END STAGE RENAL DISEASE
NETWORK OF TEXAS

Quality Assurance Performance Improvement Guide

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Introduction: Why This Guide?

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 facility with the aid of QAPI tools and the establishment of an effective QAPI foundation. 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 and facilities striving to embed QAPI principles into their day to day work of providing quality care and services for patients.

This guide provides detailed information about 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 patients in practical and creative problem solving.

Your QAPI results are generated from your own experiences, priority-setting, and team spirit. A more basic reason to build care systems based on a QAPI philosophy is to ensure a systematic, comprehensive, data-driven approach to care. This effort is not only about meeting minimum standards—it is about continually aiming higher.

Please note this information has been modified for your facility. You may obtain the original version at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIAtaGlance.pdf

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. Facilities 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 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. 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 staff, as they become active partners in performance improvement; and
- Above all, better care and better quality of life for your patients.

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.

Launching QAPI is not necessarily easy or quick, but it has a compelling logic and it is feasible for all facilities.

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 facility regulations.
- You track, investigate, and try to prevent recurrence of adverse events.
- You compare the quality of your facility to that of other facilities in your state or company.
- You receive and investigate complaints.
- You seek feedback from patients and staff.
- You set targets for quality.
- You strive to achieve improvement in specific goals related to blood stream infections, fluid levels, depression, transplantation, Facility Patient Representatives, etc.,(for example by joining the NCC LAN calls, QIA Projects, Network Website).
- You are committed to balancing a safe environment with patients, families and caregivers.
- You strive for deficiency-free surveys.
- You assess patients' 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 facilities. It emphasizes improvements that can not only elevate the care and experience of all patients, but also improve the work environment for staff, families and 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 patients' own goals for health, quality of life, and daily activities
- Bringing meaningful patient and family voices into setting goals and evaluating progress
- Incorporating patients, family and 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.

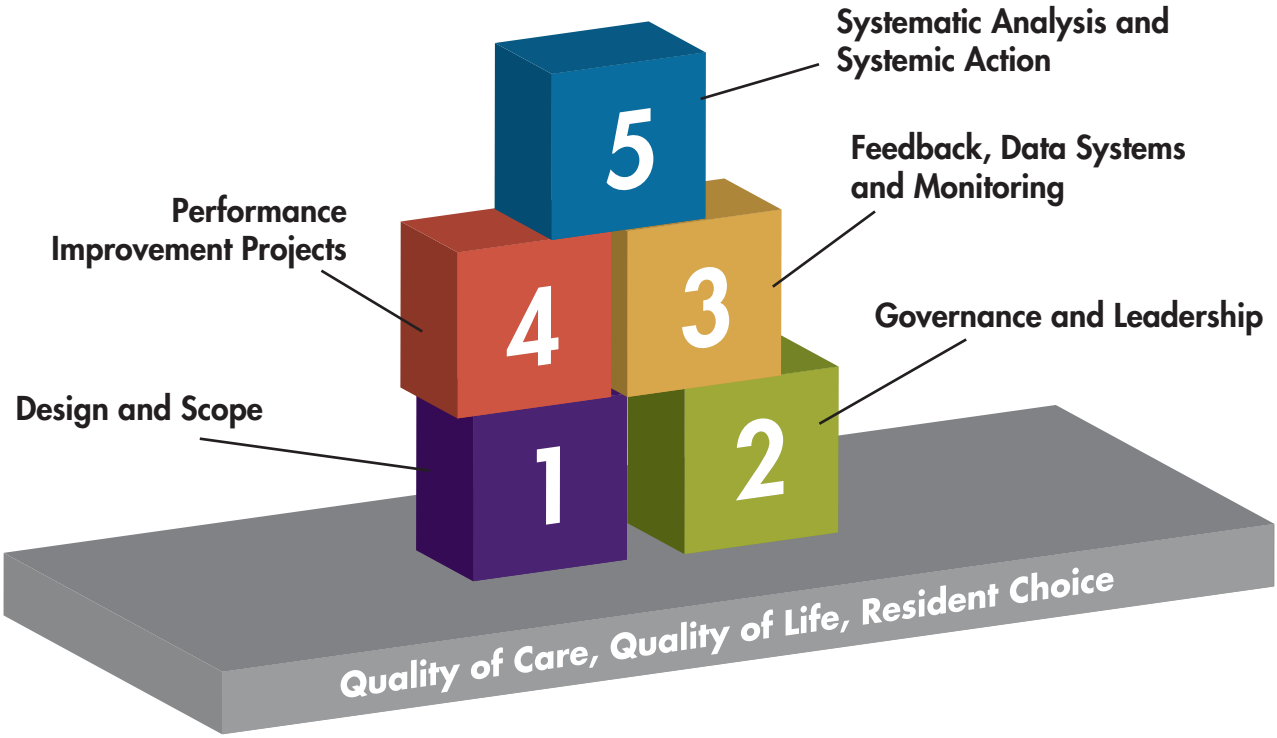
Scenario 1

The Issue: Your facility, Sunny Dialysis, received deficiencies during their annual survey because patients had unexplained BSI's, and low transplantation referrals and high depression rate during intake were not accurately and consistently documented.

What Sunny Dialysis did: The QA Committee developed a Plan of Correction, which contained the following components: Reviewing hygiene practices with all patietns, and updating Plan of Care converstations to include transplantation information with the eligible patients; in-servicing the Social Work Department on obtaining and documenting depression screening at intake. They stated they would conduct 3 monthly audits of BSI and Depression records, with results reported to the QA committee. This plan of correction was accepted by the State Survey Agency.

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 patients, and your assessment of your current quality challenges and opportunities.

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 patient choice. It aims for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for patients (or family and/or caregivers). It utilizes the best available evidence to define and measure goals. Facilities 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 facility develops a culture that involves leadership seeking input from facility staff, patients, 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 patient-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, patients, 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 patient, family member and caregiver. The administrator and senior leaders must create an environment that promotes QAPI and involves all patients, family members and caregivers. Executive leadership sets the tone and provides resources. Their challenge is to help leadership flourish in each facility.

Put a Personal Face on Quality Issues

Leadership should:

- give patients, family and caregivers the opportunity to meet board members and executive leaders to generate support for QAPI.
- tour the organization regularly, meeting with patient, family member and caregiver where they receive treatment.
- 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. The steering committee must learn and use systems thinking—a facility has many competing interests and needs. Top leadership such as the Social Worker, Facility Administrator and Medical Director must be part of this structure.

  — 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:

  — Patients and Staff 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, patients and caregivers.
  - — Emphasizing communication across shifts and between department heads.
  - — Creating an environment where patients and caregivers feel free to bring quality concerns forward without fear of punishment.
  - — Understand your facility's current culture and how it will promote performance improvement:
  - — Create the expectation that everyone in your facility is working on improving care and services.
  - — Establish an environment where patients, families and caregivers feel free to speak up to identify areas that need improvement.
  - — Expect and build effective teamwork among departments and patients, families 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, dietician) 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 patients lose weight decided that a dietician personnel needed to be on that team so that procedures for healthy weight loss 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 patients, the members realized that many of the patients reported reassurance from the Social Worker and asked the QA committee to add him/her to the team that was planning the approach.

  — A PIP team working on reducing falls asked that the Social Worker and Medical Director department be involved as it considered root causes of falls and realized that home dialysis equipment in the home 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 Medical Director 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.

- Patients and family members 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, please take the attached 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.

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.

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.

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 facilities'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 facility. 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 facility including all staff, modalities, and patient groups (for example, your Facility Patient Representatives, your peer-to-peer groups, or mentoring programs. Think also of the range of patients. Do you have some younger patients? You may need to consciously develop a distinct plan to create quality of life for those patients.
- Some large organizations or corporations may choose to develop a general plan for all facilities in the group—in fact many organizations already have a corporate quality plan. Flexibility must be built in because individual facilities 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.

STEP 6: Conduct a QAPI Awareness Campaign

COMMUNICATE WITH ALL PATIENTS AND CAREGIVERS

- Let everyone know about your QAPI plan—often and in multiple ways.
- Plan ongoing patient, family and 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 facility's own experiences with certain patients, family and caregiver 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 patients and caregiver 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 organizations coming in and out of your facility. You may work with a Dietician who visits regularly. They each have a role in your system.
- Convey the message that any and every patint and 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 does the facility try to balance issues of depression and patient choice/autonomy? These type of question 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 patients during Lobby Days. Also seek examples where patient choice did not prevail. Brainstorm how to solve problems like this, even if jobs and routines would change.

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

COMMUNICATE WITH PATIENTS AND FAMILIES

- Make sure all patients and families know that their views are sought, valued, and considered in facility healthcare decision-making and process improvements by announcing and discussing QAPI in patient and family councils and other venues.
- Ask patients 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 patients and their families.
- Try to view concerns through patients' eyes. For example, getting back to a patient in 60 minutes may seem responsive, but may feel like an eternity to the patient. How would that feel to a patient waiting an answer to a call for help with their treatment?
- Consider including QAPI information in routine communications to patients and 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., BSI, Diet, Depression
- Medications, e.g., those that require close monitoring, antipsychotics, narcotics
- Complaints from patients and families
- Hospitalizations and other service use
- Patient satisfaction
- Family and Caregiver satisfaction
- Care plans, including ensuring implementation and evaluation of measurable interventions
- State survey results and deficiencies
- Results from patient assessments
- Business and administrative processes—for example, financial information, staff turnover, patient, family and caregiver competencies, and staffing patterns. Data related to staff who call out sick or are unable to report to work on short notice, staff 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 patient'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 facility'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 depression 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 blood stream infections 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 facilities in your state and nationally using https://www.usrds.org/ and http://data.medicare.gov/data/dialysis-facility-compare. Some states also have state report cards. You may compare your facility 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 patients leave the facility or come back, including discharges to the hospital or home dialysis. You may examine discharge rates from your facility.

- 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.
- Facility comparison (provides quality information about every certified facility in the state).
- State survey results and plans of correction.
- Patient care plans for documented progress towards specified goals.
- Trends in complaints.
- Patient and family satisfaction for trends.
- Patterns of staff turnover or absences.
- Patterns of BSI and other infection control.

During this step, you may decide to spend more time discussing the quality themes you have identified with patients and staff. 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 staff, and arrange to meet with your FPRs.

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 patients to exercise choice should also be considered as they may lead to patient satisfaction.
- 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 staff, such as technicians, 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.

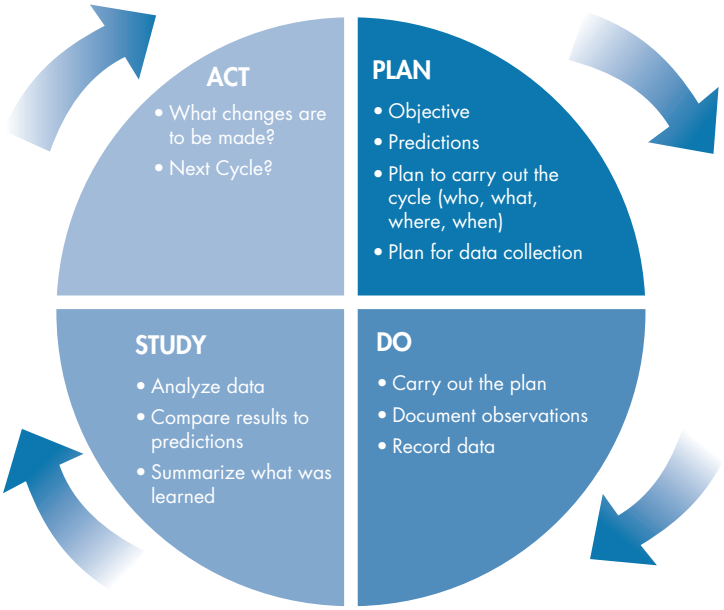
Use the Goal Setting Worksheet to help your PIP team establish appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.

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 patients. 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: hand washing, cleaning stations
- forcing functions or constraints: design of treatment area; 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 staff, patients, and families.
- Patients' perspectives need to be considered in setting QAPI priorities. Solicit FPRs' viewpoints and talk to patients 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.

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 transplant and home referrals documented in their medical record from 61 percent to 90 percent by December 31, 2018.]

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 staff that everyone is working toward the same aim.

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 staff who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new staff orientation and training. For example, new staff understand and can describe their role in identifying opportunities for improvement. Another example is that new staff expect that they will be active participants on improvement teams. Notes:					
Training is available to all staff 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 patient, 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 staff members 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 staff 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 staff, patients, 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 patient 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 staff 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, patients and families. This process identifies problems that pose a high risk to patients or staff, is frequent in nature, or otherwise impact the safety and quality of life of the patients. 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 patient 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 patients. 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 staff and another patient. 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 staff 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 staff, 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 patient 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:					

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 patients 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, patients, 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 patients.	**COST** The cost incurred by our organization each time this issue occurs.	**RELEVANCE** The extent to which addressing this issue would affect patient quality of life and/or quality of care.	**RESPONSIVENESS** The likelihood an initiative on this issue would address a need expressed by patients, 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. Which type of changes primarily will be involved (i.e., system changes, environmental changes, staffing changes)?
4. Which staff will be most affected by the initiative? What training needs will this initiative present?
5. Is there an identified champion(s) for this initiative?