QAPI at Work

Theory, Tools, Application

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Objectives

1. Understand the importance of using the right data to prioritize and select areas for improvement
2. Use tools and techniques such as Goal Setting, Root Cause Analysis, and Plan-Do-Study-Act cycles to work through a QAPI project
3. Be able to verbalize how multidisciplinary teamwork and resident engagement can help achieve success

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QAPI in the Final Rule

- Phase I (November 28, 2016) – Continued to require participation in QAA Committee and maintain existing QAA requirements
- Phase II (November 28, 2017) – QAPI plan as required by ACA in place and available to share with surveyors
- Phase III (November 28, 2019) – Full implementation of QAPI program (implementing performance improvement initiatives)

QA + PI = QAPI

- QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving

Quality Assurance

- Measure compliance with standards
- Required, reactive
- Outliers, bad apples
- Few take responsibility

Performance Improvement

- Continuously improve processes
- Chosen, proactive
- Processes, systems
- All take responsibility

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Five Elements of QAPI

Design and Scope	Governance and Leadership	Feedback, Data, Monitoring	Performance Improvement	Systematic Analysis and Systemic Action
• Ongoing and Comprehensive • Includes all systems of care • Aims for safety and high quality with all clinical interventions • Emphasizes autonomy and choice for residents • Evidence based • Addressed in written QAPI plan	• QAPI is a priority • Leadership seeks input from staff, residents and families • Ensures adequate resources • QAPI training • Sustainability through staff turnover • Just Culture • Education • All voices heard	• Systems to monitor care and service • Data from multiple sources • Use of Performance Indicators and benchmarks • Tracking, investigating and monitoring Adverse events • Action plans to prevent adverse event reoccurrence	• Concentrated effort on a particular problem • Involves gathering information to clarify issue • Intervening for improvement • Examines and improves care and services in identified areas	• Organized approach to decide causes of problems • Policies and procedures on the use of Root Cause Analysis • Look across all involved systems to prevent future events and sustain improvement • Focus on continual learning and continuous improvement

Design and Scope

- Ongoing, include all services and all departments
- Address all systems of care and management practices – QAPI self assessment tool
- Aims for safety and high quality with all clinical care
- Utilize best available evidence to define and measure goals
- Emphasizes resident choice
- Written QAPI plan should adhere to above principles

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Governance and Leadership

- Foster a culture where QAPI is a priority
- Ensure adequate resources to conduct QAPI efforts and education – staff, residents, families
- Develop policies to sustain QAPI despite changes in personnel and turnover
- Set expectations around balancing safety with resident-centered rights and choice
- Create atmosphere where staff are comfortable identifying and reporting quality problems

Feedback, Data, Monitoring

- Use data from multiple sources to identify what you need to monitor (Casper reports, QMs)
- Make data meaningful – use it to drive decisions, prioritize what you will work to improve, and identify gaps and opportunities
- Set goals, benchmarks, thresholds
- Collect the data that enables tracking and monitoring measures
- Track, investigate, and monitor adverse events

Performance Improvement

- Concentrated effort on a particular problem
- Involves gathering information to clarify the issue
- Interventions are aimed at improving
- Examines and improves care and services in identified areas
- Teamwork is core component of PIPs

Systematic Analysis and Systemic Action

Systematic Analysis

- Organized approach
- Root Cause Analysis
- Systems perspective
- Focus on system gaps
- Purpose is to understand why events occur and plan to correct cause

Systemic Action

- PDSA
- Sustain change
- Continuous improvement
- Without systemic action, changing the system, a band aid is applied and change can not last

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QAPI Self-Assessment Tool

QAPI

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:					

QAPI SELF-ASSESSMENT TOOL

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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:					

QAPI SELF-ASSESSMENT TOOL

Nursing Home Name:_____

CCN#:_____

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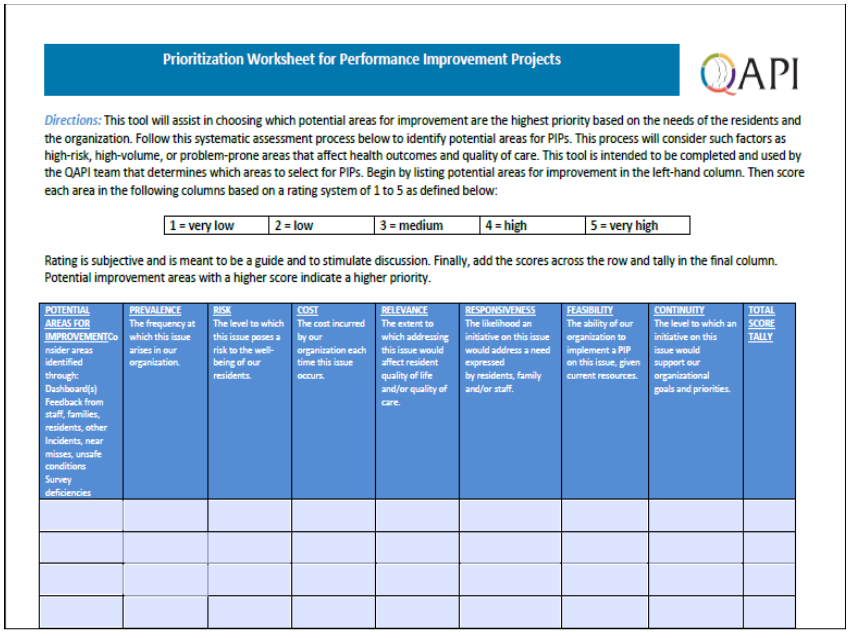

Prioritization Worksheet for Performance Improvement Projects

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 IMPROVEMENTCo nsider 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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Performance Improvement Projects (PIP)

- What are they?
- Three questions for improvement:
  - What are we trying to accomplish? (AIM statement)
  - How will we know the change is an improvement? (Measurement)
  - What change can we make that will result in improvement? (RCA and PDSA)

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AIM Statement

- What is an AIM Statement?
  - EXAMPLE: We will decrease falls with injury for newly admitted residents on the Dementia unit 10% by March 30, 2017 under the direction of Ivy Gotanidea, Unit Manager
  - This includes population involved, measureable goal, time frame and under who's guidance
  - Well-defined, easy to understand

How Will We Know the Change is an Improvement?

- Describe the measureable outcome you want to see
- Three types of measures
  - Outcome Measurement - focus on individual event
  - Process Measurement - focus on system performance
  - Balance Measurement - focus on assessing unintended change
- EXAMPLE using AIM "We will decrease falls with injury for newly admitted residents on the dementia unit 10% by March 30, 2017"
  - Outcome: Number of fall events decrease by 4
  - Process: Number of falls with injury within 30 days of admission has decreased 11%
  - Balance: Newly ordered psychotropic medication for residents on the dementia units within 30 days of admission has risen 25%

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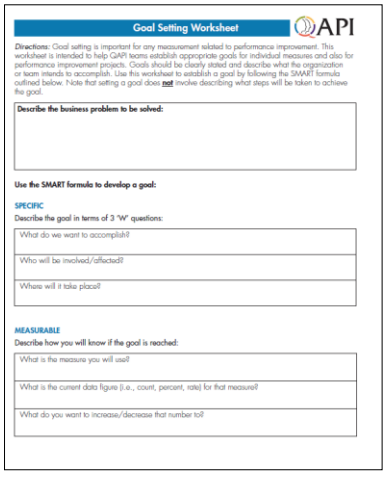
SMART Worksheet for AIM writing



Goal Setting Worksheet QAPI

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

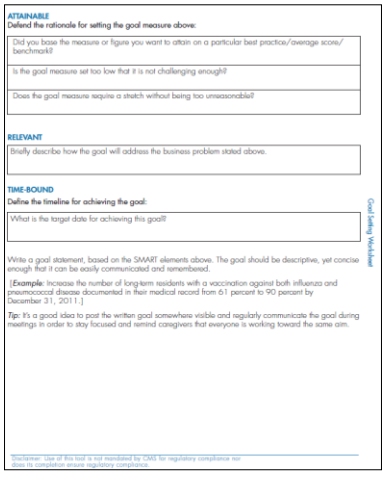
Describe the goal in terms of 3 "W" questions:

- 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.

Goal Setting Worksheet

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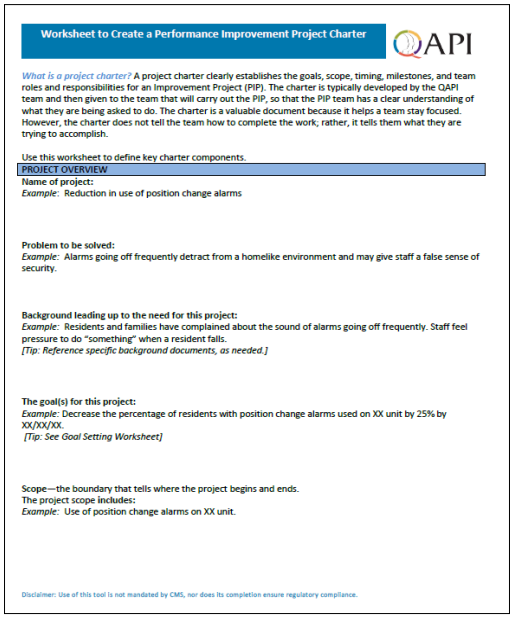

Worksheet to Create a Performance Improvement Project Charter QAPI

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.

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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):

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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.

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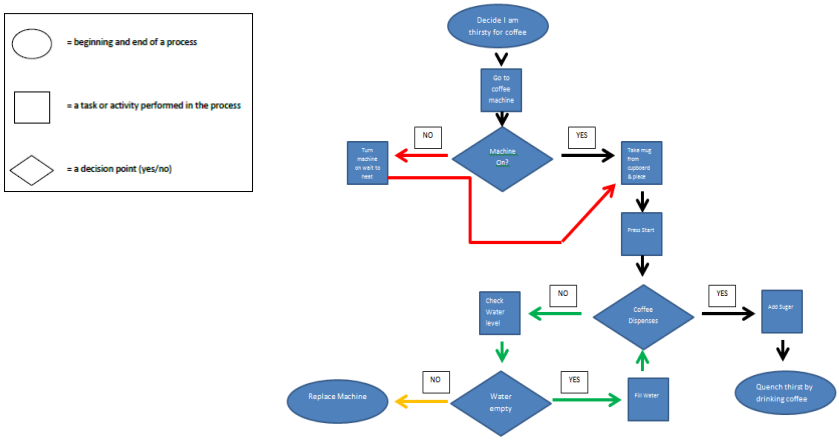
What Change Can We Make to Improve?

- Define the current process – consider flowcharting or process mapping to assist
- Identify opportunities for improvement
  - Points where breakdown occurs
  - Places where workarounds have developed
  - Places where variation occurs
  - Duplicate or unnecessary steps
- Complete Root Cause Analysis for identified opportunities
- Decide what change in the process you will test based on root cause analysis
- Develop a Plan-Do-Study-Act Cycle to test change

Flow Charting/Process Mapping



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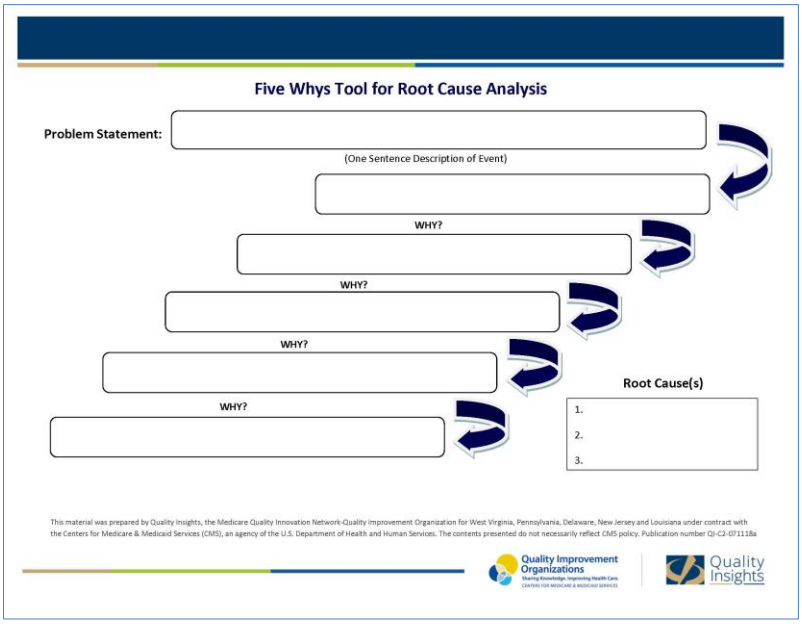
Root Cause Analysis

- Clearly state event to be analyzed
  - **Poor statement:** Falls are increasing on the dementia unit
  - **Better Statement:** Falls with injury are increasing in the hour before dinner on the dementia unit.
- Often there will be more than one root cause identified
- Avoid focusing on individuals, keep concentration on systems
- Complete with various team members
- You have arrived at the root cause when the following questions can be answered "No"
  - Would the event have occurred if this cause had not been present?
  - Will the problem reoccur if this cause is corrected?



Root Cause Analysis Takes Practice

- When asking a person why Falls with injury are increasing in the hour before dinner on the dementia unit, a typical response might be “because they are confused and don’t remember not to get up.”
- This is not a root cause and will lead down a “dead end Why path.” (Why are they confused?)
- The person administering the analysis must be skilled in leading the team member back to the purpose of the exercise without leading the response. In this case, rephrasing the Why statement to be “Why are people who can not remember to stay seated falling at dinner time?” allows the process to continue.
- With practice this process becomes easier for both those asking the questions and those providing the responses.

Plan-Do-Study-Act (PDSA)

- Form of rapid cycle improvement
- Small tests of change rather than system wide until proven
- Cycles are intended to be short in duration, evaluated then adopted, adapted or abandoned
- Many times you will need multiple PDSA cycles to effectively improve a system

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PDSA Worksheet

Aim Statement: _____

PLAN: Area to work on:

Describe the change you are testing:

What question does this test seek to answer? (If I do 'x', will 'y' happen?)

What do you predict or expect the result will be?

What measure will you use to learn if this test is successful or has promise?

Plan for change or test: who, what, when, where

Data collection plan: who, what, when, where

Team
Facilitator:
Members:

DO: Report what happened when you carried out the test. Describe observations, findings, problems encountered, special circumstances

STUDY: Compare your results to your predictions. What did you learn? Any surprises?

ACT: What will you do next? Adopt, adapt or abandon the change?

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Sustainability Decision Guide

QAPI

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?

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QAPI Features

- 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

Celebrate Success

- Well organized celebrations build collective power – evaluation, preparation, celebration.
- Give voice to the challenges that were overcome, acknowledge what you might do differently, individual "shout-outs", introduce what might be coming next.
- Food, fun, fraternizing

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Resource List

- www.qualityinsights-qin.org
- www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.html
- www.nhqualitycampaign.org

Practice Session

- Scenario 1 – QA
- Scenario 2 – QAPI
- RCA and PDSA tools – individual and system

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