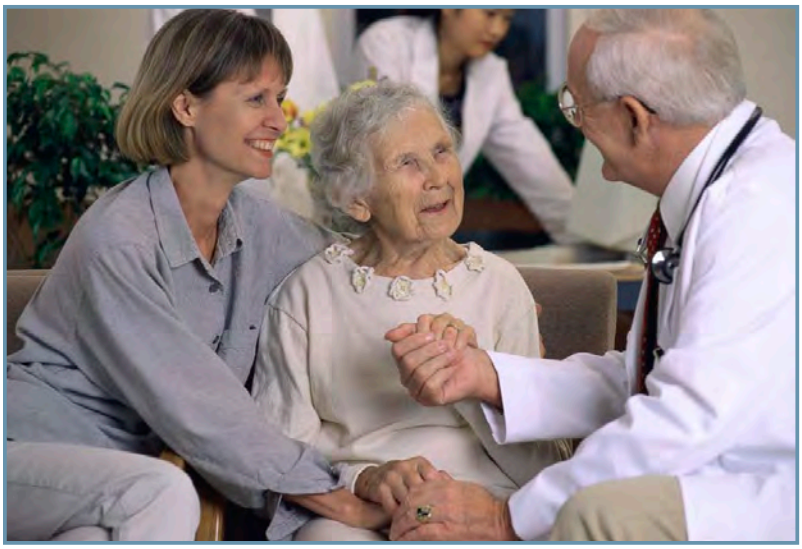
Try this:

An exercise where groups that cross disciplines and roles brainstorm the various ways their work influences the work of others. For example, activities personnel may find that their events are cut short because no one is available to help residents to and from activity areas. Also seek examples where resident choice did not prevail. For instance, evening caregivers may say residents cannot be up and out of their rooms after 9:30 pm because no one will be able to help them to bed after 10:00 pm. Brainstorm how to solve problems like these, even if jobs and routines would change.

If systems don't exist, they may need to be developed. If systems impede quality, they must be changed.

COMMUNICATE WITH RESIDENTS AND FAMILIES

- Make sure all residents and families know that their views are sought, valued, and considered in facility decision-making and process improvements by announcing and discussing QAPI in resident and family councils and other venues.
- Ask residents and family members to tell you about their quality concerns. Many facilities today are using some type of customer-satisfaction survey—results should be used to identify opportunities for improvement that will proactively have an impact on all residents and their families.
- Try to view concerns through residents' eyes. For example, getting back to a resident in 10 minutes may seem responsive, but may feel like an eternity to the resident. How would that feel to a resident waiting an answer to a call light or for help to the bathroom?
- Consider including QAPI information in routine communications to families.



Family and resident complaints are often underused, and yet they are a valuable way of identifying more general problems.

STEP 7: Develop a Strategy for Collecting and Using QAPI Data

Your team will decide what data to monitor routinely. Areas to consider may include:

- Clinical care areas, e.g., pressure ulcers, falls, infections
- Medications, e.g., those that require close monitoring, antipsychotics, narcotics
- Complaints from residents and families
- Hospitalizations and other service use
- Resident satisfaction
- Caregiver satisfaction
- Care plans, including ensuring implementation and evaluation of measurable interventions
- State survey results and deficiencies
- Results from MDS resident assessments
- Business and administrative processes—for example, financial information, caregiver turnover, caregiver competencies, and staffing patterns, such as permanent caregiver assignment. Data related to caregivers who call out sick or are unable to report to work on short notice, caregiver injuries, and compensation claims may also be useful.

This data will require systematic organization and interpretation in order to achieve meaningful reporting and action. Otherwise, it would only be a collection of unrelated, diverse data and may not be useful.

Compare this to an individual resident's health—you must connect many pieces of information to reach a diagnosis. You also need to connect many pieces of information to learn your nursing home's quality baseline, goals, and capabilities.

- Your team should set targets for performance in the areas you are monitoring. A target is a goal, usually stated as a percentage. Your goal may be to reduce restraints to zero; if so, even one instance will be too many. In other cases, you may have both short and longer-term goals. For example, your immediate goal may be reducing unplanned rehospitalizations by 15 percent, and then subsequently by an additional 10 percent. Think of your facility or organization as an athlete who keeps beating his or her own record.
- Identifying benchmarks for performance is an essential component of using data effectively with QAPI. A benchmark is a standard of comparison. You may wish to look at your performance compared to nursing homes in your state and nationally using Nursing Home Compare (www.medicare.gov/nhcompare); some states also have state report cards. You may compare your nursing home to other facilities in your corporation, if applicable. But generally, because every facility is unique, the most important benchmarks are often based on your own performance. For example, seeking to improve hand-washing compliance to 90 percent in 3 months based on a finding of 66 percent in the prior quarter. After achieving 90 percent for some period of time, the benchmark can be raised higher as part of ongoing, continuous improvement.
- It may be helpful to monitor what happens when residents leave the nursing home or come back, including discharges to the hospital or home. You may examine discharge rates from your post-acute care area, preventable hospitalizations (i.e., hospitalizations that can be avoided through good clinical care), and what happens after the resident returns from the hospital.

- You'll want to develop a plan for the data you collect. Determine who reviews certain data, and how often. Collecting information is not helpful unless it is actually used. Be purposeful about who should review certain data, and how often—and about the next steps in interpreting the information.

STEP 8: Identify Your Gaps and Opportunities

This step involves reviewing your sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems. Or, are there opportunities to make improvements?

Potential areas to consider when reviewing your data:

- MDS data for problem patterns.
- Nursing Home Compare (provides quality information about every certified nursing home in the country).
- State survey results and plans of correction.
- Resident care plans for documented progress towards specified goals.
- Trends in complaints.
- Resident and family satisfaction for trends.
- Patterns of caregiver turnover or absences.
- Patterns of ER and/or hospital use.

During this step, you may decide to spend more time discussing the quality themes you have identified with residents and caregivers. They may pick up patterns you have not yet identified, and they may have ideas about what is at the root of the problem. Consider hosting a series of small group meetings with your caregivers, and arrange to meet with your Resident Council. You may wish to provide refreshments and have an informal discussion.

This step should lead to the next steps involving PIPs. Such projects are expected to be chosen to deal with "high risk, high volume, problem-prone areas" related to quality of care or quality of life. Take time to notice the things you are doing well—that's important too, and deserves recognition.

But while you are celebrating accomplishments, you can also begin to set priorities for improvement around issues that the team identifies.

STEP 9: Prioritize Quality Opportunities and Charter PIPs

Prioritizing opportunities for improvement is a key step in the process of translating data into action.

As you continue to implement QAPI, you and your team will:

- Prioritize opportunities for more intensive improvement work. Problems versus opportunities are a matter of perspective and often require discussion.
- Choose problems or issues that you consider important (consider if the issue is high risk, high frequency, and/or problem prone). Remember that problems affecting psychosocial well-being and the ability of residents to exercise choice should also be considered as they may lead to resident suffering.
- Consider which problems will become the focus for a PIP.

- All identified problems need attention—and usually from more than one person, but they do not all require PIPs.
- Begin some PIPs with problems you think you can solve relatively easily. A quick win is worthwhile.

Charter PIP teams:

We use the word "charter" on purpose. A PIP is more than a casual effort - it entails a specific written mission to look into a problem area. The PIP team should include people in a position to explore the problem (usually direct caregivers, such as nursing assistants, are needed). If the problem being addressed involves, for example, dietary choices, then someone from the dietary department should also be on the PIP team.

Chartering implies that the team has been entrusted with a mission, and that it reports back to the Steering Committee at intervals. Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously. The development of a charter adds strength, importance, and formality to the PIP process. The team typically has a leader—either chosen in the charter or by the team itself. Soon after it begins its work, the PIP should develop a proposed time line, and indicate the budget that is needed.

Use the Goal Setting Worksheet to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.

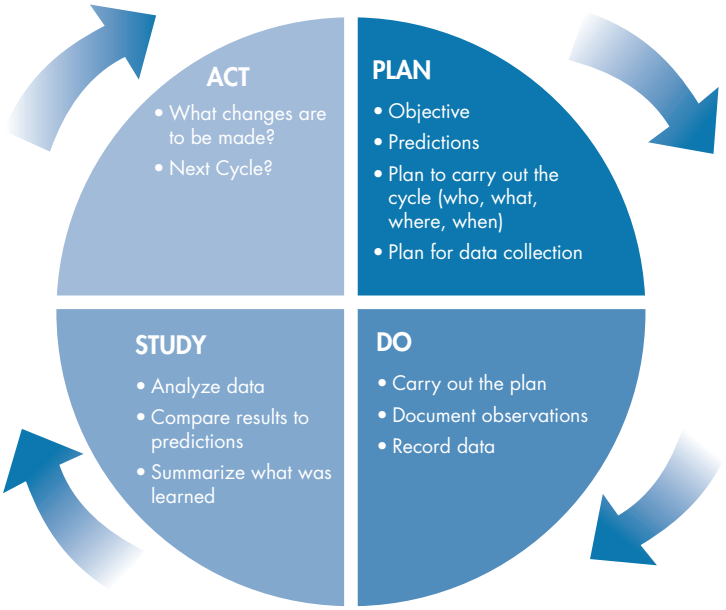
Click here to go to the Goal Setting Worksheet in Appendix A

STEP 10: Plan, Conduct and Document PIPs

Careful planning of PIPs includes identifying areas to work on through your comprehensive data review which are meaningful and important to your residents. It is important to focus your PIPs by defining the scope, so they do not become overwhelming.

You and your team may:

- consider each PIP a learning process.
- determine what information you need for the PIP.
- determine a timeline and communicate it to the Steering Committee.
- identify and request any needed supplies or equipment.
- select or create measurement tools as needed;
- prepare and present results.
- use a problem solving model like PDSA (Plan-Do-Study-Act).
- report results to the Steering Committee.



PDSA MODEL

PLAN-DO-STUDY-ACT (PDSA) CYCLE

During a PIP you will try out some changes and then see whether or not they made a difference in the area you were trying to improve. In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented. In the DO stage, the plan is carried out, including the measures that are selected. In the STUDY phase, the team summarizes what was learned. In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned. That decision determines the next steps in the cycle.

STEP 11: Getting to the "Root" of the Problem

A major challenge in process improvement is getting to the heart of the problem or opportunity.

There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue. What seems like a simple issue may involve a number of departments.

Root Cause Analysis (RCA) is a term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance. This structured method of analysis is designed to get to the underlying cause of a problem –which then leads to identification of effective interventions that can be implemented in order to make improvements.

RCA helps teams understand that the most immediate or seemingly obvious reason for the problem or an event may not be the real reason that an event occurred. The RCA process leads to digging deeper and deeper—looking for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause. The root cause(s) and any contributing factors can then be sorted into categories to facilitate the identification of various actions that can be taken to make improvements.

RCA focuses primarily on systems and processes, not individual performance.

The RCA process takes practice, but can be a valuable tool for performance improvement. In order to get familiar with RCA you and your team may consider:

- studying case examples of RCA.
- applying RCA to an adverse event and discussing this technique with the team.
- building RCA examples into training opportunities.

STEP 12: Take Systemic Action

Identifying root causes is only the first step in improving performance. Next you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. This is often the most challenging step in the process. Common solutions such as providing more training/education or asking clinicians to "be more careful" do not change the process or system. These proposed solutions are based on two assumptions: lack of knowledge contributed to the event, and if a person is educated or trained, the mistake won't happen again.

Choosing actions that are tightly linked to the root causes and that lead to a system or process change are considered to have a higher likelihood of being effective. Actions that simply support the current process are considered "weaker" and should not be selected as the sole intervention. The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.

To be effective, interventions or corrective actions should target the elimination of root causes, offer long term solutions to the problem, and have a greater positive than negative impact on other processes. In addition, interventions must be achievable, objective, and measurable.

Pilot Test:

Think about testing or "piloting" changes in one area of your facility before launching throughout. Some changes have unintended consequences.

The Department of Veterans Affairs National Center for Patient Safety's Hierarchy of Actions[2] classifies corrective actions as:

Weak: Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes.

Examples of weak actions:

- double checks
- warnings/labels
- new policies/procedures/memoranda
- training/education
- additional study

Intermediate: Actions are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff to remember or to promote clear communication. Intermediate actions modify existing processes.

Examples of intermediate actions:

- decrease workload
- software enhancements/modifications
- eliminate/reduce distraction
- checklists/cognitive aids/triggers/prompts
- eliminate look alike and sound alike
- read back
- enhanced documentation/communication
- build in redundancy

[2]U.S. Department of Veterans Affairs. National Center for Patient Safety Root Cause Analysis Tools. Retrieved from http://www.patientsafety.gov/CogAids/RCA/index.html#page+page-1.

Strong: Actions that do not depend on staff to remember to do the right thing. The action may not totally eliminate the vulnerability but provides strong controls. Strong actions change or re-design the process. They help detect and warn so there is an opportunity to correct before the error reaches the patient. They may involve hard stops which won't allow the process to continue unless something is corrected or gives the chance to intervene to prevent significant harm.

Examples of strong actions:

- physical changes: grab bars, non slip strips on tubs/showers
- forcing functions or constraints: design of gas lines so that only oxygen can be connected to oxygen lines; electronic medical records – cannot continue charting unless all fields are filled in
- simplifying: unit dose

Prevent future problems by developing and testing strong actions.

QAPI Principles Summarized

- All of QAPI may not be new to your facility. You already have a Quality Assessment and Assurance program—consider beginning by evaluating or re-evaluating that program and then conducting a self evaluation using the QAPI Self Assessment Tool.
- QAPI leadership starts at the top with executive management and the Board of Directors, Owners, or Trustees, and includes top management in each home.
- Three important principles of QAPI are Systems, Systems, and Systems. Start using systems thinking as you assess your own QAPI efforts, and develop a QAPI plan moving forward. Think of your entire center or community as you plan for monitoring, as you conduct PIPs, and particularly as you think about the way problems might be caused and how care is organized.
- Involve the people directly working in a process in order to improve that process. These are the people who really know what happens at any point in the process. It is crucial to focus on organization-wide inclusion, not for the sake of inclusion, but to truly understand what is going on in any given process.
- Communication about QAPI should be continuous throughout the whole organization. QAPI principles and ongoing training should be built into a facility-wide educational effort that involves all caregivers, residents, and families.
- Residents' perspectives need to be considered in setting QAPI priorities. Solicit residents' viewpoints and talk to residents and families about quality as they experience it.
- Two important components of your QAPI plan will be setting priorities and chartering PIP teams. Everyone should have an opportunity to participate in these activities.
- Create a record of QAPI activities. Consider using past experience as a resource as you move ahead. Keeping an ongoing record of QAPI achievements may help to sustain the improvements regardless of crises or changes in leadership. Build it into your plan.
- Celebrate and reward successes.

How to Learn More

Our QAPI website: http://go.cms.gov/Nhqapi

An excellent resource on QAPI in Nursing Homes is CMS' QAPI website. It contains a number of tools and resources including:

- Learning modules complete with videos, QAPI Process Tools and how to use them, case study examples, best practices information, sections to help engage consumers, and much more
- Downloadable QAPI process tools with instructions for their use
- Best practice examples organized by topic
- QAPI tools for specific topics and purposes with links to many related resources
- Special resources for you in your particular practice role in the "Communities of Practice" section
- News Briefs on QAPI implementation

QAPI Tools and Related Resources

QAPI PROCESS TOOLS

These are tools that help make QAPI processes work. They may include:

- checklists
- templates
- flow charts
- reporting forms or outlines
- worksheets

QAPI process tools are important to:

- organize multiple tasks.
- enhance communication within and across teams.
- help generate ideas and reach decisions.
- keep information organized and accessible.
- track successes and challenges using data.

QAPI is largely about well-functioning and tightly coordinated systems that can identify, solve, and prevent problems effectively. Using QAPI can improve diverse aspects of care and services as well as resident, family, caregiver, and staff experience and satisfaction. **TOOLS CAN HELP.**

QAPI TOPIC TOOLS

QAPI Topic Tools are used to study and improve particular topic areas. Many tools are available to assess care processes and outcomes and to allow you to follow progress in areas you want to track and/or improve. Topic tools can take many forms, ranging from simple to complex, and they use multiple sources of information.

- Checklists or audits completed by caregivers and practitioners. Checklists can be used to review records of various kinds to determine that all steps have been taken. For example, an admission or fall prevention checklist.
- Rating forms completed by caregivers. For example,residents' mood states are rated when residents cannot respond to direct questions.
- Structured observation (e.g., observations of interactions among residents and caregivers or of physical environments). Observations are objective and made at specific times and places; later they may be summarized into a score.
- Direct interviews with residents and family. Such tools, sometimes called resident self-report tools, may be related to single areas of functioning.
- Protocols to guide caregivers' behavior to improve quality in a particular area. Such protocols may include procedures and forms meant to shape caregiver behavior around pressure ulcer prevention, respecting residents' rights, etc. This comprehensive set of tools could be considered a QAPI process toolkit as well.

Nursing homes may wish to select established tools that have been tested and use them consistently.

QAPI RESOURCES FOR PROVIDERS

Each state is served by a Quality Improvement Organization that offers resources and tools for nursing homes. To find your Quality Improvement Organization, visit http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1144767874793

RESOURCES AND TOOLS AVAILABLE THROUGH QIOS

Oklahoma Foundation for Medical Quality
Provides tools and resources for nursing homes.
http://www.ofmq.com/nhtoolsandresources Improvement basics for nursing homes, Change management, and Facilitating group agreement.

Stratis Health
The following recorded webinars cover some basic principles of QI and can be used for caregiver education: http://www.stratishealth.org/events/recorded.html

WEBSITES ON SELECTED QUALITY TOPICS

Advancing Excellence in America's Nursing Homes
Supported by CMS, the Commonwealth Fund, and others, The Advancing Excellence Campaign provides tools and resources to improve nursing home care in clinical and organizational areas.
http://www.nhqualitycampaign.org/

Agency for Healthcare Research and Quality
The Department of Defense and the Agency for Healthcare Research and Quality developed the Team STEPPS program to optimize performance among teams of healthcare professionals and improve collaboration and communication. The Long-Term Care version addresses issues specific to nursing homes: http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/index.html.

Department of Veterans Affairs
National Center for Patient Safety supports and leads the patient safety activities for all VA medical centers and has developed tools including Root Cause Analysis investigations: http://www.patientsafety.gov/CogAids/RCA/.

Getting Better All the Time: Working Together for Continuous Improvement
The Isabella Geriatric Center and Cobble Hill Health Center have developed a web manual on quality improvement approaches as a guide for nursing home caregivers. This is a particularly practical and lively resource that explains and illustrates performance monitoring and improvement approaches in ways that are understandable to most nursing home caregivers. *Getting Better All the Time* was written by Ann Wyatt, a social worker and nursing home administrator; it aims to present a model of quality improvement that integrates quality of care and quality life.
http://www.susanwehrymd.com/files/gettingbetterall-the-time.pdf

Interact II
An example of a more extensive set of tools, INTERACT II is a system of tools to improve how nursing home caregivers communicate around change in resident condition. This comprehensive set of tools could be considered a QAPI process toolkit as well. www.interact2.net

Institute for Health Care Improvement (IHI)
IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.
http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

WEBSITES ON PERSON-CENTERED CARE

Implementing Change in Long-Term Care: A Practical Guide to Transformation
This resource was prepared by Barbara Bowers and others with a grant from the Commonwealth Fund to the Pioneer Network. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process.
http://www.pioneernetwork.net/Data/Documents/Implementation_Manual_ChangeInLongTermCare%5B1%5D.pdf

Picker Institute Publications
These include a *Long-Term Care Improvement Guide*, commissioned in 2010 and a *Patient-Centered Care Improvement Guide*, commissioned in 2008, both by Susan Frampton and others. The website also carries information on current books related to person centered care that Picker Institute recommends.
http://pickerinstitute.org/publications-and-resources/

Appendix A: QAPI Tools

Disclaimer: Use of these tools is not mandated by CMS for regulatory compliance nor does their completion ensure regulatory compliance.

QAPI Self-Assessment Tool

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of Review:_____ Next review scheduled for:_____

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregiver orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary actions. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families. Notes:					
Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process. Notes:					
For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level). Notes:					
We have a system to effectively collect, analyze, and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice, or applicable clinical guidelines. Notes:					
Our organization has, or supports the development of, employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology to caregivers involved in QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents. Notes:					
When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish. Notes:					
For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference. Notes:					
For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents. Notes:					
Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation from happening with another caregiver and another resident. Notes:					
When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful, or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels. Notes:					
When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected and that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention there is a measure looking at whether the change is being carried out and a measure looking at the impact on fall rate. Notes:					
When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and having the desired impact (this is commonly done at 6 or 12 months). Notes:					

Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

Directions: Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

A **vision statement** is sometimes called a picture of your organization in the future; it is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Meadowlark Hills is each resident's home. We are committed to enhancing quality of life by nurturing individuality and independence. We are growing a value-driven community while leading the way in honoring inherent senior rights and building strong and meaningful relationships with all whose lives we touch.

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts which support our mission by [reference aspects of mission statement here].

STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your nursing home. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

The **Scope** outlines what types of care and services are provided by the organization that impact clinical care, quality of life, resident choice, and care transitions. Be sure to incorporate the care and services delivered by all departments.

For example:

Post-acute care
Dementia care and services
Dietary
Dining

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

STEP 6. ASSEMBLE DOCUMENT

Once you've completed steps 1-5, assemble the vision and mission statements, guiding principles, and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See *"Guide for Developing a QAPI Plan."*

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.* Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.

b. Describe how the QAPI plan will address:

   i. Clinical care

   ii. Quality of life

   iii. Resident choice (i.e., individualized goals for care)

c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).

d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).

b. Describe how QAPI will be adequately resourced.

   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.

   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.

   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.

   iv. Indicate how you will determine if resources are adequate for QAPI.

   v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

c. QAPI Leadership

i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.

ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:

- Establishing a format and frequency for meetings
- Establishing a method for communication between meetings
- Establishing a designated way to document and track plans and discussions addressing QAPI.

iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.

b. Identify the sources of data that you will monitor through QAPI

i. Input from caregivers, residents, families, and others

ii. Adverse events

iii. Performance indicators

iv. Survey findings

v. Complaints

c. Describe the process for collecting the above information.

d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.

e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.

f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.

i. Indicate how potential topics for PIPs will be identified.

ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.

iii. Indicate how and when PIP charters will be developed.

iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any "unintended" consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.

b. Determine when you will revisit the plan (i.e., at least annually).

c. Determine how you will track revisions or updates to the plan.

Goal Setting Worksheet

Directions: Goal setting is important for any measurement related to performance improvement. This worksheet is intended to help QAPI teams establish appropriate goals for individual measures and also for performance improvement projects. Goals should be clearly stated and describe what the organization or team intends to accomplish. Use this worksheet to establish a goal by following the SMART formula outlined below. Note that setting a goal does **not** involve describing what steps will be taken to achieve the goal.

Describe the business problem to be solved:

Use the SMART formula to develop a goal:

SPECIFIC

Describe the goal in terms of 3 'W' questions:

What do we want to accomplish?
Who will be involved/affected?
Where will it take place?

MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?
What is the current data figure (i.e., count, percent, rate) for that measure?
What do you want to increase/decrease that number to?

ATTAINABLE

Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a particular best practice/average score/ benchmark?
Is the goal measure set too low that it is not challenging enough?
Does the goal measure require a stretch without being too unreasonable?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.

[*Example:* Increase the number of long-term residents with a vaccination against both influenza and pneumococcal disease documented in their medical record from 61 percent to 90 percent by December 31, 2011.]

Tip: It's a good idea to post the written goal somewhere visible and regularly communicate the goal during meetings in order to stay focused and remind caregivers that everyone is working toward the same aim.

Appendix B: QAPI Definitions

Performance Improvement (PI)

PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI in nursing homes aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

Performance Improvement Project (PIP)

A PIP project typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to each facility.

Quality Assurance and Performance Improvement (QAPI)

QAPI is a data-driven, proactive approach to improving the quality of life, care, and services in nursing homes. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

Quality Assurance (QA)

QA is a process of meeting quality standards and assuring that care reaches an acceptable level. Nursing homes typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.

Root Cause Analysis (RCA)

Root cause analysis is a term to describe a systematic process to get to the underlying cause of a problem.

Systems Thinking

Systems thinking is a perspective that considers how things influence one another as a whole, rather than individual elements, or static "snapshots."

Tab Two

Policy and Procedures

Quality Assurance and Performance Improvement (QAPI) Program – Governance and Leadership

Policy Statement

The Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI Committee, which reports its findings, actions and results to the Administrator and governing body.

Policy Interpretation and Implementation

1. The Administrator, whether a member of the QAPI Committee or not, is ultimately responsible for the QAPI Program, and for interpreting its results and findings to the governing body.
2. The governing body is responsible for ensuring that the QAPI program:
   a. Is implemented and maintained to address identified priorities;
   b. Is sustained through transitions of leadership and staffing;
   c. Is adequately resourced and funded, including the provision of money, time, equipment, training and staff coverage sufficient to conduct the activities of the program;
   d. Is based on data, resident and staff input, and other information that measures performance; and
   e. Focuses on problems and opportunities that reflect processes, functions and services provided to the residents.
3. The QAPI Coordinator coordinates the activities of the QAPI Committee.
4. The responsibilities of the QAPI Committee are to:
   a. Collect and analyze performance indicator data and other information;
   b. Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services;
   c. Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process;
   d. Utilize root cause analysis to help identify where identified problems point to underlying systematic problems;
   e. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care;
   f. Establish benchmarks and goals by which to measure performance improvement;
   g. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and
   h. Communicate all phases of the QAPI process to the Administrator and governing body through sharing meeting minutes, committee activities and results of QAPI activities.
5. The committee has the full authority to oversee the implementation of the QAPI Program, including, but not limited to, the following:
   a. Establishing performance and outcome indicators for quality of care and services delivered in the facility;
   b. Choosing and implementing tools that best capture and measure data about the chosen indicators;
   c. Appropriately interpreting data within the context of standards of care, benchmarks, targets and the strengths and challenges of the facility; and
   d. Communicating the information gathered and their interpretation to the owner/governing board (body).

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6. The following individuals serve on the committee:
   a. Administrator, or a designee who is in a leadership role;
   b. Director of Nursing Services;
   c. Medical Director;
   d. Infection Preventionist; and
   e. Representatives of the following departments, as requested by the Administrator:
      (1) Pharmacy;
      (2) Social Services;
      (3) Activity Services;
      (4) Environmental Services;
      (5) Human Resources; and
      (6) Medical Records.
7. The committee meets at least quarterly (or more often as necessary). Committee members are reminded of meeting day, time and location via e-mail at least two business days prior to the meeting.
8. Special meetings may be called by the Administrator as needed to present issues that need to be addressed before the next regularly scheduled meeting.

References	
OBRA Regulatory Reference Numbers	§483.75(f) QAPI – Governance and Leadership.
Survey Tag Numbers	F865
Other References	
Related Documents	
Version	1.3 (H5MAPL0696)

Quality Assurance and Performance Improvement (QAPI) Program – Feedback, Data and Monitoring

Policy Statement

The QAPI programs is based on the collection information obtained from data, self-assessment and systems of feedback. Information is collected, evaluated and monitored by the QAPI committee.

Policy Interpretation and Implementation

1. Information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI committee in order to identify problems that are high risk, high volume or problem prone and to guide decisions regarding opportunities for improvement.
2. The QAPI process focuses on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of life, resident safety, resident choice or resident autonomy, and on making a good faith effort to correct or mitigate these outcomes.
3. Systems and tools used to identify, collect and evaluate data from all departments to monitor performance indicators include, but are not limited to:
   a. Self-assessment tools:
      - Ongoing facility assessment
      - Monthly resident census data
      - Annual Survey results
      - QAPI self-assessment tools
   b. Data collection tools:
      - Monthly surveillance reports for quality of care indicators
      - Monthly Quality Measures reports
      - Monthly Staff turnover reports
      - Monthly Summary of Accident and Incident Reports (and/or other adverse event tracking tools)
   c. Feedback from staff, residents and families:
      - Resident and family satisfaction surveys
      - Staff suggestions and exit interviews
      - Feedback from Resident Council Meetings
      - Complaint survey results
4. Data and information collected are reviewed by the committee and prioritized according to the risk, volume, and potential problems.
5. Root cause analysis is conducted to identify problematic processes and systems that need to be addressed.
6. Corrective actions and performance improvement activities are initiated and monitored. The committee tracks and documents the progress of existing initiatives as well as newly identified ones, as part of the ongoing QAPI process.
7. The number and scope of performance improvement activities reflect the scope and complexity of this organization's services and available resources, as identified in the facility assessment.

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8. The QAPI program is committed to no less that one project annually that focuses on a high-risk or problem-prone area identified through data collection and analysis.

References	
OBRA Regulatory Reference Numbers	§483.75(c) QAPI – Program Feedback, Data Systems and Monitoring; §483.75(e) QAPI – Program Activities
Survey Tag Numbers	F866; F867
Other References	
Related Documents	

Version	1.0 (H5MAPL1470)

Quality Assurance and Performance Improvement (QAPI) Program – Design and Scope

Policy Statement

The facility QAPI Program is ongoing, comprehensive and addresses all care and services provided by the facility. The scope of our performance improvement efforts is reflective of the complexity of services and resources of the organization.

Policy Interpretation and Implementation

1. The QAPI Program is designed to address all systems and practices in this facility that affect residents, including clinical care, quality of life, resident choice and safety.

2. The indicators of quality are defined and measured based on the current evidence supporting the best indicators of desired outcomes for residents in nursing facilities.

3. The indicators of quality for this facility reflect the care and services provided that are unique to our facility and resident population, as identified in the facility assessment.

4. The QAPI functions prioritize identified problem areas that are high-risk, high volume and/or problem prone.
   a. "**High Risk.**" Refers to care or service areas associated with significant risk to the health or safety of residents, e.g., tracheostomy care; pressure injury prevention; administration of high risk medications such as warfarin, insulin, and opioids.
   b. "**High Volume**." Refers to care or service areas performed frequently or affecting a large population, thus increasing the scope of the problem, e.g., transcription of orders; medication administration; laboratory testing.
   c. "**Problem-prone**." Refers to care or service areas that have historically had repeated problems, e.g., call bell response times; staff turnover; lost laundry.

References	
OBRA Regulatory Reference Numbers	§483.75(b) Quality assurance and performance improvement (QAPI) program – Program Scope and Design
Survey Tag Numbers	F865
Other References	
Related Documents	Quality Assurance and Performance Improvement (QAPI) Program
Version	1.0 (H5MAPL1469)

Quality Assurance and Performance Improvement (QAPI) Program – Analysis and Action

Policy Statement

Quality deficiencies that are identified through feedback and data and will undergo appropriate corrective action. Corrective actions are monitored against established goals and benchmarks by the QAPI committee.

Policy Interpretation and Implementation

1. The QAPI program, overseen by the QAPI committee is designed to identify and address quality deficiencies through the analysis of the underlying cause and actions targeted at correcting systems at a comprehensive level.
2. The methodology for analysis and action is guided by a written QAPI plan that includes:
   a. Definition of the problem, based on information obtained through data, self-assessment and feedback systems.
   b. An analysis of the root cause of the problem from a systems perspective.
   c. Establishing measurable goals or benchmarks for improvement.
   d. Specific interventions aimed at correcting the problem and achieving the stated goals or benchmarks.
   e. Methods and frequency of monitoring performance improvement objectives.
3. The QAPI committee is responsible for analyzing identified problems, establishing corrective actions, measuring progress against the established goals and benchmarks, communicating information to staff and residents, and reporting findings to the Administrator and governing board.

References	
OBRA Regulatory Reference Numbers	§483.75(d) QAPI – Program systematic analysis and systematic action
Survey Tag Numbers	F867
Other References	
Related Documents	
Version	1.0 (H5MAPL1471)

Quality Assurance and Performance Improvement (QAPI) Program

Policy Statement

This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents.

Policy Interpretation and Implementation

The objectives of the QAPI Program are to:

1. Provide a means to measure current and potential indicators for outcomes of care and quality of life.
2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.
3. Reinforce and build upon effective systems and processes related to the delivery of quality care and services.
4. Establish systems through which to monitor and evaluate corrective actions.

Authority

1. The owner and/or governing board (body) of our facility is ultimately responsible for the QAPI Program.
2. The governing board/owner evaluates the effectiveness of its QAPI Program at least annually and presents findings to the QAPI Committee.
3. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements.
4. The QAPI Committee reports directly to the Administrator.

Implementation

1. The QAPI Committee oversees implementation of our QAPI Plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct its QAPI functions, and the activities of the QAPI Committee.
2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include:
   a. Tracking and measuring performance;
   b. Establishing goals and thresholds for performance measurement;
   c. Identifying and prioritizing quality deficiencies;
   d. Systematically analyzing underlying causes of systemic quality deficiencies;
   e. Developing and implementing corrective action or performance improvement activities; and
   f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.
3. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan.

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Disclosure of Information

1. Information regarding QAPI activities may be disclosed only in accordance with applicable laws and regulations.

2. The QAPI Plan is presented to the State Survey Agency annually during the recertification survey, and as requested during any other survey or by CMS.

3. Protection from disclosure is generally afforded documents generated by the QAPI committee, such as minutes, internal papers, or conclusions, unless these documents contain the evidence necessary to determine compliance with QAPI regulations.
   a. Surveyors may require facilities to disclose QAPI committee records (which they may review and copy) to determine the extent to which facilities are compliant with QAPI regulations.
   b. Surveyors may not use this information as a basis to cite new deficiencies, or to expand the scope and severity of already identified concerns.

4. Incident and accident reports, wound logs, or other reports or records used to track adverse events are not protected from disclosure. Surveyors may request these documents as part of their normal investigation of other areas of concern throughout the survey to support their findings.

5. Only documents and information covered under The Federal Patient Safety and Quality Improvement Act of 2005 ("patient safety work product") and are part of a patient safety evaluation system (PSES) are protected from disclosure.

Coordination

1. The QAPI Coordinator coordinates QAPI Committee activities and changes to the QAPI Plan.

2. The QAPI Coordinator assists other committees, individuals, departments, and/or services in developing quality indicators, monitoring tools, assessment methodologies and documentation, and in making adjustments to the plan.

3. The QAPI Coordinator serves as a liaison between the QAPI Committee and individuals, services, and/or departments regarding QAPI activities.

References	
OBRA Regulatory Reference Numbers	§483.75(a) Quality assurance and performance improvement (QAPI) program
Survey Tag Numbers	F865
Other References	The Federal Patient Safety and Quality Improvement Act of 2005 (PSQIA)
Related Documents	Quality Assurance and Performance Improvement (QAPI) Program – Design and Scope
Version	1.2 (H5MAPL0698)

Acute Care Transfer Log

INTERACT
Version 3.0 Tool

You can use this tool as a worksheet for recording all acute care transfers during a month. Print more pages as needed. This tool is not necessary if you use the **INTERACT Hospitalization Rate Tracking Tool**, which allows you to enter the data directly into an Excel spreadsheet, and calculates rates and generates reports. A similar tracking tool is available through the Advancing Excellence Campaign in America's Nursing Homes at www.nhqualitycampaign.org

Facility Name ______________________________ **Month / Year** ________ / ________

Resident ID	Date of Most Recent Admission to Facility	Admitted to Facility from[1] *(circle)*	Status on Admission[2] *(circle)*	Date of Acute Care Transfer	Time of Transfer *(circle AM or PM)*	Outcome of Transfer[3] *(circle)*	Reason for Transfer[4]
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	
	/ /	Hosp H O	PAC LTC	/ /	AM PM	IP OBS ER	

1 **Hosp** = acute care hospital; **H** = home; **O** = Other location

2 **PAC** = post-acute care *(most often Medicare Part A skilled care)* for rehabilitation and/or management of medical or post-surgical conditions; **LTC** = long-term care

3 **IP** = admitted as an inpatient; **OBS** = admitted on observation status; **ER** = emergency room visit only with return to the facility *(includes residents who die in the ambulance or ER)*

4 Examples of options on the above referenced Tracking Tools: Bleeding, Cellulitis, Chest Pain, CHF, COPD, Dehydration/Electrolyte Imbalance, Fall, GI *(vomiting, diarrhea, pain)*, Pneumonia/Respiratory Infection, Seizure, Sepsis, Shortness of Breath, UTI, Other

Tab Three

Worksheet and Forms

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES
Qsource.

Quality Improvement
Summary Worksheet

INTERACT
Version 3.0 Tool

This Worksheet is a guide to learning from individual root cause analyses of hospital transfers. It can be used to summarize findings documented on INTERACT **Quality Improvement (QI) Tools** to determine if there are common factors involved in your hospital transfers. Identifying these common factors will help focus your education and care process changes in order to further improve care and reduce potentially preventable hospital transfers. An Excel template **QI Summary Worksheet** is also available on the INTERACT website. There are several steps involved, which are outlined below.

STEP 1: Document the number and timeframe of completed QI Tools included in this summary

1. Number of completed QI Review Forms included in this summary: _____
2. Time frame of completed QI Review Forms: From _____ to _____

STEP 2: Compare the answers across each section of the QI Review Tools. Circle 'Yes' for the same or similar answers across a majority of the completed QI Tools

A. Resident characteristics

1. Age of residents transferred to the hospital *(e.g. are most over 85?)* Yes
2. Length of stay prior to hospital transfers? *(e.g. less than 7 days)* Yes
3. Risk factors for hospitalizations? Yes
   (note which ones)
4. Diagnoses associated with hospitalizations? Yes
   (Note which ones)

B. Changes in condition that lead to transfer

1. Signs or symptoms that led to the transfers? Yes
   (Note which ones)

C. Actions taken prior to the transfers

1. Tools that were used to manage the change in condition prior to the transfer? Yes
2. Tools that might have been used but were <u>not</u>? Yes
3. Type of medical evaluation conducted prior to the transfers? Yes
4. Timing of advance care planning discussions with resident and/or family? Yes

Findings

(continued)

Quality Improvement
Summary Worksheet (cont'd)

INTERACT®
Version 3.0 Tool

D. Hospital transfer and contributing factors

1. Day of the week of hospital transfer? ..... Yes
2. Time of day of hospital transfer? ..... Yes
3. MD/NP/PA authorizing the transfer? ..... Yes
4. Non-clinical factors that contributed to the hospital transfer?
   a. MD/NP/PA insisted on transfer? ..... Yes
   b. Resident preferred or insisted on transfers? ..... Yes
   c. Family members preferred or insisted on transfers? ..... Yes
   d. Resources needed to provide care in NH not available? ..... Yes
   e. Facility policies do not support providing care in NH? ..... Yes

Findings .....

.....

.....

E. Transfers rated as potentially preventable

1. Factors related to transfers rated as preventable? ..... Yes
2. Reasons provided for preventable transfers? ..... Yes

Findings .....

.....

.....

STEP 3: Summarize Common Factors Across

1. What factors were most common and similar across QI Tools?

_____

_____

_____

2. Based on this summary what areas would you target for:

a. Staff education: _____

_____

b. Care process changes: _____

_____

c. Other improvement efforts: _____

_____

Measure/Indicator Collection and Monitoring Plan

Directions: For each measure/indicator that you choose to collect and monitor for QAPI, answer the following questions. The information gleaned from these questions will help you determine how best to track, display and assess or evaluate the results of the various measures you have chosen for QAPI. If you have a relatively small number of measures or indicators that you are tracking, you may wish to include all measures in one table and use this as an overview tool that could be completed by the person coordinating QAPI in your organization. Alternatively, you may choose to use this table for individual measures or groupings of measures that address similar topics.

What are we measuring (measure/indicator)?	When are we measuring this (frequency)?	How do we measure this (where do we get our data)?	Who is responsible for tracking on this measure?	What is our performance goal or aim?	How will data findings be tracked and displayed?
Example: High risk pressure ulcers	Quality Indicator (QI) monthly report	Data comes from MDS assessments	DON	<6%	DON uses Excel run chart template to document monthly rates over time. DON also tracks and graphs the number of in house acquired versus admitted pressure ulcers, pressure ulcers by stage, and time to heal. Results are provided to QAPI committee and posted in "North" conference room.
Example: Staff satisfaction	Yearly – April	Corporate satisfaction survey	Administrator	Participation rate: 70% Overall satisfaction: xx%	Administrator uses bar chart to show results for individual satisfaction

What are we measuring (measure/indicator)?	When are we measuring this (frequency)?	How do we measure this (where do we get our data)?	Who is responsible for tracking on this measure?	What is our performance goal or aim?	How will data findings be tracked and displayed?
				Would recommend as place for care: xx% Would recommend as place to work: xx%	questions and key composite measures for current and previous 3 years. Results are provided to QAPI committee and posted in "North" conference room.
Example: Staff turnover	Monthly and annualized	Human resources department	Human Resources Director	<20%	Human Resources Director uses the Advancing Excellence in America's Nursing Homes "Monitoring Staff Turnover Calculator." Results reviewed at QAPI committee.

What are we measuring (measure/indicator)?	When are we measuring this (frequency)?	How do we measure this (where do we get our data)?	Who is responsible for tracking on this measure?	What is our performance goal or aim?	How will data findings be tracked and displayed?

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)
Performance Improvement Team Documentation

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)
Performance Improvement Team Documentation

TASKS	RESPONSIBLE TEAM MEMBER	START DATE	ESTIMATED COMPLETION DATE	ACTUAL COMPLETION DATE	COMMENTS (STATUS, OUTCOMES, EVALUATION, ETC.)

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)
Performance Improvement Team Documentation

PDSA Cycle Template

Directions: Use this Plan-Do-Study-Act (PDSA) tool to plan and document your progress with tests of change conducted as part of chartered performance improvement projects (PIPs). While the charter will have clearly established the goals, scope, timing, milestones, and team roles and responsibilities for a project, the PIP team asked to carry out the project will need to determine how to complete the work. This tool should be completed by the project leader/manager/coordinator with review and input by the project team. Answer the first two questions below for your PIP. Then as you plan to test changes to meet your aim, answer question 3 below and plan, conduct, and document your PDSA cycles. Remember that a PIP will usually involve multiple PDSA cycles in order to achieve your aim. Use as many forms as you need to track your PDSA cycles.

Model for Improvement: Three questions for improvement

1. **What are we trying to accomplish (aim)?**
   State your aim (review your PIP charter – and include your bold aim that will improve resident health outcomes and quality of care)

2. **How will we know that change is an improvement (measures)?**
   Describe the measureable outcome(s) you want to see

3. **What change can we make that will result in an improvement?**

   Define the processes currently in place; use process mapping or flow charting

   Identify opportunities for improvement that exist (look for causes of problems that have occurred – see Guidance for Performing Root Cause Analysis with Performance Improvement Projects; or identify potential problems before they occur – see Guidance for Performing Failure Mode Effects Analysis with Performance Improvement Projects) (see root cause analysis tool):
   - Points where breakdowns occur
   - "Work-a-rounds" that have been developed
   - Variation that occurs
   - Duplicate or unnecessary steps

   Decide what you will change in the process; determine your intervention based on your analysis
   - Identify better ways to do things that address the root causes of the problem
   - Learn what has worked at other organizations (copy)
   - Review the best available evidence for what works (literature, studies, experts, guidelines)
   - Remember that solution doesn't have to be perfect the first time

Plan What change are you testing with the PDSA cycle(s)? What do you predict will happen and why? Who will be involved in this PDSA? (e.g., one staff member or resident, one shift?). Whenever feasible, it will be helpful to involve direct care staff. Plan a small test of change. How long will the change take to implement? What resources will they need? What data need to be collected?	**List your action steps along with person(s) responsible and time line.**
Do Carry out the test on a small scale. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage.	**Describe what actually happened when you ran the test.**

Study Study and analyze the data. Determine if the change resulted in the expected outcome. Were there implementation lessons? Summarize what was learned. Look for: unintended consequences, surprises, successes, failures.	**Describe the measured results and how they compared to the predictions.**
Act Based on what was learned from the test: Adapt – modify the changes and repeat PDSA cycle. Adopt – consider expanding the changes in your organization to additional residents, staff, and units. Abandon – change your approach and repeat PDSA cycle.	**Describe what modifications to the plan will be made for the next cycle from what you learned.**

Measure/Indicator Development Worksheet

Directions: Use this worksheet to develop a performance measure/indicator. A new measure/indicator might be created as part of your overall QAPI monitoring or for a Performance Improvement Project. You will likely want to use existing measures when possible, but there may be times when you want to develop a new measure/indicator that is specific to your needs.

Note: What is the difference between an indicator and a measure? An indicator provides evidence that a certain condition exists but does not clearly identify the situation or issue in any detail. Indicators enable decision-makers to assess progress towards the achievement of intended outputs, outcomes, goals, and objectives. A measure is a stronger reflection of the underlying concept; a more developed and tested way of describing the concept that is being evaluated. However, in practice the two terms are used interchangeably.

MEASURE/INDICATOR OVERVIEW

NAME OF MEASURE/INDICATOR:
Example: Residents with a completed skin assessment within 12 hours of admission.

PURPOSE OR INTENT FOR MEASURE/INDICATOR:
Example: The purpose of this measure is to make sure our process of completing a skin assessment within 12 hours of admission is done consistently.

MEASURE/INDICATOR TYPE:

__ **Structural Measure:** Structural measures focus on the fixed characteristics of an organization, its professionals and staff. These measures distinguish between a capability or asset and the activity that may rely on that structure. In addition, structural measures are typically based on the organization or professional as the unit of assessment in the denominator. Example: The extent to which a facility use of electronic health records is implemented facility-wide. Numerator = Number of departments with EHR; Denominator = Number of all departments in facility.

__ **Process Measure:** Process measures assess the steps or activities carried out in order to deliver care or services. These measures focus on the action by professionals and staff. Consideration should be given to sample sizes for denominators, exclusion criteria, and alternative processes or work-arounds that may exist. Example: The percentage of newly admitted residents receiving admission skin assessments.

__ **Outcome Measure:** Outcome measures focus on the product (or outcome) of a process or system of care or services, which can identify different or more complex underlying causes. Example: The rate or incidence of nursing home acquired pressure ulcers.

The measure in the example above (residents with a completed skin assessment within 12 hours of admission) is a process measure.

DEFINING THE MEASURE/INDICATOR SPECIFICATIONS	
NUMERATOR: (i.e., when will a person or event be counted as having met the desired result – this is the top number of the fraction you will calculate)	*Example: any resident with a completed skin assessment within 12 hours of admission* *Numerator: 19*
DENOMINATOR: (i.e., what is the total pool of persons or events you will be counting – this is the bottom number of the fraction you will calculate)	*Example: all residents admitted in last month. Denominator= 23*
EXCLUSION CRITERIA: (i.e., is there any reason you would exclude a particular person or event from the denominator count?]	*Example: exclude those residents in the nursing home for less than 24 hours because all assessment data not available* *Denominator after exclusions: 20*
RESULT CALCULATION: (i.e., typically expressed as Numerator/Denominator x 100 = rate %)	*Example: 19 / 20 X 100 = 90%*
INDICATOR/MEASURE GOAL: (i.e., the numerical goal aimed for – may be based on an already-established goal for the particular indicator)	*Example: Goal = 100%*
INDICATOR/MEASURE THRESHOLD: (i.e., the minimum acceptable level of performance)	*Example: Threshold = 95%*

MEASURE/INDICATOR DATA COLLECTION	
DATA SOURCE:	*Example: Medical records, admission skin assessment form*
SAMPLE SIZE AND METHODOLOGY: (i.e., will you measure the total population under study or draw a sample to represent the whole? If sampling, how large will the sample size be? How will you determine the sample?)	*Example: The total population admitted in the last month who were in the nursing home for at least 24 hours will be reviewed.*
FREQUENCY OF MEASUREMENT: (i.e., how frequently will the indicator result be calculated: daily, weekly, monthly, quarterly, annually?)	*Example: Monthly*
DURATION: (i.e., what is the timeframe for which	*Example: Will collect this data for three consecutive months; then based on findings, will either develop corrective action and continue*

the data will be collected: number of cases/events in the past weeks, months, quarters? This will depend on how frequently cases/events occur.)	*monitoring monthly, or consider decreasing frequency of monitoring.*

Prioritization Worksheet for Performance Improvement Projects

Directions: This tool will assist in choosing which potential areas for improvement are the highest priority based on the needs of the residents and the organization. Follow this systematic assessment process below to identify potential areas for PIPs. This process will consider such factors as high-risk, high-volume, or problem-prone areas that affect health outcomes and quality of care. This tool is intended to be completed and used by the QAPI team that determines which areas to select for PIPs. Begin by listing potential areas for improvement in the left-hand column. Then score each area in the following columns based on a rating system of 1 to 5 as defined below:

1 = very low	2 = low	3 = medium	4 = high	5 = very high

Rating is subjective and is meant to be a guide and to stimulate discussion. Finally, add the scores across the row and tally in the final column. Potential improvement areas with a higher score indicate a higher priority.

POTENTIAL AREAS FOR IMPROVEMENT Consider areas identified through: Dashboard(s) Feedback from staff, families, residents, other Incidents, near misses, unsafe conditions Survey deficiencies	**PREVALENCE** The frequency at which this issue arises in our organization.	**RISK** The level to which this issue poses a risk to the well-being of our residents.	**COST** The cost incurred by our organization each time this issue occurs.	**RELEVANCE** The extent to which addressing this issue would affect resident quality of life and/or quality of care.	**RESPONSIVENESS** The likelihood an initiative on this issue would address a need expressed by residents, family and/or staff.	**FEASIBILITY** The ability of our organization to implement a PIP on this issue, given current resources.	**CONTINUITY** The level to which an initiative on this issue would support our organizational goals and priorities.	**TOTAL SCORE TALLY**

Additional factors to take into account:

1. What existing standards or guidelines are available to provide direction for this initiative?
2. What measures can be used to monitor progress?
3. Is the topic publicly reported on Nursing Home Compare and/or is it a goal of the Advancing Excellence in America's Nursing Homes campaign?
4. Which type of changes primarily will be involved (i.e., system changes, environmental changes, staffing changes)?
5. Which staff will be most affected by the initiative? What training needs will this initiative present?
6. Is there an identified champion(s) for this initiative?

Worksheet to Create a Performance Improvement Project Charter

What is a project charter? A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an Improvement Project (PIP). The charter is typically developed by the QAPI team and then given to the team that will carry out the PIP, so that the PIP team has a clear understanding of what they are being asked to do. The charter is a valuable document because it helps a team stay focused. However, the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish.

Use this worksheet to define key charter components.

PROJECT OVERVIEW

Name of project:
Example: Reduction in use of position change alarms

Problem to be solved:
Example: Alarms going off frequently detract from a homelike environment and may give staff a false sense of security.

Background leading up to the need for this project:
Example: Residents and families have complained about the sound of alarms going off frequently. Staff feel pressure to do "something" when a resident falls.
[Tip: Reference specific background documents, as needed.]

The goal(s) for this project:
Example: Decrease the percentage of residents with position change alarms used on XX unit by 25% by XX/XX/XX.
[Tip: See Goal Setting Worksheet]

Scope—the boundary that tells where the project begins and ends.
The project scope **includes:**
Example: Use of position change alarms on XX unit.

PROJECT APPROACH

Recommended Project Time Table:

PROJECT PHASE	START DATE	END DATE
Initiation: Project charter developed and approved		
Planning: Specific tasks and processes to achieve goals defined		
Implementation: Project carried out		
Monitoring: Project progress observed and results documented		
Closing: Project brought to a close and summary report written		

Project Team and Responsibilities:

TITLE	ROLE	PERSON ASSIGNED
Project Sponsor	Provide overall direction and oversee financing for the project	
Project Director	Coordinate, organize and direct all activities of the project team	
Project Manager	Manage day-to-day project operations, including collecting and displaying data from the project	
Team members*		

*Choice of team members will likely be deferred to the project manager based on interest, involvement in the process, and availability.

Material Resources Required for the Project (e.g., equipment, software, supplies):

Barriers

What could get in the way of success?	What could you do about this?
Example: A resident could fall and staff could automatically blame the lack of an alarm.	*Example:* Educate staff on the lack of relationship between alarms and falls; collect data on removal of one alarm at a time.
Example: Staff complaints of need for additional staff to watch everyone if alarms are removed.	*Example:* Focus on anticipation of resident needs, and assess if additional hands-on-deck are needed during busy times on unit.

PROJECT APPROVAL

The signatures of the people below relay an understanding and approval of the purpose and approach to this project. By signing this document you agree to establish this document as the formal Project Charter and sanction work to begin on the project as described within.

TITLE	NAME	SIGNATURE	DATE
Administrator			
Project Sponsor			
Project Director*			
Project Manager*			

*May not always have both roles.

Performance Improvement Project (PIP) Launch Check List: Helpful hints for project leaders, managers, or coordinators

Directions: Use this check list to ensure you have covered important steps in launching your performance improvement project. This tool is intended to be used by the person asked to lead a PIP or any project where a team has been formed. Use this check list to make sure you have everything you need in place when you start a project. Ensuring you have these steps in place can help you save time and confusion down the road.

Project Name:

Project Stakeholders and Team Members

- ☐ The team has received a project charter that has been approved by the leadership.
- ☐ The project team has been assembled and roles and responsibilities have been assigned.
- ☐ The project charter is understood and accepted by all project team members.
- ☐ The project team understands how the project fits with the overall goals of the organization.
- ☐ Each project team member understands how his/her assignment fits into the overall project.
- ☐ The project and its goals have been communicated to stakeholders outside of the project team, as needed (e.g., residents and families, staff, board of directors, owners).

Project Resources

- ☐ Financial support for the project has been obtained.
- ☐ A project budget has been established.
- ☐ Staff time to work on the project has been allocated.
- ☐ Material resources required for the project have been identified and secured.

Project Process

- ☐ A detailed timeline and work plan have been created.
- ☐ Training needs have been identified and training has been conducted.
- ☐ A schedule for regular project team meetings has been set.
- ☐ Indicators/measures have been established to monitor project goals (see Goal Setting Worksheet).
- ☐ The format and frequency for documenting project status has been defined.
- ☐ The format, frequency, and audiences for communicating project status has been defined.
- ☐ A process to identify issues that come up during this project is established (e.g., unintended consequences, new opportunities for process changes, surprises).
- ☐ The location for storing all project documents, and processes for file naming conventions and version control has been established.
- ☐ The time for project kickoff has been identified and any related activity required (e.g., announcement, meeting, event) has been planned.

Sustainability Decision Guide

Directions: This is a resource to help leaders or teams determine if the interventions and changes they are making are sustainable. This guide will help identify why interventions may not be sustainable, and therefore need to be reconsidered. Use this guide at any point during a Performance Improvement Project (PIP), ideally when strategies have been found that appear to be successful and consideration is being given to adopting them broadly within the organization. The more questions that can be answered as "yes," the higher the likelihood of sustainability.

SYSTEMS

- ☐ Has the change been defined in terms of how it fits with the overall organizational mission, vision and strategic plan?
- ☐ Are there policies and procedures written in support of the change?
- ☐ Are those who need to carry out the new actions up to date with the information they need to be successful?
- ☐ Have the organization's systems been revised to encourage the new action? How are staff members reminded to carry out the new actions? Are you monitoring that the new actions are being carried out and is staff being supported in their ability to carry out the new actions?
- ☐ Are there system barriers that prevent the new action from occurring? Are there certain identifiable parts of the system that pose a roadblock to doing things in the new way?
- ☐ Are there incentives or rewards for people who do not adopt the new action that need to be addressed or removed?
- ☐ Has the change been integrated into new employee orientation and training?

PEOPLE

- ☐ Has strong leadership support for the change been established? Has the leadership communicated a clear and convincing message about the change and its purpose? Are multiple levels of leadership engaged (e.g., board of directors, administrator, and department managers)? Is the leadership vocal and visible in its support? How will the leadership continue to promote the change and encourage staff to stick with it over time?
- ☐ Have roles and responsibilities for carrying out new actions been clearly defined and assigned?

- ☐ Are the people responsible for carrying out the change equipped to manage it? Do staff members have the appropriate skills and knowledge to successfully undertake any new actions required? Have training needs been addressed? Is additional or differently trained staff required?

- ☐ Are there champions for the change who are actively modeling the desired actions? Are there informal or natural leaders among the staff who could be encouraged to act as role models? Are there members of your staff exhibiting clear resistance to the change that should be addressed?

ENVIRONMENT

- ☐ Is the organization ready to take on this change? What issues in the workplace culture should be addressed before the change can be expected to become permanent? Is the reason given for the change in line with the values and attitudes of the staff?

- ☐ Has adequate funding (if applicable) been budgeted to support the change?

- ☐ Have resources (equipment, materials, staff time, information) been made available? What additional resources would help to encourage the new actions to take place?

- ☐ Are there things that can be done to the physical environment that make it unavoidable to do things in the new way (e.g., automation of processes; removal of certain objects necessary to do things the previous way)?

MEASUREMENT

- ☐ Has ongoing periodic measurement and review been scheduled to ensure the new action has been adopted and is performed consistently?

- ☐ Are indicators/measures chosen that tie directly to the new action? Can the indicator/measure distinguish the performance of different work groups (e.g., by unit, department, shift)? Are some work units carrying out the change more successfully than others? Can lessons for success be learned from certain work units and shared with others?

- ☐ Can certain indicators/measures be reviewed more frequently (even daily) by staff to show incremental changes, which can serve as a reminder for the new action and provide encouragement and reinforcement?

- ☐ Does measurement point to any changes in procedure that should be made to help facilitate the change?

Storyboard Guide for PIPs

Directions: A storyboard is a tool that can be used to simply and clearly communicate the story of a performance improvement project (PIP). The aim of a storyboard is to allow audiences to quickly grasp the main points of the story by providing only the most essential information and including one or more easy-to-understand charts that demonstrate the impact of the effort.

Storyboards may be presented in various formats, such as a one-two page handout, a large display poster, or even as presentation slides. The same key content should be presented in each. This guide is intended to be used by the person leading QAPI efforts in your facility, administrative leaders, or any other staff needing to communicate to an audience the results of a specific performance improvement project. An example of a storyboard is included in this guide.

Key Content to Include in your Storyboard:

1. **Problem.** One sentence on the issue or opportunity being addressed by this PIP.
2. **Aim.** One sentence on what this PIP aims to achieve.
3. **Intervention(s).** Briefly describe what change was introduced to address the problem or opportunity. If there was more than one change, use bullet points to list the multiple interventions.
4. **Measures/Indicators.** List what measure(s) or indicator(s) are being used to monitor whether the change is effective.
5. **Results.** One to two sentences on the results. Consider including a graph with notes that gives a picture of the impact of the changes over time, or stories that describe the success.
6. **Lessons Learned.** Document 1-2 key lessons that were learned through the PIP.
7. **Next Steps.** Performance improvement is a continuous process. In one to two sentences, describe the next steps (e.g., to further refine the intervention; to introduce the change in other parts of the nursing home; to take steps to standardize the change).

Depending on space limitations and the nature of your audience, you may choose to include additional information such as pictures or images that help bring the story to life; the names of the PIP team members; a description or visual of any quality improvement tools utilized; specific references from the literature that support the change approach.

Example of a storyboard starts on the next page:

Sunnyside Nursing Home
Busy City, Massachusetts
November 21, 2012

Problem: Beginning in April 2011, Sunnyside began to see an increase in pressure ulcers among its high-risk residents; in June 2011, more than 10% of high-risk residents had been diagnosed with a pressure ulcer.

Aim: To reduce the occurrence of pressure ulcers in high-risk residents to less than 5% by November 2012.

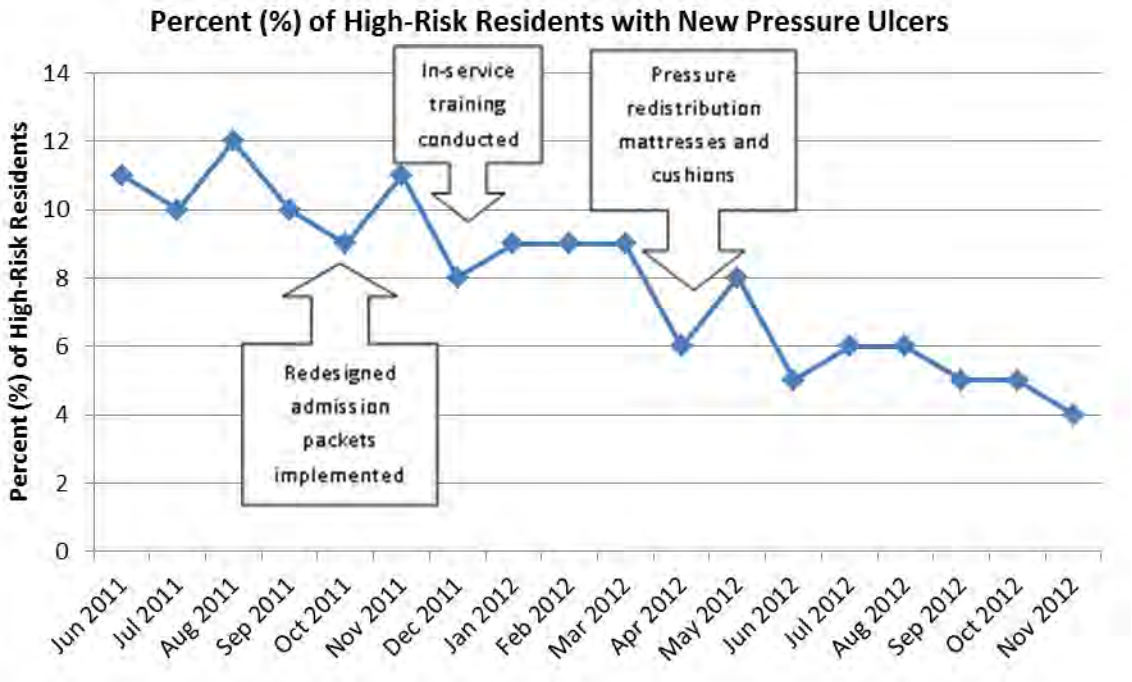
Interventions:

- Redesign admissions packet to include the comprehensive pressure ulcer risk assessment form, to be completed within a resident's first 24 hours of admission;
- Require a half day in-service training for all nursing assistants and licensed nursing staff on assessment for pressure ulcer risk and prevention;
- Utilize pressure redistribution mattresses for all residents at high-risk for pressure ulcers.
- Utilize pressure redistribution wheel chair cushions as applicable for all residents at high-risk for pressure ulcers.

Measures:

- Process measure: Number of new residents with completed pressure ulcer risk assessment with 24 hours of admission (Measure Goal: 100% of new residents by March 2012).
- Process measure: Number of residents at high risk for pressure ulcers with pressure redistribution mattresses. (Measure Goal: 100% of residents at high risk for pressure ulcers will have pressure redistribution mattresses by May 2012)
- Process measure: Number of residents at high risk for pressure ulcers and that use a wheel chair, with pressure redistribution wheel chair cushions. (Measure Goal: 100% of high risk residents using wheel chairs will have pressure redistribution cushions for their wheelchairs by May 2012)
- Outcome measure: Percent of high-risk residents with new, nursing home-acquired pressure ulcers (Measure Goal: Less than 5% by November 2012).

Results: As of April 2012, all new residents at Sunnyside received a comprehensive pressure ulcer risk assessment with 24 hours of admission. 100% of high risk residents have pressure redistribution mattresses. 100% of high risk residents that use a wheel chair have a pressure redistributing wheelchair cushion. The facility experienced a reduction in new pressure ulcers among high-risk residents over the 18-month period, from a high of 12% in August 2011 to a low of 5% in November 2012.



Lessons Learned:

- Although Sunnyside had a policy in place that each new resident should receive a pressure ulcer risk assessment, the admission packets were not set-up to help prompt staff to do so consistently with each admission.
- Nursing staff need more frequent training on pressure ulcer risk assessment and prevention.

Next Steps:

- Continue monitoring to make sure current pressure ulcer rates are maintained or improve.
- Integrate the pressure ulcer assessment tool into the facility's electronic resident records system.
- Develop a more frequent training program on pressure ulcers for nursing staff.

Contact Information:

If you have any questions about this information, please contact xxx at xxx.

Source: Adapted with permission from the Institute for Healthcare Improvement (http://www.IHI.org).

QAPI Leadership Rounding Guide

Directions: Leadership rounding is a process where leaders (e.g., administrator, department heads, and nurse managers) are out in the building with staff and residents, talking with them directly about care and services provided in the organization including QAPI initiatives. Rounding with staff and residents is an effective method for leaders to hear firsthand what is going well and what issues need to be addressed within the organization. It serves as an important signal of leadership's commitment to performance improvement, and promotes a culture of QAPI in the organization. Use this to guide your rounds to monitor the progress of QAPI initiatives.

Questions to Consider Before Rounding

1. Which leader(s) will conduct rounds?
2. How frequently will rounds take place?
3. What questions do you want to ask? What do you want to learn? (See sample questions below.)
4. What barriers/issues have already been identified that employees should be asked about in order to gather input on solutions?

Rounding

1. Leaders conduct rounds as planned, maintaining a positive tone, building relationships with staff by taking the time to listen and respond to employees' and residents' needs.
2. Ask questions and document key points. See **optional** rounding form below.
3. When employees raise issues or ask for help, assure them you will follow up.
4. Follow up on previous issues or requests —share with staff how the issues were addressed or resolved.

To Do After Rounding

1. Identify frequently noted issues/themes.
2. Prioritize issues (e.g., by level of urgency, threat, ability to resolve).
3. Conduct follow-up to show responsiveness to the issues raised (note: this may involve following up with employees individually, developing an organizational report that outlines the input collected and proposed solutions—potentially utilizing the priority levels developed in step #2—or including the findings as a component to be communicated during the next rounding session).
4. Consider ways to acknowledge outstanding employee/unit efforts (e.g., thank you notes or other rewards/recognition).
5. Identify training or coaching opportunities for employees/units. Plan next rounding session.

Rounding Form

PERSON CONDUCTING ROUNDS:_____DATE:_____UNIT(S):_____

BACKGROUND: *(to be completed prior to rounding)*

TOPIC
___Specific PIP(s): _____
___Specific aspect of care (e.g., bathing, medication reconciliation) _____
___Specific work place or workflow issue _____
___Other _____

Information needed prior to rounding:
What is your organization trying to achieve?
How will improvement be recognized?
Current data or description of performance:
Improvements made to-date:

BARRIERS/ISSUES ALREADY KNOWN: *(sharing these may be an opportunity to ask for staff input on solutions)*

PREVIOUS BARRIERS/ISSUES THAT HAVE BEEN ADDRESSED BY LEADERSHIP: *(reporting these back to staff shows responsiveness)*

Questions for leaders to ask staff (include any qualitative and quantitative information obtained).

What things are going well around this initiative or this aspect of care or service? What evidence do you see of success?	*Notes:*
What is <u>frustrating</u> you with the work around this initiative or this aspect of care or service? What barriers/issues do you see threatening this initiative or aspect of care or service? How should they be addressed?	*Notes:*

What additional resources/tools/equipment are needed?	*Notes:*
Are there any colleagues who deserve special recognition for their efforts on this initiative or this aspect of care or service?	*Notes:*
Are there any colleagues who could be helped through coaching/training to make this initiative or aspect of care or service more successful?	*Notes:*
What feedback, if any, have you heard from residents and families about changes taking place as part of this initiative or this aspect of care or service?	*Notes:*
What else would you like the leadership to know about this initiative or this aspect of care or service?	*Notes:*

Leaders –summarize notes from conversations you had with residents or families on this topic:

Quality Improvement Tool
For Review of Acute Care Transfers

INTERACT
Version 4.0 Tool

The **INTERACT QI Tool** is designed to help your team analyze hospital transfers *(including ER visits, observation stay and admissions)* and identify opportunities to reduce transfers that might be preventable. Complete this tool for each or a representative sample of hospital transfers in order to conduct a root cause analysis and identify common reasons for transfers. Examining trends in these data with the **INTERACT QI Summary Tool** can help you focus educational and care process improvement activities.

Patient/Resident_____ Age _____

Date of most recent admission to the facility_____/_____/_____

Primary goal of admission: ☐ Post-acute care ☐ Long-stay ☐ Others:_____

SECTION 1: Risk Factors for Hospitalization and Readmission

a. Conditions that put the resident at risk for hospital admission or readmission:

☐ Cancer, on active chemo or radiation therapy
☐ Heart Failure *(HF)*
☐ Congestive Obstructive Pulmonary Disease *(COPD)*
☐ Dementia
☐ Diabetes
☐ End-stage renal disease
☐ Fracture *(Hip)*
☐ High Risk Medications
☐ Anticoagulant ☐ Diabetic Agent ☐ Opioids
☐ Multiple active diagnoses and/or co-morbidities
(e.g. HF, COPD and Diabetes in the same patient/resident)
☐ Polypharmacy *(e.g. 9 or more medications)*
☐ Surgical complications

b. Was Patient/Resident hospitalized in the ***30 days before their most recent admission to the facility?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

_____

c. Other hospitalizations or emergency department visits in the ***past 12 months?*** ☐ No ☐ Yes *(list dates and reasons)*
(Other than the one being reviewed in this tool)

_____

SECTION 2: Describe the Acute Change in Condition and Other Non-Clinical Factors that Contributed to the Transfer

a. Date the change in condition first noticed_____/_____/_____

b. Briefly describe the change in condition and other factor(s) that led to the transfer and then check each item below that applies

_____

_____

c. Vital signs at time of transfer

Temp _____ Pulse_____ Pulse Ox *(if indicated)*_____% on ☐ Room Air ☐ O_2 (_____)

Respiratory rate_____ BP_____/ _____ Glucose *(diabetics)*_____

Quality Improvement Tool

For Review of Acute Care Transfers (cont'd)

INTERACT
Version 4.0 Tool

d. Check ***all*** that apply

New or Worsening Symptoms or Signs

- ☐ Abdominal distention/suspected bowel obstruction
- ☐ Abdominal Pain
- ☐ Abnormal vital signs *(low/high BP, high/low respiratory rate)*
- ☐ Altered mental status
- ☐ Behavioral symptoms *(e.g. agitation, psychosis)*
- ☐ Bleeding *(other than GI)*
- ☐ Cardiac arrest
- ☐ Chest pain
- ☐ Constipation
- ☐ Cough
- ☐ Dehydration/volume depletion
- ☐ Diarrhea
- ☐ Dizziness/vertigo
- ☐ Edema *(new or worsening)*
- ☐ Fall
- ☐ Fever
- ☐ Food and/or fluid intake *(decreased or unable to eat and/or drink adequate amounts)*
- ☐ Function decline *(worsening function and/or mobility)*
- ☐ GI bleeding, blood in stool
- ☐ Hematoma
- ☐ Hypertension *(uncontrolled)*
- ☐ Hypoxia – (*low p O2<90)*
- ☐ Loss of consciousness *(syncope, other)*
- ☐ Nausea/vomiting
- ☐ Pain *(uncontrolled)*
- ☐ Respiratory arrest
- ☐ Respiratory infection *(bronchitis, pneumonia)*
- ☐ Shortness of breath
- ☐ Seizure
- ☐ Skin wound or pressure ulcer/injury
- ☐ Stroke / TIA / CVA
- ☐ Trauma *(fall-related or other)*
- ☐ Unresponsive
- ☐ Urinary incontinence
- ☐ Weight loss
- ☐ Other *(describe)*

Abnormal Labs or Tests Results

- ☐ Blood sugar *(high)*
- ☐ Blood Sugar *(low)*
- ☐ EKG
- ☐ Hemoglobin or hematocrit *(low)*
- ☐ INR *(high)*
- ☐ Kidney function *(BUN, Creatinine)*
- ☐ Pulse oximetry *(low oxygen saturation)*
- ☐ Urinalysis or urine culture
- ☐ White blood cell count *(high)*
- ☐ X-ray
- ☐ Other *(describe)*

Diagnosis or Presumed Diagnosis

- ☐ Acute renal failure
- ☐ Anemia *(new or worsening)*
- ☐ Asthma
- ☐ Cellulitis
- ☐ COPD *(Chronic Obstructive Pulmonary Disease)*
- ☐ DVT *(Deep Vein Thrombosis)*
- ☐ Fracture (site:_____)
- ☐ HF *(Heart Failure)*
- ☐ Pneumonia
- ☐ Sepsis
- ☐ UTI *(Urinary Tract Infection)*
- ☐ Other *(describe)*
- ☐ Need for diagnostic and other procedures including transfusions
  - ☐ Gastrostomy tube blockage or displacement
  - ☐ Transfusion *(planned)*
  - ☐ Other

Other Factors Contributing to the Transfer

- ☐ Advance directive not in place
- ☐ Clinician insisted on transfer despite staff willing to manage in facility
- ☐ Direct admission *(from dialysis or other specialty office)*
- ☐ Discharged from the hospital too soon
- ☐ Family members/representative preferred or insisted on transfer
- ☐ Planned admission *(for surgery or other procedure)*
- ☐ Resident preferred or insisted on transfer
- ☐ Resources to provide care in the facility were not available
- ☐ Other *(describe)*

Quality Improvement Tool
For Review of Acute Care Transfers (cont'd)

INTERACT
Version 4.0 Tool

SECTION 3: Describe Action(s) Taken to Evaluate and Manage the Change in Condition Prior to Transfer

a. Briefly describe how the changes in Section 2 were evaluated and managed and check each item that applies

_____

_____

b. Check *all* that apply

Tools Used
- ☐ Stop and Watch
- ☐ SBAR
- ☐ Care Path*(s)*
- ☐ Change in Condition File Cards
- ☐ Transfer Checklist
- ☐ Acute Care Transfer Form *(or an equivalent paper or electronic version)*
- ☐ Advance Care Planning Tools
- ☐ Infection or Sepsis Guidance
- ☐ Other Structured Tool or Form *(describe)*

Medical Evaluation
- ☐ Telephone only
- ☐ NP or PA visit
- ☐ Physician visit
- ☐ Other *(e.g. in a specialist office or while on dialysis)*

Testing
- ☐ Blood tests
- ☐ EKG
- ☐ Urinalysis and/or culture
- ☐ Venous doppler
- ☐ X-ray
- ☐ Other *(describe)*

Interventions
- ☐ New or change in medication*(s)*
- ☐ IV or subcutaneous fluids
- ☐ Increase oral fluids
- ☐ Oxygen *(if available)*
- ☐ Other *(describe)*

c. Were ***advance care planning or advance directives*** considered in evaluating/managing the change? *(e.g. orders for Do Not Resuscitate (DNR), Do Not Intubate (DNI), palliative or hospice care, other such as POLST, MOLST or POST):* ☐ No ☐ **Yes**

If **yes**, were the relevant advance directives *(check only one)*:
- ☐ Modified as a result of this change in clinical condition/transfer?
- ☐ Already in place and documented?
- ☐ New as a result of this change in clinical condition/transfer?

Describe _____

Quality Improvement Tool
For Review of Acute Care Transfers (cont'd)

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SECTION 4: Describe the Hospital Transfer

a. Date of transfer_____/_____/_____ Day _____ Time (am/pm) _____

b. Clinician authorizing transfer: ☐ Primary physician ☐ Covering physician ☐ NP or PA ☐ Other *(specify)*

c. Outcome of transfer: ☐ ED visit only ☐ Held for observation ☐ Admitted to hospital as inpatient

Hospital diagnosis(es) *(if available)* _____

d. Resident died in ambulance or hospital: ☐ No ☐ Yes ☐ Unknown

e. **Factors contributing to transfer** *(check all that apply and describe)*

☐ Advance directive not in place
☐ Clinician insisted on transfer despite staff willing to manage in the facility
☐ Direct admission *(from dialysis or other specialty office)*
☐ Discharged from the hospital too soon
☐ Family members/representative preferred or insisted on transfer
☐ Planned admission *(for surgery or other procedure)*
☐ Resident preferred or insisted on transfer
☐ Resources to provide care in the facility were not available

SECTION 5: Identify Opportunities for Improvement

a. In retrospect, does your team think this transfer might have been prevented? ☐ No ☐ Yes *(describe)*

If yes, check one or more that apply:

☐ The new sign, symptom, or other change might have been detected earlier
☐ Changes in the resident's condition might have been communicated better among facility staff, with physician/NP/PA, or other health care providers
☐ The condition might have been managed safely in the facility with available resources
☐ Resources were not available to manage the change in condition safely or effectively despite staff willing to manage in the facility *(check all that apply)*
  ☐ On-site primary care clinician ☐ Staffing ☐ Lab or other diagnostic tests
  ☐ Pharmacy services ☐ Other *(describe)* _____
☐ Resident and family or resident representative preferences for hospitalization might have been discussed earlier
☐ Advance directives and/or palliative or hospice care might have been put in place earlier
☐ Discharged from the hospital too soon
☐ Other *(describe)*

b. In retrospect, does your team think this resident might have been transferred sooner? ☐ No ☐ Yes *(if yes, describe)*

c. After review of how this change in condition was evaluated and managed, has your team identified any opportunities for improvement?
☐ No ☐ Yes *(describe specific changes your team can make in your care processes and related education as a result of this review)*

Name of person completing form _____ Date of completion _____/_____/_____

QAPI Self-Assessment Tool

Directions: Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization's progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of Review:_____ Next review scheduled for:_____

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work. For example, we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For example, we can say that all service lines and departments use data to make decisions and drive improvements, and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments; and is revised on an ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed of what is being learned from the data, and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams, and providing resources to support QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregiver orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead, we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the latter is addressed through disciplinary actions. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects, and how the work is guided by caregivers involved in the topic as well as input from residents and families. Notes:					
Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families, and stakeholders, and other data that reflects the services provided by our organization. For example, we have listed all available measures, indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measures that are not currently relevant and that we are not actively using in our decision making process. Notes:					
For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level). Notes:					
We have a system to effectively collect, analyze, and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice, or applicable clinical guidelines. Notes:					
Our organization has, or supports the development of, employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology to caregivers involved in QAPI. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents. Notes:					
When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish. Notes:					
For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress, and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference. Notes:					
For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents. Notes:					
Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation from happening with another caregiver and another resident. Notes:					
When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful, or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels. Notes:					
When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected and that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention there is a measure looking at whether the change is being carried out and a measure looking at the impact on fall rate. Notes:					
When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and having the desired impact (this is commonly done at 6 or 12 months). Notes:					

Guide for Developing a QAPI Plan

DIRECTIONS:

The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI.* Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles and scope for QAPI, therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals

Based on the *Guide to Develop Purpose, Guiding Principles, and Scope for QAPI*, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See *Goal Setting Worksheet*).

II. Scope

a. Describe how QAPI is integrated into all care and service areas of your organization.

b. Describe how the QAPI plan will address:

   i. Clinical care

   ii. Quality of life

   iii. Resident choice (i.e., individualized goals for care)

c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).

d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).

b. Describe how QAPI will be adequately resourced.

   i. Designate one or more persons to be accountable for QAPI leadership and for coordination.

   ii. Indicate the plan for developing leadership and facility-wide training on QAPI.

   iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.

   iv. Indicate how you will determine if resources are adequate for QAPI.

   v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

c. QAPI Leadership

i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.

ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:

- Establishing a format and frequency for meetings
- Establishing a method for communication between meetings
- Establishing a designated way to document and track plans and discussions addressing QAPI.

iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.

b. Identify the sources of data that you will monitor through QAPI

i. Input from caregivers, residents, families, and others

ii. Adverse events

iii. Performance indicators

iv. Survey findings

v. Complaints

c. Describe the process for collecting the above information.

d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.

e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.

f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

a. Describe the overall plan for conducting PIPs to improve care or services.

i. Indicate how potential topics for PIPs will be identified.

ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.

iii. Indicate how and when PIP charters will be developed.

iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.

c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.

d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any "unintended" consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.

b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.

c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

Outline the audiences for QAPI communications and the frequency and format of these communications.

VIII. Evaluation

a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)

b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. Date your plan.

b. Determine when you will revisit the plan (i.e., at least annually).

c. Determine how you will track revisions or updates to the plan.

Five Elements

Element 1: Design and Scope

A QAPI program must be ongoing and comprehensive, dealing with the full range of services offered by the facility, including the full range of departments. When fully implemented, the QAPI program should address all systems of care and management practices, and should always include clinical care, quality of life, and resident choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents). It utilizes the best available evidence to define and measure goals. Nursing homes will have in place a written QAPI plan adhering to these principles.

Element 2: Governance and Leadership

The governing body and/or administration of the nursing home develops a culture that involves leadership seeking input from facility staff, residents, and their families and/or representatives. The governing body assures adequate resources exist to conduct QAPI efforts. This includes designating one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment, and technical training as needed. The Governing Body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI despite changes in personnel and turnover. Their responsibilities include, setting expectations around safety, quality, rights, choice, and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement.

Element 3: Feedback, Data Systems and Monitoring

The facility puts systems in place to monitor care and services, drawing data from multiple sources. Feedback systems actively incorporate input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor a wide range of care processes and outcomes, and reviewing findings against benchmarks and/or targets the facility has established for performance. It also includes tracking, investigating, and monitoring Adverse Events that must be investigated every time they occur, and action plans implemented to prevent recurrences.

Element 4: Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. The facility conducts PIPs to examine and improve care or services in areas that the facility identifies as needing attention. Areas that need attention will vary depending on the type of facility and the unique scope of services they provide.

Element 5: Systematic Analysis and Systemic Action

The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. The facility uses a thorough and highly organized/ structured approach to determine whether and how identified problems may be caused or exacerbated by the way care and services are organized or delivered. Additionally, facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis. Systemic Actions look comprehensively across all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

QAPI Action Steps

Action Item	Owner	Due Date
1. Define Leadership Responsibility & Accountability		
2. Develop Deliberate Approach to Teamwork		
3. Conduct a Self Evaluation - QAPI Self Assessment Tool		
4. Identify Organizational Guiding Principles		
5. Develop QAPI Plan		
6. Conduct QAPI Awareness Campaign		
7. Develop Strategy for Collecting and Using QAPI Data		
8. Identify Gaps & Opportunities		
9. Prioritize and Charter Projects (PIPs)		
10. Plan, Conduct, and Document PIPs		
11. Identify the Root Cause of Problems (RCA)		
12. Take Systematic Action		

Reference: QAPI at a Glance (CMS)

Institute for Healthcare Improvement

IHI TOOL

Aim Statement Worksheet

Aim Statement Worksheet

An aim statement is the answer to the first question in the Model for Improvement, "What are we trying to accomplish?" Effective aim statements delineate clear, specific plans for the work ahead.

Use the prompts below to write an effective aim statement. Then use the checklist to double-check your work.

What? What's the problem or opportunity? Make sure it relates to a fundamental customer need.

E.g. Increase the percent of children who receive a Health Needs Assessment

How much? By how much will you improve? Or "how good" do you want to get?

E.g. 95% of children who should receive a Health Needs Assessment will receive one

By when? What is the date by which you will achieve the level of improvement you've set out to accomplish?

E.g. January 31, 2020

For whom? Who is the customer or population who will benefit from the improvement?

E.g. Children under the age of 12 who have an initial referral to Child Protective Services

Where? What are the boundaries of the process or system you're trying to improve? Where does it begin and end?

E.g. In Middlesex County

Complete aim statement:

E.g. By January 31, 2020, of children under the age of 12 for whom a Health Needs Assessment is recommended, 95% will receive the assessment in Middlesex County.

Ask a colleague to double-check your work and recommend improvements:

- ☐ Is the problem or opportunity clearly stated?
- ☐ Do you know what the team is going to do about the problem?
- ☐ Has the team set a numerical goal to quantify the amount of improvement they'd like achieve?
- ☐ Do you know the calendar date by which the team plans to achieve the goal?
- ☐ Is it clear who will benefit from the improvement?
- ☐ Is the scope of the project clear?
- ☐ Do you know why this improvement effort is important?

Institute for Healthcare Improvement

Quality Assurance Performance Improvement Meeting Minutes

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Facility: _____

Meeting Date: _____ **Month Reviewed:** _____

Administrator _____

Medical Director _____

Director of Nursing _____

Activities Director _____

Admissions Director _____

Assistant Director of Nursing _____

Business Office Manager _____

Dietary Manager _____

Housekeeping Director _____

Human Resources Director _____

MDS/ Care Plan Coordinator _____

Medical Records/ EHR _____

Social Services Director _____

Maintenance Director _____

Pharmacist _____

Plant Operations Director _____

Rehab/ Therapy Director _____

Consultant _____

Other _____ _____

Other _____ _____

Quality Assurance Performance Improvement Meeting Minutes

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ANCILLARY SERVICES REPORTS: (ATTACH COPY OF ALL REPORTS

PHARMACY:

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

LAB:

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

RADIOLOGY:

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

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CENSUS ACTIVITY

Payer	Budgeted	Actual
Private Pay		
Medicare		
Medicaid		
Insurance		
Hospice		
TOTAL		

New Admissions	
Discharges (Total)	
30 Day Returns to Hospital	
Deceased	
Home	
AMA	
Discharged to Other Location	

MARKETING/ ADMISSIONS:

Total # of Referrals:	
Total # of Denials:	
List # for each reason: High Cost Meds: Not able to provide clinical service: Violent/ Severe Behaviors Drug/Alcohol Abuse Insurance/ Payer Source Other (Specify)	
Total # of Referrals Converted to Admission:	
Reason for Referral Not Converted if Accepted: (List # for each Reason) Family/ Resident Chose Another Facility Delay in Accepting Location Other (Specify)	

ACTION PLAN DECISION: Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)

☐	No Trend Identified		☐	Trend Identified			Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐	Action Plan to be Developed		☐	Initiate PIP
			☐	Action Plan Ongoing/ No Change		☐	PIP Ongoing/ No change
			☐	Action Plan Revised		☐	PIP Revised
Comments/ Trends :							

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RISK MANAGEMENT/ FALLS

Occurrence & Incident Types	Number of Occurrences
Falls (total)	
Fall with Minor Injury (laceration, bruising, abrasion, skin tear, etc)	
Fall with Major Injury/ Fracture (subdural hematoma, fracture)	
Fall with Transfer to Acute Care/ ER	
Residents w/ 2+ Repeat Falls	

FALLS BY SHIFT/ LOCATION:

UNIT/ FLOOR:	DAY SHIFT	EVE SHIFT	NIGHT SHIFT	Total	COMMENTS
TOTAL FALLS:					

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

OTHER RISK MANAGEMENT OCCURRENCES:

Bruises	
Lacerations	
Skin Tears	
Burns	
Choking	
Medication Errors (Total)	
Med Errors w/ Incident (negative outcome)	
Pharmacy Related Med Errors (Improper labeling, dosage, etc.)	

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

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PRESSURE INJURIES:

	STG 1	STG 2	STG 3	STG 4	UNSTG	DTI	COMMENTS
# FACILITY ACQUIRED:							
# ADMITTED (COMMUNITY ACQUIRED)							
# OF NEW FACILIY ACQUIRED DURING THE MONTH:							
# OF WORSENING WOUNDS:							

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

INFECTION CONTROL: Attach copies of monthly reports.

Total # of HAI (Nosocomial) Infections Treated:	
Total # of HAI Treated Meeting McGeer's Criteria:	
HAI Infection Rate:	
Any Outbreaks Reported?	
Any Infections/ Diseases Reported to Health Dept?	

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

Quality Assurance Performance Improvement Meeting Minutes

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WEIGHTS:

Total # of Residents with New Significant Weight loss	
# of Residents with G-tube/ Tube Feeding	
# of G-Tube with significant weight loss:	
# of Significant Weight Loss under Hospice:	
# of Planned Weight Loss:	

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

RESTRAINTS:

Total # of Restraints: _____	
Type of Restraint(s) Used:	
# of Restraints Reduced/ Eliminated:	
# of New Restraints this Month:	

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

Quality Assurance Performance Improvement Meeting Minutes

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SOCIAL SERVICE/ GRIEVANCE OFFICER

- ***CONCERN FORM COMPLETED FOR EACH RESIDENT COUNCIL MEETING CONCERN?*** _____

TOTAL # OF GRIEVANCES:	**# OF INVESTIGATION & FOLLOW UP COMPLETED WITHIN 5 BUSINESS DAYS**	**# OF GRIEVANCES/ CONCERNS THAT MET REPORTING CRITERIA:**
• **RESIDENT CARE/ ADL**		
• **MISSING ITEMS**		
• **FOOD SERVICE/ MEALS**		
• **ENVIRONMENT / CLEANLINESS**		
• **FINANCIAL/ BILLING**		
• **CUSTOMER SERVICE**		
• **NOTIFICATIONS**		
• **OTHER (SPECIFY)**		

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

ABUSE REPORTING:

TYPE OF ALLEGATION	**TOTAL #**	**# SUBSTANTIATED**
STAFF TO RESIDENT ABUSE:		
RESIDENT TO RESIDENT		
NEGLECT		
MISAPPROPRIATION		
INVOLUNTARY SECLUSION		

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

Quality Assurance Performance Improvement Meeting Minutes

All Information included in this report and the attachments hereto were prepared as part of the Facility Risk Management program and are to be considered confidential and privileged

ENVIRONMENT / LIFE SAFETY

List Areas of Concern/ Equipment Failure/ Repairs	List corrective steps taken and current status

EMERGENCY PREPAREDNESS / DRILL(S)

Review Drill(s) Performed

Drill Performed	**Steps taken for Performance Improvement**
Fire Drill (s)	
Elopement Drill{s)	
Internal Disaster Drill(s) (Specify)_____	
External Disaster Drill(s) (specify)_____	
Evacuation	
Tornado	

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐	Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐	Action Plan to be Developed		☐ Initiate PIP
			☐	Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐	Action Plan Revised		☐ PIP Revised
Comments/ Trends :							

Quality Assurance Performance Improvement Meeting Minutes

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HUMAN RESOURCES:

Workers Compensation Current Open Claims:

Employee {Initials)	Type of Injury	Date of Injury	Lost Time	Light Duty Time	Full Duty Release	Re-education

EMPLOYEE TURNOVER:

POSITION	# NEW HIRE	# TERMED	# RESIGNED	# OF CURRENT OPEN POSITIONS
LICENSED NURSE				
CNA				
DIETARY				
HOUSEKEEPING/LAUNDRY				
MAINTENANCE				
SOCIAL SERVICE				
NURSING ADMIN (DON/ADON/MANAGER/ MDS)				
ADMINISTRATOR/ ASST ADMIN				
OTHER (SPECIFY) _____				

# of Exit Interviews Completed: _____

RELIAS TRAINING STATUS- CNA/ NURSING/ DIRECT CARE STAFF:

NOTE: CNA'S REQUIRE 12 HOURS OF COMBINED TRAINING PER YEAR ON DEMENTIA, ABUSE, CARE OF COGNITIVELY IMPAIRED

TYPE OF TRAINING	# incomplete NEW HIRE	# incomplete ANNUAL	
DEMENTIA **(6 HR NEW HIRE training to be complete in first 30 days if working on dementia unit, otherwise within 6 months of hire; 3 HR ANNUALLY)**			
ABUSE			
CARE OF COGNITIVELY IMPAIRED			

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

Quality Assurance Performance Improvement Meeting Minutes

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ADMINISTRATOR:

Date of Last Annual Survey: _____

Any Open Survey Cycles? _____

If yes, list - Survey Date: _____

Compliance Date: _____

Denial of Payment Date: _____

Outstanding Tag #s: _____

Survey/ Inspection Activity since Last Quality Assurance Performance Improvement Meeting

Agency / Date	Type of Visit	Survey Results	Current Status

5 STAR RATING:

OVERALL QUALITY # STARS	HEALTH INSPECTION # STARS	QUALITY MEASURES # STARS	STAFFING # STARS	RN STAFFING # STARS

ACTION PLAN IN PLACE FOR AREAS OF 2 STAR OR LESS? (ATTACH COPY)

QUALITY MEASURES:

(Attach copy of Report for most recent 3 month period.)

QUALITY MEAUSRE >75TH PERCENTILE	PERCENTILE	RATING POINTS	ACTION PLAN IN PLACE?

ACTION PLAN DECISION: **Check All That Apply: (ATTACH COPY OF REPORTS & ACTION PLANS)**

☐	No Trend Identified		☐ Trend Identified		Performance Improvement Plan (PIP)
☐	Isolated Event/ Quick Fix- No Action Plan Needed		☐ Action Plan to be Developed		☐ Initiate PIP
			☐ Action Plan Ongoing/ No Change		☐ PIP Ongoing/ No change
			☐ Action Plan Revised		☐ PIP Revised
Comments/ Trends :					

OTHER REPORTS: (ATTACH COPIES)

_____ **THERAPY CASELOAD REPORT**

_____ **MDS / CMI / TRIPLE CHECK**

Committee review of the following policies, procedures and guidelines:

P&P / Guideline	Continued Acceptance Y/N	Revision Required? Y/N

NEXT MEETING DATE: _____

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)
Performance Improvement Team Documentation

DATE COMPLETED:		**TEAM MEMBERS**	
Team Leader:		FACILITY	
PROBLEM STATEMENT:		1.	
GOAL:		2.	
ROOT CAUSE(S) (Determined by drilling down by all PIP team members after gathering data to verify root cause)		3.	
		4.	
		5.	
		6.	
		7.	
		8.	
BARRIER(S) (Determined after Root Cause analysis done by PIP team)			

METRIC(S)	PREINTERVENTION	FIRST REMEASUREMENT	SECOND REMEASUREMENT	FINAL REMEASUREMENT	COMMENTS

Tab Four

Tools

Stretch and SMART Goal Setting Worksheet

AAPACN
AMERICAN ASSOCIATION OF POST-ACUTE CARE NURSING

Purpose: Goal setting for personal, professional, and organizational growth is a proven tactic to help individuals and teams achieve higher performance. Directors of nursing services (DNSs) can use this worksheet to help their team or themselves develop a stretch goal combined with a SMART goal.

Directions: After reading the introduction and the example, answer the questions in the blank template to develop goals for either personal, professional, or organizational growth.

Introduction

Stretch goals and SMART goals complement each other. A stretch goal is ambitious and urges the individual or team to "stretch" beyond what they think they can achieve. A stretch goal inspires big dreams and motivates people to undertake significant challenges. In contrast, a SMART goal is specific, measurable, attainable, relevant, and time-bound. When a stretch goal is paired with a SMART goal, the individual or team has a roadmap to follow and is inspired to make progress toward the bigger vision.

Example

Stretch Goal
Be inspired to think big!

What is my/our big dream or ambitious challenge I/we want to achieve?
I want to be recognized as a top expert nurse leader for post-acute care.

SMART Goal
Be strategic and think about the actions that will help make progress.

S	M	A	R	T
Be specific about what is to be accomplished.	Have a clear definition of success.	Ensure that the goal is realistic.	Confirm that the goal is worth pursuing.	Select a motivating but doable completion date.

Specific — What goal is narrower but represents a concrete step that helps achieve the stretch goal?
I will become an AAPACN-certified director of nursing services (DNS-CT).

Measurable — How will progress be measured?
I will complete two courses of the AAPACN DNS-CT program a month until all 10 courses are complete, so I can become a DNS-CT.

Attainable — What barriers must be overcome, and what resources, including people, are necessary to make progress?
I will need the support of the nursing home administrator and the assistant director of nursing to cover my responsibilities for two hours per week while I focus on completing the DNS-CT program.

Relevant — Why is this a priority, and what value does it add?
To be recognized as a top expert nursing leader for post-acute care, achieving the SMART goal of becoming a DNS-CT is relevant and realistic. It's also something I can be proud of, it will help me feel more confident in my decisions, and it will help me better support my team during challenges—all outcomes that contribute to the stretch goal.

Time-Bound — By what date will the achievement be accomplished?
I will start January 1 and finish May 31.

Name: **Date:**

Stretch Goal

Be inspired to think big!

What is my/our big dream or ambitious challenge I/we want to achieve?

SMART Goal

Be strategic and think about the actions that will help make progress.

S	M	A	R	T
Be specific about what is to be accomplished.	Have a clear definition of success.	Ensure that the goal is realistic.	Confirm that the goal is worth pursuing.	Select a motivating but doable completion date.

Specific — What goal is narrower but represents a concrete step that helps achieve the stretch goal?

Measurable — How will progress be measured?

Attainable — What barriers must be overcome, and what resources, including people, are necessary to make progress?

Relevant — Why is this a priority, and what value does it add?

Time-Bound — By what date will the achievement be accomplished?

Instructions to Develop a Dashboard

Directions: A dashboard can be helpful as a way to monitor the progress of QAPI in your organization, or the progress of individual projects. The complexity of a dashboard can vary based on the needs of the organization and whether or not you have an automated system to assist in pulling data into the dashboard. Your team should use this tool to guide the process of developing a dashboard. The steps below are intended to help the team members understand the value of a dashboard and the process for creating a dashboard.

Step 1 – Review dashboard basics:

What is a dashboard?
Like the panel of signals that allow a driver to monitor the functioning of a car, a dashboard is a system to track key performance indicators within an organization. It is meant to be designed so that it is easy to read and quick to understand, providing signals of where things are going well and where there are problems to address. It should include short term indicators – to make sure that milestones are being met, and outcome measures that reflect whether goals are being met.

Why is a dashboard important?
Regular monitoring of data is critical for effective decision-making in any organization. At the same time, the amount of data available can be overwhelming and long data reports containing all possible information are not likely to be used and may not be meaningful. A dashboard is an ideal way to prioritize the most important indicators for a particular organization and encourage regular monitoring of the results.

What does a dashboard look like?
Dashboards may be simple text documents, data spreadsheets, or sophisticated graphs developed with computer programs. Data results are reported for multiple time periods to show trends over time and include benchmarks or goals to put performance into context. An organization's main dashboard ideally fits onto one page, showing only a select set of the most important indicators to monitor. Sub-dashboards may then be created so that users can "drill-down" to see more detailed data on a specific issue. Dashboards typically employ a system of visual alerts—such as red-yellow-green stoplight coloring, speedometers or thermometers—that help to draw viewers' attention to data results indicating an area for concern.

Step 2 – Decide how your dashboard will be used:

What type of dashboard do we need?
Different dashboards may be useful for different audiences. For instance, a dashboard geared to a board of directors would need to monitor not only the overall quality and specific clinical or organizational quality indicators for the facility but also its financial health. Similarly a top administrator needs to have a high-level view of the performance of the organization, while an individual staffing unit may have a dashboard that concerns the area of care for which it is specifically responsible. Additionally, you may decide to create a dashboard that distinctively monitors the success of a particular QAPI activity. Ideally, any sub-dashboards created will be tied to the main organizational dashboard so that all efforts are working in sync with the overarching vision and goals of the organization.

Step 3 – Create your dashboard:

The following is a list of steps to consider in developing a dashboard. These steps are not necessarily listed in the order in which they must take place, but represent a general path to follow in creating a dashboard panel for your organization.

- ☐ Determine what type of dashboard you are creating and its purpose. For example, this may be a main organizational dashboard for the purpose of monitoring the facility's overall health or a project-centered dashboard to examine the results of specific improvement efforts.

- ☐ Assemble the team. Depending on which type of dashboard you are creating, the highest level of leadership taking ultimate responsibility for the indicators will need to be involved. Other key team members include those responsible for producing the results measured, those affected by the results as well as any other users of the dashboard tool. Gathering input from your quality committee will provide the best vantage point to select the most appropriate indicators as well as help to ensure buy-in and support for the process.

- ☐ Write an objective for what the dashboard should monitor. For a main organizational dashboard, this will involve reviewing the organization's mission, vision and strategic plan to elicit the most important goals for the organization to achieve. For a project-level dashboard, the objective will relate to the outcomes the improvement efforts are trying to produce. A dashboard in this case can help to emphasize the different parts of the system that influence whether or not the outcome is achieved.

- ☐ Establish the principal measure domains to include. Based on your written objective for what the dashboard should monitor, determine all of the principal measure domains that must be included in order to adequately meet your measurement objectives. Domains could include clinical outcomes, satisfaction, quality of life, safety, finances, staffing or various other domains (see *Inventory of Potential Measures and Indicators*).

- ☐ Determine what indicators are available within each of the measure domains you have selected. Indicators can be drawn from your own internal data sources, from the literature regarding appropriate and expected rates of an activity or situation, from state-sponsored report cards or inspections, national campaigns such as Advancing Excellence in America's Nursing Homes or federal initiatives such as CMS' Nursing Home Compare.

- ☐ Select indicators. This step will involve reviewing the list of potential indicators available, gathering input from team members and other stakeholders, and looking for sources that will provide either an evidence-base for setting a specific goal level for the indicator or a benchmark goal based on the performance of other facilities.

- ☐ Set indicator goals. Upon selecting the indicators to include in your dashboard and reviewing available sources to set goals, establish the preliminary goal level you aim to achieve for each indicator. You may choose to set progressive goals over a particular period of time (e.g., goal of a 10% reduction in the first year followed by a 20% reduction in the following year.)

- ☐ Define the specifications for each indicator. Establish how each indicator will be defined and measured by identifying its numerator, denominator, data source, measurement period and any exclusions allowed. This may include a listing of any data codes used in health record management systems.

- ☐ Develop a data collection plan. Establish the frequency at which the indicator will be measured and the person(s) responsible for collecting the data and entering it into the dashboard. Different indicators may be collected on different time lines and data time periods should be denoted clearly on the dashboard.

Step 4 – Use your dashboard:

- ☐ Determine how the dashboard will be displayed. Determine the type of dashboard you will use to communicate findings (text document, data spreadsheet, etc).

- ☐ Establish a dissemination plan. Thinking about who the users are, determine how the dashboard will be shared with others. Will you post the dashboard on a bulletin board? Will only certain staff have password-access to an online dashboard? Will you share dashboard findings with residents and families? What about the general public?

- ☐ Develop a plan to review the dashboard and act on the findings. Establish the people responsible for regularly reviewing dashboard findings, at what frequency they will be reviewed and what protocol should be followed to initiate any follow-up action required. Make sure the quality committee and executive leadership is included in those responsible for reviewing and acting on dashboard results.

- ☐ Gather baseline data. Test the dashboard by following the data collection plan to populate the indicators with baseline data. This may involve looking back and pulling historical data to show trends to date for the indicators selected.

- ☐ Review baseline findings and make adjustments as necessary. Consult with the team to evaluate how the dashboard functions following baseline data input. Make adjustments as necessary or return to earlier steps if it is determined that different indicators are needed.

- ☐ Determine a pilot period. Based on the frequency determined for monitoring the dashboard, set a defined period to pilot the new dashboard and establish a date for formal review of the dashboards performance in meeting the originally defined monitoring objective.

Step 5 – Revisit your dashboard:

Remember that a dashboard is a living tool and, therefore, should evolve over time. Establishing regular review periods will help to prevent the dashboard from becoming stagnant and growing obsolete by considering new data sources that have since become available and identifying indicators that are no longer considered useful.

Monitor whether the data collected and shared are acted upon by leadership, the quality committee, and others as appropriate. Remember that simply tracking and trending data will not lead to meaningful change in the lives of residents.

Continue to look for new and innovative indicators to include in your dashboard. The purpose of a dashboard is to challenge your organization not only to meet its goals but to continue to improve and grow in different ways.

Brainstorming, Affinity Grouping, and Multi-Voting Tool

Directions: Brainstorming, Affinity Grouping, and Multi-voting are approaches for generating, categorizing, and choosing among ideas from a group of people. Using these techniques encourages every person within the group to contribute, instead of just one or two. They spark creativity in group members as they listen to the ideas of others and generate a substantial list of ideas, rather than just the few things that first come to mind. Finally, the techniques allow a group of people to choose among ideas or options thoughtfully.

The following descriptions of Brainstorming, Affinity Grouping and Multi-voting are intended to be used by QAPI teams when ideas are needed and decisions need to be made.

Brainstorming

Brainstorming is an idea-generation tool designed to produce a large number of ideas through the interaction of a group of people.

1. The session leader should clearly state the purpose of the brainstorming session and lay out the ground rules, as they are discussed below.

2. Participants call out one idea at a time, either going around the group of people in turn, which structures participation from everyone, or at random, which may favor greater creativity. Another option is to begin the brainstorming session by going in turn and after a few rounds open it up to all to call out ideas as they occur.

3. Refrain from discussing, complimenting, criticizing, or evaluating ideas as they are presented. Consider every idea to be a good one. Aim for many ideas in a short amount of time. The quantity of ideas is what matters; evaluation of the ideas and their relative merit comes later. This tool is designed to get as many ideas generated in a short period of time as possible. Discussing ideas may lead to premature judgment and slow down the process.

4. Record all ideas on a flip chart, or on self-adhesive notes so that all group members can see them.

5. Build on and expand the ideas of other group members. Encourage creative thinking.

6. When generating ideas in turn, let participants pass if an idea does not come to mind quickly or if the participant does not have something to share at that time.

7. Keep going when the ideas slowdown, reach for less obvious ideas to create as long a list as possible. Do not cut off the flow of ideas.

8. After all ideas are listed, clarify each one and eliminate exact duplicates.

9. Resist the temptation to “lump” or group ideas. Combining similar ideas will come later (see Affinity Grouping).

Examples of topics when brainstorming might be helpful in nursing homes:

- Identifying was to involve direct care staff in QAPI
- Identifying ways to address the identified root cause of a problem that has occurred or is occurring
- Identifying ways to be more welcoming to new staff or to new residents
- Identifying ways to promote more a more restful night's sleep for residents
- Identifying ways that residents and families could be involved in QAPI

Affinity Grouping

Affinity Grouping is a brainstorming method in which participants organize their ideas and identify common themes.

1. Write ideas on individual cards or adhesive notes (see directions for Brainstorming).

2. Randomly place cards on a table or place notes on flip chart paper taped to the wall.

3. Without talking, each person looks for two cards or notes that seem to be related and places these together, off to one side. Others can add additional cards or notes to a group as it forms or reform existing groups. Set aside any cards or notes that become controversial.

4. Continue until all items have been grouped (or set aside). There should be fewer than 10 groupings.

5. Now discuss the groupings as a team. Generate short, descriptive sentences that describe each group and use these as title cards or notes. Avoid one- or two-word titles.

6. Items can be moved from one group to another if a consensus emerges during the discussion.

7. Consider additional brainstorming to capture new ideas using the group titles to stimulate thinking.

Multi-voting

Multi-voting is a structured series of votes by a team, in order to narrow down a broad set of options to a few.

1. Generate a list of items (see directions for Brainstorming).

2. Combine similar items into groups that everyone agrees on (see directions for Affinity Grouping).

3. Number each item.

4. Each person chooses one-third of the items. This voting can be done in a number of ways: a) each person submits their votes privately to the person will tally the votes, b) each person shares their votes publicly with the group and with the person who will tally the votes, or c) each person marks their choices from the list of items that are displayed on wall charts with an "X" or colored dot – this displays the results instantly.

5. Tally votes.

6. Eliminate items with few votes. The table below will help you determine how to eliminate items:

Group size (number of people)	Eliminate items with less than "x" votes
4 to 5	2
6 to 10	3
10 to 15	4
15 or more	5

If a decision is clear, stop here. Otherwise, repeat the multi-voting process with remaining items, as necessary.

Guide for Developing Purpose, Guiding Principles, and Scope for QAPI

Directions: Use this tool to establish the purpose, guiding principles and scope for QAPI in your organization. The team completing this worksheet should include senior leadership. Taking time to articulate the purpose, develop guiding principles, and define the scope will help you to understand how QAPI will be used and integrated into your organization. This information will also help your organization to develop a written QAPI plan. Use these step-by-step instructions to create a separate document that may be used as a preamble to your QAPI plan.

STEP 1. LOCATE OR DEVELOP YOUR ORGANIZATION'S VISION STATEMENT

A **vision statement** is sometimes called a picture of your organization in the future; it is your inspiration and the framework for your strategic planning. Consider involving staff in the development of your vision statement. Post it for everyone to view.

For example, the vision of the Good Samaritan Society is to create an environment where people are loved, valued and at peace.

STEP 2. LOCATE OR DEVELOP YOUR ORGANIZATION'S MISSION STATEMENT

A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As above, get caregivers involved in establishing your organizations mission.

For example, Meadowlark Hills is each resident's home. We are committed to enhancing quality of life by nurturing individuality and independence. We are growing a value-driven community while leading the way in honoring inherent senior rights and building strong and meaningful relationships with all whose lives we touch.

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

A **purpose statement** describes how QAPI will support the overall vision and mission of the organization. If your organization does not have a vision or mission statement, the purpose statement can still be written and would state what your organization intends to accomplish through QAPI.

For example, the purpose of QAPI in our organization is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers and other partners so that we may realize our vision to [reference aspects of vision statement here]. To do this, all employees will participate in ongoing QAPI efforts which support our mission by [reference aspects of mission statement here].

STEP 4. ESTABLISH GUIDING PRINCIPLES

Guiding Principles describe the organization's beliefs and philosophy pertaining to quality assurance and performance improvement. The principles should guide what the organization does, why it does it and how.

For example:

- Guiding Principle #1: QAPI has a prominent role in our management and Board functions, on par with monitoring reimbursement and maximizing revenue.
- Guiding Principle #2: Our organization uses quality assurance and performance improvement to make decisions and guide our day-to-day operations.
- Guiding Principle #3: The outcome of QAPI in our organization is the quality of care and the quality of life of our residents.
- Guiding Principle #4: In our organization, QAPI includes all employees, all departments and all services provided.
- Guiding Principle #5: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals.
- Guiding Principle #6: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, health care practitioners, families, and other stakeholders.
- Guiding Principle #7: Our organization sets goals for performance and measures progress toward those goals.
- Guiding Principle #8: Our organization supports performance improvement by encouraging our employees to support each other as well as be accountable for their own professional performance and practice.
- Guiding Principle #9: Our organization has a culture that encourages, rather than punishes, employees who identify errors or system breakdowns.

Add any additional Guiding Principles that may be important to your nursing home. Review the five QAPI elements to ensure you identify and capture guiding principles for your organization.

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

The **Scope** outlines what types of care and services are provided by the organization that impact clinical care, quality of life, resident choice, and care transitions. Be sure to incorporate the care and services delivered by all departments.

For example:

Post-acute care
Dementia care and services
Dietary
Dining

Once the list of care and service area has been identified, you can determine how each will use QAPI to assess, monitor and improve performance on an ongoing basis.

STEP 6. ASSEMBLE DOCUMENT

Once you've completed steps 1-5, assemble the vision and mission statements, guiding principles, and scope of QAPI into a separate document that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

The next step is to develop a written QAPI plan that will meet your purpose, guiding principles and comprehensive scope described above. See *"Guide for Developing a QAPI Plan."*

Wabash Valley Care Coalition – Warm Hand-Off Form

PATIENT NAME: _____ **DATE:**_____**CODE STATUS:** _____

Report given by: (LN)_____ @(facility)_____ to: (LN)_____ @(facility)_____
CALL BACK NUMBER (for addl. Info.)_____

Current Ht. & Wt.	HT:_____WT:_____	**1:1 STATUS**	N/A_____ Date/time off 1:1_____

Pts Chief Complaint	
Primary Diagnosis	
Additional Diagnosis	
Primary Caregiver	Name:_____ Relationship:_____ Contact #:_____
PPD & Chest X-Ray	PPD Date:_____ Location:_____ Results:_____ X-Ray Date:_____
Recent Vital Signs	**BP** | **T** | **P** | **R** | **O_2 sat** | **On Room Air or:** L/minutes
Oxygen Needs	Mask Cannula Nebulizer BiPap Current Liter flow: 1 2 3 4 5 or_____ Liters Inspirator Levels:_____
Surgery Date:	Surgeon: _____ Surgical Procedure:_____ *Incision is*: **Closed Open** Location:_____ *Cast:* **No Yes** Location:_____
Orientation	Alert & Oriented to: Self_____ Time_____Location_____ x3_____Circumstances_____ x4_____
Competence	Sign docs for self? **No Yes** If no, who is responsible?_____ Contact #_____ Able to verbalize understanding of diagnosis & treatment: **No Yes**
Diabetes Diagnosis	**N/A Yes** If yes, is BG stable? **No Yes** Last BG @:_____ results:_____
Anticoagulation	Is resident on an anticoagulant? **No Yes** *Heparin Lovenox Fragmin Coumadin Plavix ASA* Date of last PT/INR: Results:_____ Next draw due @:_____
Pain Issues	**No Yes** Last medicated @_____with (medication)_____ Script written? **No Yes**
Wound Issues/ Dressing Changes	**N/A Yes** Location:_____ Wound Vac: **N/A Yes** Dressing orders: **No Yes** Dressing last changed on: (date)_____@ (time) _____
Allergies	**No Yes** Dyes/Iodine Latex Tape Medication_____ Food_____ Enviro_____
Bowel Issues	Continent: **No Yes** Last date BM recorded:_____
Bladder Issues	Continent: **No Yes** | Catheter: **No Yes** | Last changed or removed on: (date)_____@(time)_____
Dialysis	Is the resident on Dialysis? **No Yes** | Date/Time_____ | Access Site_____
Swallowing Issues	**No Yes** Texture of current diet_____ Liquid consistency: thin nectar honey spoon
Enteral Feeding	**No Yes** Type:_____ Volume:_____ Frequency/Rate:_____
Ambulation/Transfer	Ambulatory: **No Yes** Feet:_____ | Wt Bearing: **No Partial Full** | Transfer requires: **1 or 2 person lift**
Assistive Devices	**No Yes** FWW_____ 4WW_____ Cane_____ WC _____ Oversized WC_____
Special Equipment	**No Yes** _____
Intravenous Lines	Type:_____Location:_____ Date IV inserted or last changed:_____
Medications	Copy of med list in transfer packet?_____ On IV med: **No Yes** Next IV med due @:_____
Personal Preferences	
Isolation Precautions	**No Yes** Type:_____
Palliative Care	Did patient receive Palliative Care Consult while in hospital? **No Yes**
Follow up Appointments	Date:_____ Time:_____ | Location:_____ | Contact number:_____

Root Cause Analysis

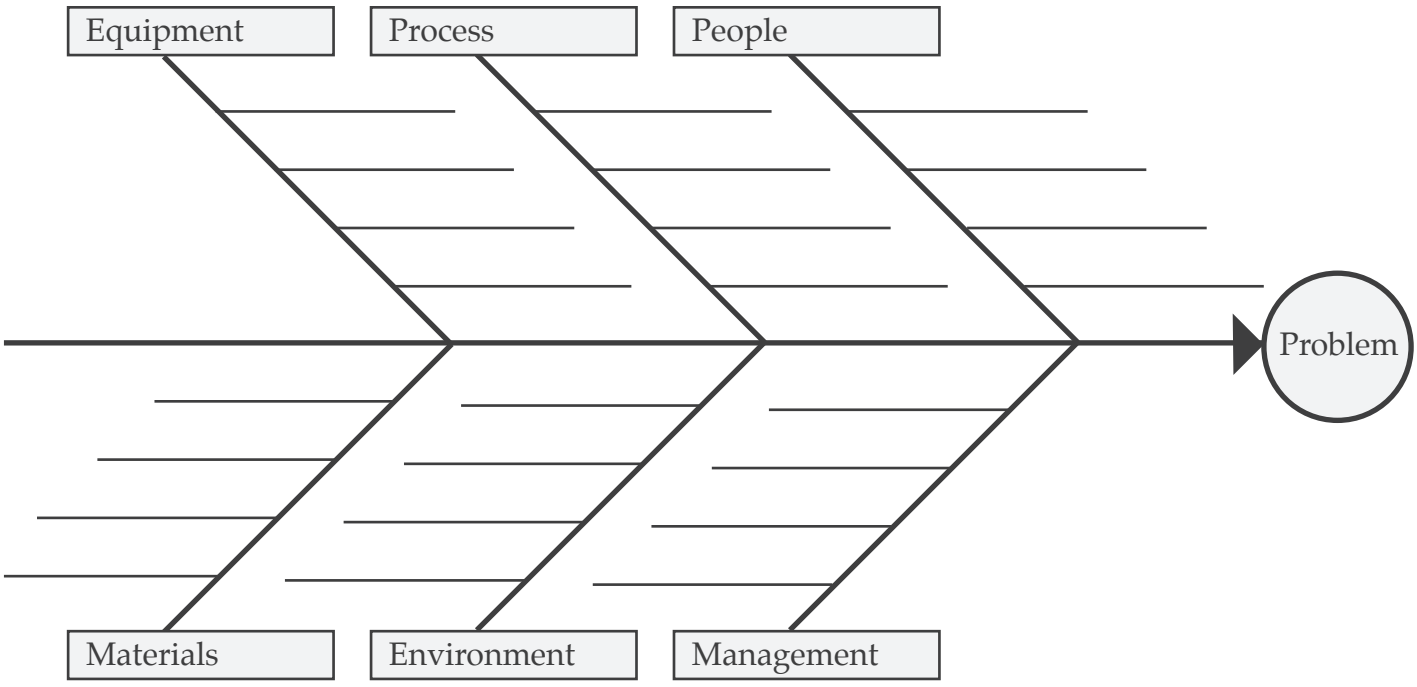
What is a Root Cause Analysis?

Just as you would pull a weed out of your garden by its root to ensure that it doesn't grow back, getting to the root cause of a system's issue is important to prevent the problem from returning. There are many formalized root cause analysis tools.

Two easy-to-use tools are the fishbone diagram and the Five Whys.

Fishbone (Cause-and-Effect) Diagram

1. Begin the fishbone diagram by placing the problem at the head of the "fish."
2. Under each general category of the fishbone, answer the question, "Why?" for the identifi d problem. For example, "Why are people the cause of this problem?"
3. Once your team has completed the fishbone diagram, discuss the various causes to get to the root of the problem. It is from this discussion that the focus for the improvement plan can begin.



Five Whys

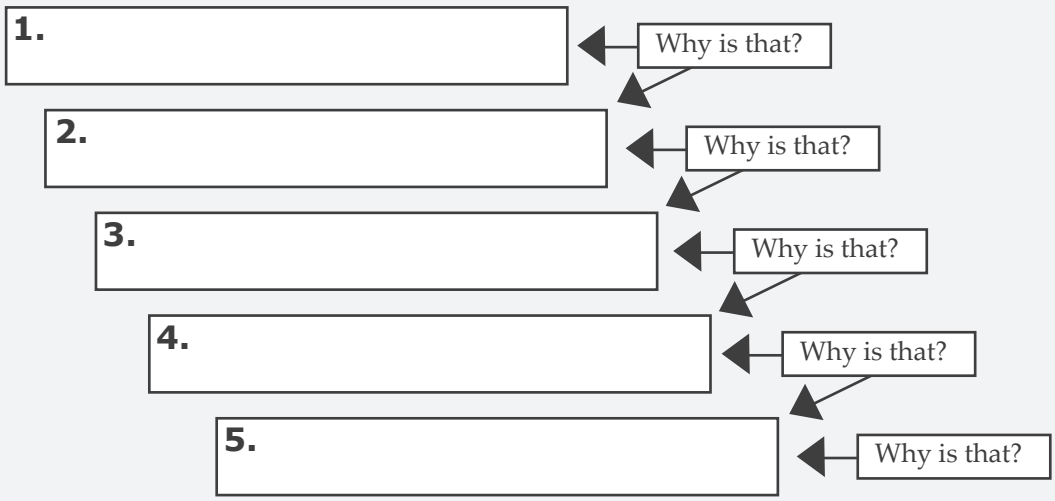
The Five Whys tool aids in identifying the root cause(s) of a problem. Begin by identifying a specific problem, and ask why it is occurring. Continue to ask "Why?" to identify causes until the underlying cause is determined. Each "Why?" should build on the previous response. There is nothing magical about the number five. Sometimes a root cause may be reached after asking "Why?" just a few times; at other times, deeper questioning is needed.

1. Define a problem; be specific
2. Ask why this problem occurs, and list the reasons in Box 1.
3. Select one of the reasons from Box 1 and ask, "Why does this occur?" List the reasons in Box 2.

Continue this process of questioning until you have uncovered the root cause of the problem. If there are no identifiable answers or solutions, address a different problem or reason.

The Problem: _____

Why does this occur?



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