QAPI: Quality versus Quantity

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What is QAPI?

- Quality Assessment and Performance Improvement (QAPI) is a data-driven and pro-active approach to "quality" improvement.
- Is ongoing, systematic, comprehensive, and data-driven (PER CMS)
- Engages everyone in the facility to continuously identify problems and opportunities for improvement
- Develops interventions that address the underlying system, not only the symptom
- Continuously monitors performance

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Quality Assurance and Performance Improvement (QAPI)

Quality Assurance (QA): QA is the specification of standards for quality of care, service and outcomes, and systems throughout the facility for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going and both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

Performance Improvement (PI): PI (also called Quality Improvement - QI) is the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decrease the likelihood of problems, by identifying opportunities for improvement, and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. PI in nursing homes aims to improve facility processes involved in care delivery and enhanced resident quality of life. PI can make good quality even better.

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QAPI Background

Mandated in the Affordable Care Act, enacted March 2010

Legislation requires the Centers for Medicare & Medicaid Services (CMS) to establish QAPI program standards and provide technical assistance to nursing home providers.

CMS identified training needs for long-term care surveyors.

"QAPI at a Glance"

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Five Elements of QAPI

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

1) Design & Scope

2) Governance & Leadership

3) Feedback, Data Systems & Monitoring

4) Performance Improvement Projects (PIPs)

5) Systematic Analysis & Systemic Action

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Governance and Leadership

- Must establish a climate of open communication and respect.
- 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.

Organizational Silos

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TEAMWORK

Maintenance, Housekeeping & Laundry Team
Board of Directors
Office Team
Corporation
Nursing Team
Administrator
Director of Nursing
Dietary Team

–NOT FROM THE TOP DOWN

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THE BIG PICTURE BASICS

The ultimate goal of QAPI is to provide person-centered care – to focus on the person receiving the care.

QAPI is not only a "program" per say; but it is "the way we do our work."

The ability to think, make decisions, and take action ***at all levels of management*** is a prerequisite for QAPI success.

QAPI is required in federally certified health care facilities: hospitals, transplant programs, dialysis centers, ambulatory care, hospice, nursing homes.

QAPI is to be consistent across all settings at a high level, but must also take into account issues unique to the specific care setting.

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Guide for Developing a QAPI PIP Team

- 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.

- Describe how the QAPI activities will be reported to the governing body; (i.e., Board of Directors, owner or QA team).

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QAPI as a Foundation

For person-centered care	For defining quality as 'how work is done'	For systems thinking
Relies on the input of residents and families Measurement of not only process but also outcomes	Broad scope – entire organization (all staff and all departments) Leadership expected to be a model	Proactive analysis Data and measurement driven Supported by tools

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What's The Difference

	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

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FTAG

F865 - QAPI Program/Plan, Disclosure/Good Faith Attempt

F866 - QAPI/QAA Data Collection and Monitoring

F867 - QAPI/QAA Improvement Activities

F868 - QAA Committee

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F865-QAPI

§483.75(a) Quality assurance and performance improvement (QAPI) program. [§483.75 and all subparts will be implemented beginning November 28, 2019 (Phase 3), unless otherwise specified]

Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.

- The facility must:
  - Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section.
  - Present its QAPI plan to the State Survey Agency [implemented November 28, 2017 (Phase 2)]
  - Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and
  - Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

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F865-QAPI

§483.75(b) Program design and scope (Element 1)

A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility.

- It must:
  - Address all systems of care and management practices;
  - Include clinical care, quality of life, and resident choice;
  - Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.
  - Reflect the complexities, unique care, and services that the facility provides.

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F865-QAPI

§483.75(f) Governance and leadership (Element 2)

- The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:
  - An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.
  - The QAPI program is sustained during transitions in leadership and staffing;
  - The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;
- The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, AND resident AND staff input, and other information.
- Corrective actions address gaps in systems, and are evaluated for effectiveness;
- Clear expectations are set around safety, quality, rights, choice, and respect.

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F866-QAPI

§483.75(c) Program feedback, data systems and monitoring. (Element 3)

- A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring.
- The policies and procedures must include, at a minimum, the following:
  - Facility maintenance of effective systems to obtain and use of feedback and input
  - Facility maintenance of ***effective systems*** to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required
  - Including how such information will be used to develop and monitor performance indicators.

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F866-QAPI

Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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F867-QAPI

§483.75(d) Program systematic analysis and systemic action. (Element 5)

- The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.
- The facility will develop and implement policies addressing:
  - How they will use a systematic approach;
  - How they will develop corrective actions, and;
  - How the facility will monitor the effectiveness to ensure that improvements are sustained.

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F867-QAPI

§483.75(e) Program activities (PIP-Element 4).

- The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas;
- Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.
- The facility must conduct distinct performance improvement projects (PIP). The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas.

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Other areas QAPI related

- F607-Abuse

  §483.12(b)(4) Establish coordination with the QAPI program required under §483.75.
- F801-Food and Nutrition Staff

  Participating in the quality assurance and performance improvement (QAPI), as described in §483.75, when food and nutrition services are involved
- F944-Training Requirements

  §483.95(d) Quality assurance and performance improvement.

  A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75.
- F837-Governing Body

  §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). [§483.70(d)(3) Governing body responsibility of QAPI program.
- F838-Facility Assessment

  Facility Assessment there are many references in QAPI/QA&A regulations 483.75

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What's The Difference

QA identified the mountain so you can fix the problem. (reactive)
QAPI identifies the molehill before it becomes the mountain. (proactive)
Moving from fighting fires to preventing them!

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You cannot become what you need to be by remaining what you are. - Zig Ziglar

Leadership is the ability to get extraordinary achievement from ordinary people. - Brian Tracy

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QAPI Must

- Involve **all** NH services
- Prove that "priorities" were identified and chosen for PI activities
- Focus on quality measures/indicators
- Take actions to demonstrate improvement and are sustainable
- Maintain documentary evidence of its operation and be able to demonstrate this to CMS
- Developed, implemented and maintained
- Effective, ongoing, nursing facility-wide – that is both clinical and nonclinical indicators of quality to be measured
- Data driven

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What is a PIP?

Performance Improvement Project

- Purpose of the PIP…. To examine and improve care or services in areas that you have identified in needing attention.

- These areas of attention vary from home to home.
  - Prioritize opportunities from collected data
  - Solicit departments for Performance Improvement Projects (or require them)
    - –Measure
    - –Process
    - –Outcome

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The Role and Responsibilities of the PIP Team

The PIP team is composed of 5-10 members

The members should have diverse perspectives of the problem or areas of opportunity for improvement

The members should have diverse perspectives of the associated process(es) that will be improved

Include employees who are closest to the work that is to be studied and changed

Individual roles and responsibilities are assigned and explained

Make sure team members have the bandwidth to participate

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Your First PIP

- Educating and training ALL staff on QAPI
- Explain that "priorities" will need to be identified and chosen for performance improvement. They can and need to be involved.
- Action plans and PIP teams--members of the PIP team have EQUAL voice.
- They will be asked to maintain documentary evidence of progress. Developed, implemented and maintained quality indicators and data collection—both clinical and nonclinical.

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How Do You Determine Your PIP?

Collect data and prioritize….

-Utilize the Facility Assessment-residents at high-risk, high-volume

- Problem-prone areas

-How frequent is the problem

- The scope and severity

-Areas which affect health, outcomes, patient safety, and quality of care.

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Selecting a Pip: Prioritizing Problems and Opportunity for Improvement

There are resources available from CMS, the QIOs, and trade associations available to assist you with the prioritization process.

Prioritization Worksheet for Performance Improvement Projects

QAPI

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 IMPROVEMENTConsider 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

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Prioritization Examples

The QAA Committee has determined there are three potential PIPs, but the facility only has the resources to charter one PIP. Using the CMS PIP Prioritization worksheet and the following information, the QAA Committee members score the potential PIPs:

1. Preventing staff back injuries and resident injuries related to resident handling and transfers
   a. Two workman's compensation claims have been filed within the last year related to back injuries that occurred during resident transfers.
   b. One resident received a skin tear during an inappropriate transfer, and another resident was eased to the floor with no injuries, but no formal complaints or lawsuits have been filed by the responsible parties/residents.
   c. The insurance company is willing to provide a consultant to assist the DNS and therapy department to work on a safe resident handling protocol.

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Prioritization Examples

Example 1: Mechanical Lifts

Problem or OFI	Intervention
Old mechanical lifts are no longer able to be serviced.	Education – Three mechanical lifts were purchased as upgrades. The staff were trained on how to operate the new lifts.
The DNS observed old lift pads being used that did not match the mechanical lifts.	Environmental – Nonmatching pads were disposed of so only matching pads are accessible for staff use.
Many types of lift pads were being ordered.	Other corrective action – At the request of the nursing home administrator, the durable medical supplier shows only the appropriate lift pads as available for the facility to order.
The results of an RCA for staff back injuries showed CNAs were not consistently using the mechanical lifts due to: • Time constraints – use of lifts does not always fit into established workflows. • Confusion about when and whom to transfer and the appropriate mechanical lift to use – there is no assessment and standard to determine this.	PIP – The facility needs new processes to assess residents, a standard to determine which lift is appropriate, and changes to workflows so that using a lift fits within the CNAs' time allowance.

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Prioritization Examples

2. Preventing pressure injury (pressure ulcers)

a. The current rate is below the state and national average, but it is above the threshold set by the facility.
b. The facility did not receive a deficiency for skin or wounds during the last two survey cycles.
c. One responsible party has voiced concerns about a pressure ulcer her mother acquired.

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Prioritization Examples

Example 2: Pressure Ulcer

Problem or OFI	Intervention
Need for clinical competency.	Education – As part of annual competency training, all CNAs are taught how pressure ulcers form and what they can do to prevent them.
Some residents with acquired pressure ulcers were not using a pressure-relieving mattress prior to the development of the wound.	Environmental – All mattresses are now pressure-relieving mattresses to aid in prevention of skin breakdown.
Some CNAs were routinely using a barrier cream during incontinent care, and others were not. The CNAs that did not use the barrier cream said some residents would complain of it burning.	Other corrective action – The stock barrier cream was switched to a new product the CNAs, residents, and wound nurse found to be safe and effective.
The results of an RCA showed that stage 1 pressure ulcers were not managed appropriately due to: • Wound nurse only available Mondays through Thursdays, thus delaying assessment and treatment. • Communication between CNAs, nurses, and wound nurse is inconsistent, with variation in how new skin problems are reported to nurses and how the nurses inform the wound nurse and physician.	PIP – New processes are necessary to consistently communicate new skin issues to the nurse, wound nurse, and physician. Revisions to processes are also necessary to assess new skin areas and receive support from wound experts timely so that appropriate treatment can be initiated.

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Prioritization Examples

3. Improving Hand Hygiene (HH) compliance

   a. Flu season is two months away, and the local community has positive COVID-19 cases. The facility experienced an outbreak of norovirus in the spring which caused staff absences and the hospitalization of three residents.

   b. The IP has observed a few occasions when staff did not perform HH when they should and suspects the problem is not limited to these occasions.

   c. The facility received a deficiency for infection control and prevention during the last survey related to HH compliance.

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Prioritization Examples

Example 3: Hand Hygiene (HH)

Problem or OFI	Intervention
The infection preventionist noticed one of the activity aides was not washing their hands properly.	Education – Just in time teaching on HH provided to the activity aide.
Residents wanted to wash their hands before some of the activities held in the living area, but there was no sink nearby.	Environmental – Hand sanitizer dispenser was hung in a convenient location, as allowed by regulations and codes.
Soap dispensers were filled once a week, on Monday, but often some dispensers would run out of soap over the weekend.	Other corrective action – The Maintenance Director directed staff to refill all soap dispensers every Tuesday and Friday.
A RCA revealed several causes for noncompliance of HH, including: • Forgetfulness • Lack of accountability and safety culture • Work flows not conducive to hand hygiene • Belief gloves provided enough protection, and more.	PIP – Multiple processes changed to improve HH compliance. More detailed examples will be provided later in this course.

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PRIORITIZATION

Prioritization Worksheet for Performance Improvement Projects

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Mechanical Lift	3	4	5	5	5	4	4	30
Pressure Ulcers	3	3	3	5	5	4	3	26
Hand Hygiene	5	5	4	5	5	5	5	34

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Documentation

HH PIP: Team Charter

WORKSHEET TO CREATE PERFORMANCE IMPROVEMENT PROJECT (PIP) CHARTER
1. Project Overview
Name of project: Hand Hygiene (HH) Compliance
Problem to be solved: Ensure compliance with HH.
Background leading up to the need for this project: The flu season is approaching, and COVID-19 is present in the community. There is a recent history of norovirus outbreak and during the last survey, the facility received a deficiency under infection control and prevention related to HH compliance.
Aim statement for this project: HH compliance will improve and thus help to prevent the spread of infections, which supports wellness for our residents, staff, and their families. **The goal(s) for this project:** HH compliance will be at 60% for all staff within the next 90 days. HH compliance will continue to trend up until a shift of at least 90% is achieved.
Scope: Full implementation will be facility wide.

2. Project Approach		
Recommended Project Timetable:		
Project Phase	**Start Date**	**End Date**
Initiation: Project charter developed and approved	Aug 1	April 1
Planning: Specific tasks and processes to achieve goals defined	Aug 5	Aug 20

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Implementation: Project carried out	Aug 21	Mar 31
Monitoring: Project progress and results documented	Aug 20	Mar 31
Closing: Project brought to a close and summary report written	April 10	April 15

Instructor commentary – All PIPs last for a specific length of time, but that time will vary depending upon the nature of the PIP. This example PIP is expected to require this length of time because it involves behavioral change and forming new habits. Also, this PIP's outcome involves a shift in the data, which is defined as eight or more consecutive data points above or below the average. The PIP team must allow sufficient time to ensure a shift has occurred.

Project Team and Responsibilities:

Title	Role	Person Assigned
Project Sponsor	Provide overall direction and oversee financing for the project.	John Sparks, DNS
Project Director/Leader	Coordinate, organize, and direct all activities of the project team.	Jacqueline LaPoint, Infection Preventionist (IP)
Project Manager	Manage day-to-day project operations, including collecting and displaying data from the project.	Jacqueline LaPoint, Infection Preventionist
Team Members*	Member/Note Taker Team Member Team Member/Timekeeper Team Member Team Member Team Member	Catherine Johns, RN Yasmine Toombs, LPN Shanice Smith, LPN Kristen Sayer, CNA Cornell Hoffman, CNA Cassie Marsh, SW Nia Hamilton, Activity aide

*Project director/leader selects team members based on interest, involvement in the process, and availability.

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

Computer with Microsoft Excel and internet and printer access
8 clipboards
1 box pens
File folders
Audit forms
Bulletin board
Meeting space
Handwashing germ training kit (blacklight and germ gel)

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Barriers:	
What could get in the way of success?	**What could you do about this?**
Competing demands on time	Team members must be flexible and assume other team members' duties when needed. The DNS can also pitch in as needed.
The facility is in an open survey window.	If survey occurs during this PIP, the NHA and DNS will continue to support this PIP as a priority and pitch in as needed.

3. Project Approval

The signatures of the people below relay an understanding and approval of the purpose of 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	Luis Hernandez NHA	Luis Hernandez	8/1
Project Sponsor	John Sparks DNS	John Sparks	8/1
Project Director* Project Manager*	Jacqueline LaPoint DNS	Jacqueline LaPoint	8/1

*May not always have both roles

DATA COLLECTION

- For all data sources, create a process to collect and document
  - –Everyone can identify data for QAPI
- Select a range of data that reflects your homes unique characteristics and services
- Assign responsibilities for data collection and monitoring – GIVE ownership
  - –EVERYONE has a role
  - –Everyone should feel
    - – IMPORTANT/VALUED
    - – Have EQUAL voice
- Determine appropriate frequency based on the type of data

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Data Sources

- Publicly reported quality measures –survey results, census, marketing
- MDS data/measures for Nursing Homes
- Clinical data
- Patient, family, and staff satisfaction survey questionnaires
- Incidents/adverse events/near misses
- Survey & Certification findings
- Spontaneous feedback from residents, families, or staff (complaints)
- Resident Council
- Other data measured at variable intervals (unexpectedly)
- Feedback Interviews and Observation
- Daily reviews and chart audits

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DATA

Monitor → Analyze → Synthesize → Evaluate

- Monitor – Observe or check the status of something (i.e., monitor the Five-Star rating and learn what and why the rating is what it is).
- Analyze – Understand the structure of something (i.e., analyze how the Five-Star rating is calculated).
- Synthesize – Combine the elements of the data to understand the whole picture and its impact on processes and systems (i.e., synthesize what gaps in processes are generating the undesired Five-Star rating).
- Evaluate – Judge or determine the quality or significance of something (i.e., evaluate the data and if the plan to improve the Five-Star rating was effective).

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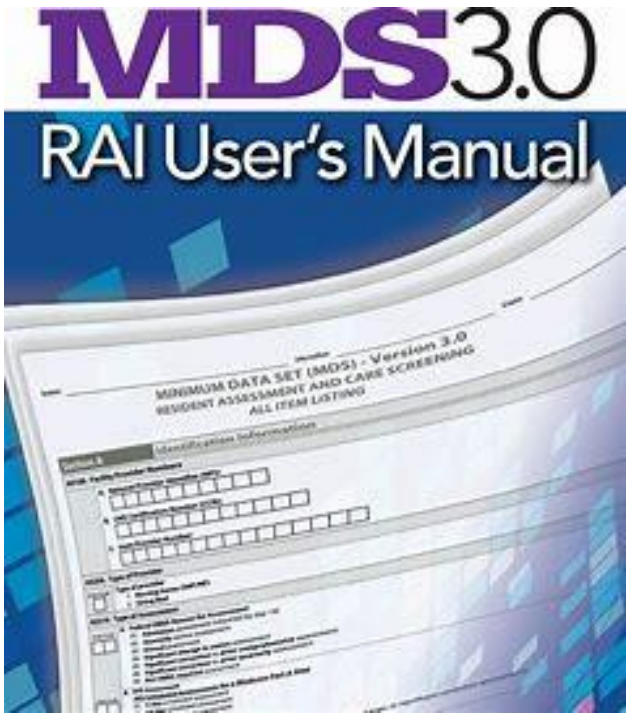
Nursing data collection

- Antipsychotics
- Med errors
- Catheters—UTI's
- Weights
- Personal alarms
- Restraints—bed rails, positioning devices
- Falls… Trends by shift with interventions documented, falls with injuries investigated
- Hand washing/gloving
- Wounds—acquired, admitted with, declining, stalled, or improving?
- Weight Loss



MDS

Care Plans

Care Plan meetings

Late Assessments

Item set coding

Reimbursement items

Quality Measures

QRP processes

5 star

Documentation

HOUSEKEEPING

Infection Control
- Mopping practices
- Chemicals
- Deep cleaning

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SOCIAL SERVICE

- Track Discharges—Hospital admissions
- Code status reviewed on admission and at least quarterly with care plan
- Concerns and Lost articles resolved—F585 residents informed of outcome
- Residents' rights taught to and reviewed with residents and staff
- ABN (Advanced Beneficiary Notices)

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ADMINISTRATION

- Survey activity—Self-report/hot line calls?
  - Resident, family satisfaction?
- Physician trends– meeting their schedule in seeing their residents? Appropriate antibiotic usage
- Pharmacy trends– drug regimen reviews done timely, problems with availability of drugs, GDR process
- Consultant reports—reviewed, interventions
- Billing practices-PDPM, Medicaid
- Culture Change/Person-centered care
- Artifacts of Culture change is a CMS tool that can be used for your QAPI data

  Link: Layout 1 (pioneernetwork.net)

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OFFICE

New Hires

- Criminal background checks
- EDL checked
- I-9 completed
- C.N.A. registry
- Family Care Registry
- Two step TB testing
- Hep B consents/documentation
- Corporate Compliance
- OIG

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Therapy Data

PART A and PART B

- Number receiving PT, OT, SLP
- Are admissions being screened timely
- Screening every quarter
- Referrals to Restorative

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Activity Data

- Evening and weekend activities
- Resident council meetings F585
  - Concerns
  - Resolved
  - Residents informed of outcome
- Individual and group activities
- Are you meeting the needs of EACH Resident

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DIETARY DATA

- Hot food hot, cold food cold? (test trays, food temps)
- All food in freezers, coolers, storage
  labeled and dated-- food grade containers
- Refrigerators and freezer temps logged
- Dishwashing temps logged
- Sanitizer testing

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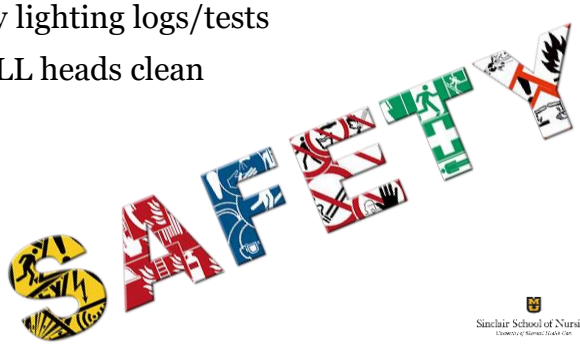
MAINTENANCE/LAUNDRY QA CONCERNS

- Fire drills completed at varied times
- Water temps
- Fire extinguisher testing and maintenance
- Generator logs/tests, emergency lighting logs/tests
- Sprinkler inspections and are ALL heads clean



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STAFFING!!!/TURNOVER RATE?

Turnover calculation

1. Start by calculating the average number of employees for the time period. To do this, add: (# of employees at the beginning of the time period) + (# of employees at the end of the time period) and divide by two.
2. Divide: (# of employees who separated from the company during that time period) by (average # of employees)
3. Multiply: (# calculated in step 2) x 100 = turnover percentage

Example:

On March 1, a company employs 30 people. On March 31, the company employed 35 people. During that month, 3 employees left the company.

1. Calculate the average number of employees: 30 + 35 = 65
2. 65 divided by 2 = 32.5
3. Divide 3 (number of employees who left) by 32.5 (the average # of employees) = 0.0923
4. Multiply 0.0923 (# calculated in step 2) x 100 = 9.23%

- Staff Stability Toolkit

https://bandfconsultinginc.com/staff-stability-toolkit

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FEEDBACK, DATA SYSTEMS, & MONITORING

- Create a system that allows your Home to effectively examine its performance
- Make data-driven decisions about which improvement efforts to undertake
- Evaluate how effective those improvement efforts are.

- Don't Just Watch The DATA
  - Identify a BASELINE
    - Set a Goal
    - Set a Threshold
    - Benchmark

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Organizational Goals

- S = Specific
  - Describe the goal in terms of three "W" questions: What do we want to accomplish?
  - Who will be involved/affected? Where will it take place?
- M = 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, percentage, rate) for that measure? What do you want to increase/decrease that number to?
- A = Attainable
  - Defend the rationale for setting the above goal measure: Did you base the measure or figure you want to attain on a particular best practice, average score, or benchmark?
  - Is the goal measure set too low, so that it is not challenging enough? Does the goal measure require a stretch without being too unreasonable?
- R = Relevant
  - Briefly describe how the goal will address the problem stated above.
- T = Time-Bound
  - Define the timeline for achieving the goal: What is the target date for achieving this goal?

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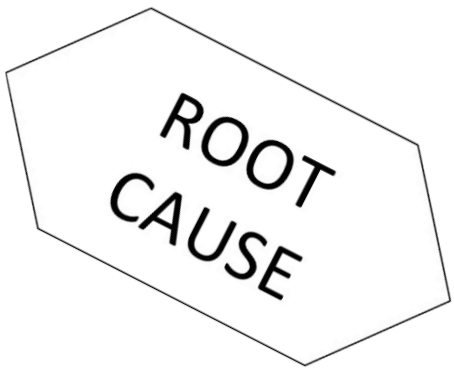
Root Cause Analysis

- Finding the real cause of the problem and dealing with it rather than simply continuing to deal with the symptoms
- Asks why, why, why at each level
- Interdisciplinary- involves those closest to the situation
- Identifies changes that need to be made
- Identifies risks and how they contributed
- Leads the team to potential process improvements
- Move beyond a culture of blame



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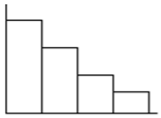
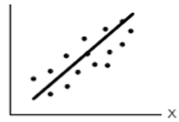
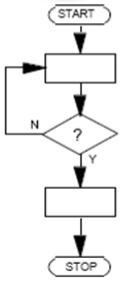
Tools for RCA


Pareto Chart

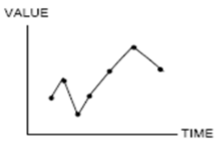

Fishbone Diagram



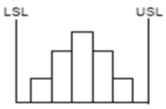
Scatter Diagram



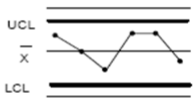
Flowchart



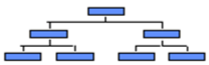
Run Chart

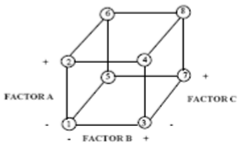


Histogram



Control Charts


Tree Diagram



Design of Experiments

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Why Analysis

Problem Statement - Resident fell last night

- Description of the event
  - It was dark and they tripped
- Why?
  - Going to the bathroom
- Why?
  - No Staff Member Helped
- Why?
  - Resident didn't push call light
- Why?
  - Resident always just gets up even though not steady
- Why?
  - Therapist told resident to be more independent

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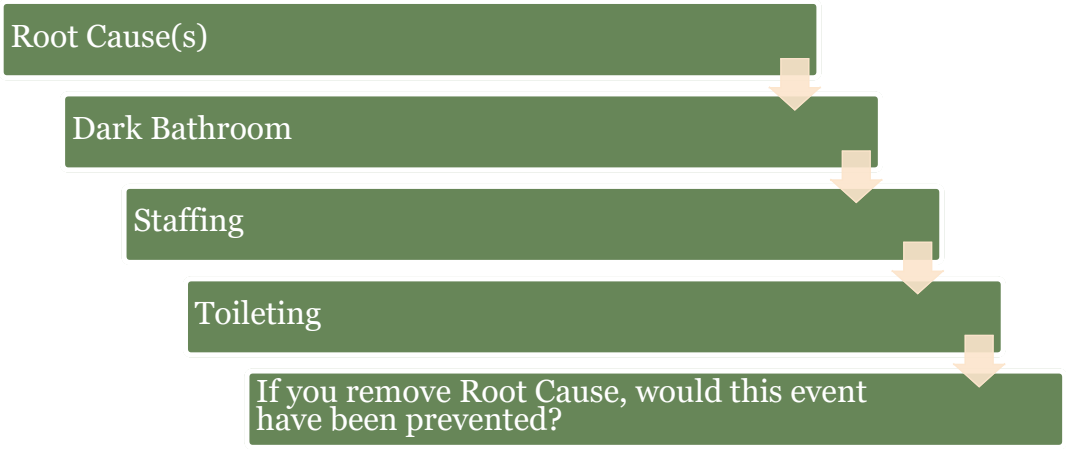
Root Cause Analysis



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Problem/Why/Root Cause

Problem Statement - Resident fell last night

- Description of the event
  - The resident fell while transferring out of bed
- Why?
  - Going to the bathroom
- Why?
  - Tripped over shoes
- Why?
  - Did not see the shoes
- Why?
  - Room was dark
- Why?
  - Vision is poor

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Intervention: Needed a night light

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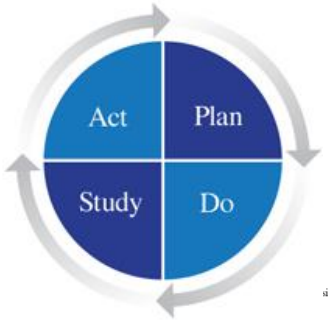
NOW WHAT??

Auditing, rounding and accountability

Plan, Do, Study and Act

- Planning is the identifying of hazards and risk
- Do is the implementing of interventions to reduce risks and hazards
- Study is the monitoring of effectiveness
- Act is the effectiveness and modifying as necessary

– *William Deming*



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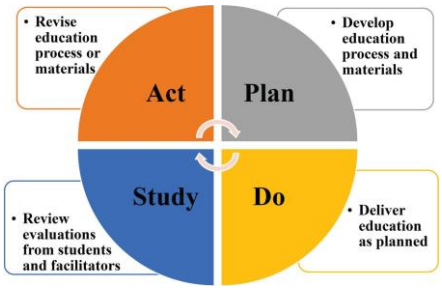

PSDA

1) Choose measures that will tell you if a change worked
2) Develop a **P**lan
3) Defined sampling plan and time frame
4) Activate your Plan (just **D**o it)
5) Set realistic performance thresholds
6) **S**tudy your findings (re-evaluate)

If something didn't work—Re-design (**A**ct)

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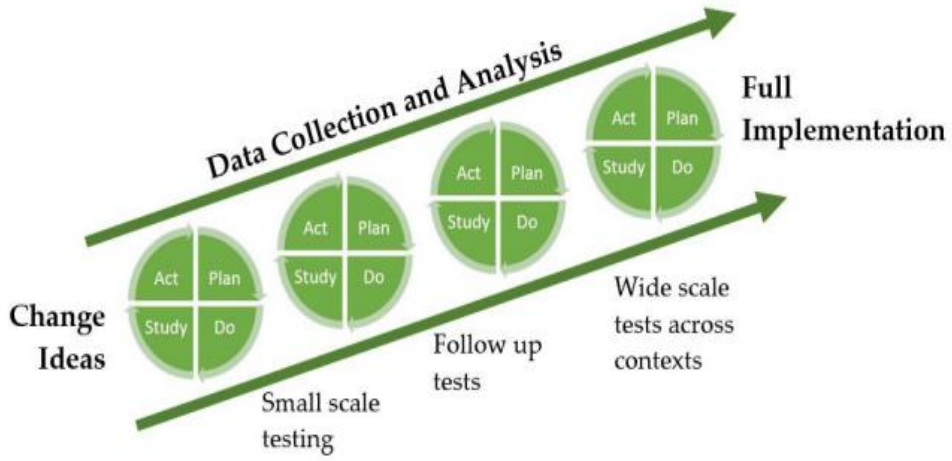
PDSA Cycles



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Outcome Measures

A measure which evaluates the result of an intervention

For example, the impact on the condition or well-being of patients

Assesses whether the change you have put in place had the desired effect.

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Structural measures

- The number of falls that occurred during a lift transfer.
- The number of patients identified as high risk that developed a facility-acquired pressure ulcer.
- Number of incidents when a patient received the wrong medication.
- The number of patients that had a fall --risk assessment tool completed in the expected timeframe.
- The number of patients with a Braden score of 12 or lower that received a wound care nurse consult.

- A measure that evaluates whether needed structure is in place and working well.

  Examples

  –All mattresses replaced

  –New workstations installed

  –All audible alarms removed

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Remember…

Quality improvement measurement is for learning, not research.

- Watch for measurement fatigue
- All measures have limitations
- Don't measure everything!
- Try to add to existing measurement (build on what you have)

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Goal of Feedback, Data Systems and Monitoring

- Create a system that works for your home.
- Make clear decisions about which improvement efforts to undertake
- Evaluate how effective those improvement efforts are.

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Give Feedback and give lots of it!

- Everyone who is involved in the measure
- Everyone who cares about the results
- To upper-level management
- To board members: if it's important to a department → share with staff! If it's important to patients and families → share!
- BE TRANSPARENT when you can.

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"The first step is that you have to be big enough to say what you're doing isn't working. Then you can fix it, do it better, and move forward."

— Scott West, Administrator, Birchwood Terrace Healthcare

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QAPI Resources

- CMS QAPI Homepage-Wide range of resources available https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html
- QAPI Written Plan How-To Guide https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Plan-How-to-Guide.pdf
- QAPI AT A GLANCE https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPIAtaGlance.pdf
- QAPI New Brief https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPINewsBrief.pdf
- QAPI Self Assessment Tool https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPISelfAssessment.pdf
- Pioneer Network-Artifacts of Culture: Layout 1 (pioneernetwork.net)

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QAPI Resources

Institute for Healthcare Improvement-PDSA
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Quality Innovation Network-QIOs (QIN-QIOs) https://qioprogram.org/

Nursing Home Help (QIPMO/Leadership Coaching) https://nursinghomehelp.org/

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Infection Control Team

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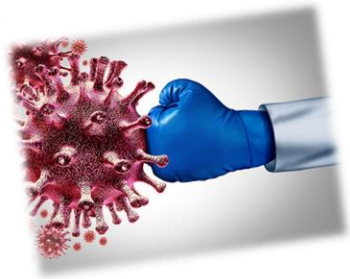

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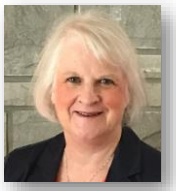

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Leadership Coaches and Admin Team

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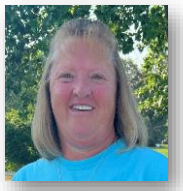

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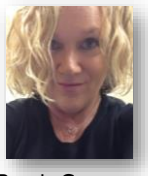

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QUESTIONS

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