

Quality Assurance and Performance Improvement Policy and Procedure Checklist

Purpose and Intent of §483.75(a-g)

The purpose of the Quality Assurance and Performance Improvement (QAPI) policy is to outline a process for development of a QAPI plan. These requirements are intended to ensure facilities develop a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

To assure that the individual facility has followed all the required steps for the development and implementation of a Quality Assurance and Performance Improvement Plan in accordance to the new Requirements of Participation (RoP), the following checklist captures specific action items for successful completion. The left column represents the actual Requirements of Participation (RoP) language and the right column indicates specific leadership strategies for successful completion and implementation of the revised RoP. When preparing updated policies and procedures, it is recommended to include actual RoP language as applicable.

Suggested Checklist Program and Policy and Procedure

Regulation	Recommended Actions
F865 §483.75(a) Quality assurance and performance improvement (QAPI) program §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this	<input type="checkbox"/> Review, develop and/or implement the Quality Assurance and Performance Improvement Plan in accordance with the (RoP). See regulatory requirements as well as template plan, policy and procedure. Due by November 28, 2017. <input type="checkbox"/> Assure that plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as: (A) Tracking and measure performance; (B) Establishing goals and thresholds for performance measurement;

<p>regulation; [§483.75(a)(2) implemented November 28, 2017 (Phase 2)]</p> <p>§483.75(a)(3) 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;</p> <p>§483.75(a)(4) 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.</p> <p>§483.75(b) Program design and scope. 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:</p> <p>§483.75(b)(1) Address all systems of care and management practices;</p> <p>§483.75(b)(2) Include clinical care, quality of life, and resident choice;</p> <p>§483.75(b)(3) 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.</p> <p>§483.75(b)(4) Reflect the complexities, unique care, and services that the facility provides.</p>	<p>(C) Identifying and prioritizing quality deficiencies;</p> <p>(D) Systematically analyzing underlying causes of systemic quality deficiencies;</p> <p>(E) Developing and implementing corrective action or performance improvement activities; and</p> <p>(F) Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.</p> <p><input type="checkbox"/> Educate all staff and the interdisciplinary team about the Quality Assurance and Performance Improvement plan and their role in development and implementation of interventions. Include correlation to Facility Assessment, Emergency Preparedness Plan, facility wide policies, corporate compliance, ethics</p> <p><input type="checkbox"/> Review the Quality Assurance and Performance Improvement Plan with the Medical Director in conjunction with the Quarterly Quality Assurance Committee meeting</p> <p><input type="checkbox"/> Update staff education materials for orientation, annual education, and agency staff orientation, as needed.</p> <p><input type="checkbox"/> Update policies and procedures per department to reflect QAPI process and plan</p> <p><input type="checkbox"/> Update additional policies or programs including but not limited to: Grievance, business office, corporate compliance, ethics, quality measures,</p>
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	Facility Assessment, Emergency Preparedness
<p>§483.75(f) Governance and leadership. 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:</p> <p>§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.</p> <p>§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;</p> <p>§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;</p> <p>§483.75(f)(4) 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.</p> <p>§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and</p> <p>§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.</p> <p>§483.75(h) Disclosure of information.</p>	<ul style="list-style-type: none"><input type="checkbox"/> Review, develop and/or implement plan/policy as it relates the Quality Assurance and Performance Improvement<input type="checkbox"/> Assure that the policy contains the essential components defined under §483.75(f) in the left column.
<p>F866</p> <p>§483.75(c) Program feedback, data systems and monitoring. (§483.75(c) will be implemented during Phase 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:</p>	<ul style="list-style-type: none"><input type="checkbox"/> Phase 3 implementation<input type="checkbox"/> Assure that the policy contains the essential components defined under §483.75(c) in the left column.<input type="checkbox"/> Ensure there is a process in place to obtain feedback from staff, residents, and resident representatives.



<p>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.</p> <p>§483.75(c)(2) 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 at §483.70(e) and including how such information will be used to develop and monitor performance indicators.</p> <p>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.</p> <p>§483.75(c)(4) 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.</p>	<p><input type="checkbox"/> Educate staff, residents, and resident representatives on how to share feedback</p>
<p>F867</p> <p>§483.75(d) Program systematic analysis and systemic action.</p> <p>(§483.75(d) will be implemented during Phase 3)</p> <p>§483.75(d)(1) 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.</p> <p>§483.75(d)(2) The facility will develop and implement policies addressing:</p> <ul style="list-style-type: none">(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;(ii) How they will develop corrective actions that will be designed to effect change at the	<p><input type="checkbox"/> Phase 3 implementation</p>



<p>systems level to prevent quality of care, quality of life, or safety problems; and</p> <p>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.</p> <p>§483.75(e) Program activities.</p> <p>(§483.75(e)) will be implemented during Phase 3)</p> <p>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.</p> <p>§483.75(e)(2) 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.</p> <p>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. 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 at §483.70(e).</p> <p>Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section</p>	
<p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a)</p>	<p><input type="checkbox"/> Ensure a system for monitoring departmental performance data routinely to identify deviations in performance and adverse events.</p> <p><input type="checkbox"/> Prioritize identified issues to determine which concerns pose a high</p>



<p>through (e) of this section. The committee must:</p> <ul style="list-style-type: none"> (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements 	<p>risk to resident safety, health, and well-being, those which are problem-prone, and those which are high volume (occur with frequency)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ensure that corrective actions address the underlying cause of the issue comprehensively, at the systems level. <input type="checkbox"/> Review Facility Assessment and Quality Measures Policies and procedures to include QAPI
<p>F868 §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <ul style="list-style-type: none"> (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection Preventionist. <p>[483.75(g)(1)(iv) Implemented beginning November 28, 2019(Phase 3)]</p> <p>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:</p> <ul style="list-style-type: none"> (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. 	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure that at a minimum, the required individuals attend the QAA meetings. <input type="checkbox"/> QAA meetings are held at least quarterly and with enough frequency to conduct required QAPI/QAA activities. <input type="checkbox"/> Describe how the QAA committee will develop and implement corrective action, and monitor to ensure performance goals or targets are achieved, and revise corrective action when necessary.



The below areas serve as a cross reference for facility leaders to conduct additional policy and procedure review across departments to incorporate the changes set forth in **F865-F868 §483.75(a) Quality assurance and performance improvement (QAPI)**. This listing is not all encompassing however should serve as a resource for leaders as they update their internal policies, procedures and operational processes.

Cross Reference: (additional areas for review)

- CMS Regulations
- State and Local Regulations
- Employee Orientation
- Annual Training Requirements
- Facility Assessment
- Quality Measures
- Emergency Preparedness Plan
- All IDT Policies and Procedures
- Admission Policy
- Corporate compliance
- Postings
- Resident Council
- Family Council
- Resident Rights
- Grievance Policy
- Medical Director
- Staff Training and Education

References

CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf>

CMS. (2017). CMS S&C Memo 17-36-NH. Retrieved August, 2017, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf>

“Process Tool Framework” link: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf>

“QAPI Self-Assessment Tool”, located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPISelfAssessment.pdf>

The first QAPI News Brief, Volume 1

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPINewsBrief.pdf>

QAPI News Brief released for 2016 at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Newsbrief-Volume-2.pdf>

Resource Tool

QA vs. QAA vs. QAPI History and Background

CMS, in the State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities, defines QA in the context of Quality Assessment and Quality Assurance [F868, 483.75(g)]:

- QA: **“Quality Assessment”** is an evaluation of a process and/or outcomes of a process to determine if a defined standard of quality is being achieved.”
- QA: **“Quality Assurance”** is the organizational structure, processes, and procedures designed to ensure that care practices are consistently applied and the facility meets or exceeds an expected standard of quality. Quality assurance includes the implementation of principles of continuous quality improvement.”
- QA&A: **“Quality Assessment and Assurance”** “is a management process that is ongoing, multi-level, and facility-wide. It encompasses all managerial, administrative, clinical and environmental services, as well as the performance of outside (contracted or arranged) providers and suppliers of care and services.” This process is continuous and had the following objectives prior to the Final Rule (Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities):
 - To keep systems functioning “satisfactorily and consistently including maintaining current practice standards”
 - To prevent deviation from appropriate care processes
 - To determine and identify any issues and concerns with systems in the facility and
 - To correct inappropriate care processes”

[https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf)

[Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf)

- QAPI: **Quality Assurance and Performance Improvement**, was passed by Congress in March of 2010 as part of the Affordable Care Act, Section 6102 (c): “QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). 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.”

- CMS (Centers for Medicare and Medicaid) QAPI Description and Background:
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition.html>

Traditionally, by requirement (F520), the facility QAA Committee, comprised of at least the DON, physician (in most cases the Medical Director) and at least 3 other facility employees would meet at least quarterly. The meeting would identify quality issues and put together a plan of action for implementation on any deficient areas for improvement. This process was primarily a reactive process, identifying deficient practice(s) for correction. QAPI, is a process intended to not only address deficient practices, but to identify potential concerns with quality and proactively work on an ongoing process/system for quality.

The Final Rule – Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, by the Centers for Medicare & Medicaid Services and published on October 4, 2016, has made a few changes to the QAA Committee Requirements. The QAA Committee is required to meet at least quarterly to identify issues and to develop and implement plans of action to correct identified deficiencies and to coordinate and evaluate activities under the QAPI program, to include performance improvement projects. The DON, the Medical Director or Designee and at least 3 other members of the facility staff (at least one must be the administrator, owner, a board member or other individual in a leadership role) are required to attend. This committee will report to the governing body or designated person who will function as a governing body activities of the committee and implementation of the QAPI program. Another requirement of the Committee is to regularly review and analyze data, to include data that is collected under the facility QAPI program as well as data from the drug regimen reviews and to act upon that data to make improvements.

Additionally, in the Final Rule, a new section was added to include: §483.75 Quality assurance and performance improvement. The requirements include:

- Each facility will need to develop, implement and maintain a QAPI program that is effective, data driven and comprehensive and will focus on “indicators of the outcomes of care and quality of life”
- The facility will need to maintain documentation and be able to demonstrate evidence that the program meets CMS requirements
- The facility will be required to present their QAPI plan to the State Survey Agency no later than 1 year after promulgation of the regulation
- The facility will be required to present their QAPI plan to a State Survey Agency or Federal surveyor during their annual recertification survey and at the request during any other survey or upon CMS request

- Present evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested
- CMS. (2017). CMS S&C Memo 17-36-NH. Retrieved August, 2017, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf>
- CMS: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities: <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>
- Survey and Certification Group, Division of Nursing Homes (DNH), in 2013, posted a webpage for nursing homes with QAPI Tools and Resources to assist nursing homes in developing a QAPI program: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools.html>
- There are many good tools and resources identified under the “Process Tool Framework” link: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf>
- Especially helpful for facilities to start out is the “QAPI Self-Assessment Tool”, located at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPISelfAssessment.pdf>
- The first QAPI News Brief, Volume 1, was published in 2013, outlining a description and explanation of what QAPI is, including the 5 Elements of QAPI: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPINewsBrief.pdf>
- Since that time, one additional QAPI News Brief was released for 2016 at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPI-Newsbrief-Volume-2.pdf>
- The CMS Publication entitled, “CMS Survey and Certification Group 2016/2017 Nursing Home Action Plan” also identifies the requirements for nursing homes to develop and implement a QAPI program at: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/2016-2017-Nursing-Home-Action-Plan.pdf>

All of these resources, recommendations and regulatory requirements lead us to the present—which requires Nursing Homes to comply with the development and implementation of a solid Quality Assurance and Performance Improvement (QAPI) Program.



QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

POLICY:

It is the policy of the facility to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment.

OBJECTIVE OF THE QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT POLICY

The objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristic and needs of the residents.

DEFINITIONS:

"Adverse Events": An adverse event is defined as an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes near misses.

"Corrective Action": A written and implemented plan of action for correcting or improving performance in response to an identified quality deficiency. Use of the term corrective action in this guidance is not synonymous with a Plan of Correction (formal response to cited deficiencies). This is also separate from the written QAPI plan.

"High Risk, High Volume, Problem-Prone":

"High risk": Refers to care or service areas associated with significant risk to the health or safety of residents, e.g., tracheostomy care; pressure injury prevention; administration of high risk medications such as warfarin, insulin, and opioids.

"High Volume": Refers to care or service areas performed frequently or affecting a large population, thus increasing the scope of the problem, e.g., transcription of orders; medication administration; laboratory testing.

"Problem-prone": Refers to care or service areas that have historically had repeated problems, e.g., call bell response times; staff turnover; lost laundry.



“Near Miss”: A potential harm event that did not reach a resident.

“Plan Do Study Act (PDSA) Cycle”: An iterative four-step improvement method used to quickly test change in a process, resulting in continuous improvement. Also known as a Deming cycle, rapid-cycle improvement, or Plan Do Check Act (PDCA) cycle.

Beginning November 28, 2017, the QAPI plan will be available to present to a State Survey Agency or Federal surveyor during their survey and at the request during any other survey or upon CMS request

PROCEDURE:

1. The facility will develop, implement and maintain a QAPI program that is effective, data driven, comprehensive and will focus on indicators of the outcomes of care and quality of life.
2. The plan describes the process for identifying and correcting quality deficiencies and contains the necessary components such as:
 - a. Tracking and measure performance;
 - b. Establishing goals and thresholds for performance measurement;
 - c. Identifying and prioritizing quality deficiencies;
 - d. Systematically analyzing underlying causes of systemic quality deficiencies;
 - e. Developing and implementing corrective action or performance improvement activities; and
 - f. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.
3. The facility maintains documentation and can demonstrate evidence that the program meets CMS requirements
4. The facility presents evidence in the form of documentation to substantiate the ongoing implementation and QAPI program compliance with regulations to the State Survey Agency, Federal Surveyor or CMS if requested.
5. The Quality Assessment and Assurance Committee consists at a minimum of:
 - a. The director of nursing services;
 - b. The Medical Director or his/her designee;
 - c. At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and

- d. The infection Preventionist – effective November 28, 2019.
6. The QAPI plan describes the methods to validate and update staff competencies at the time of hire and periodically.
7. The QAPI plan ensures that residents provide input to prioritize the areas to monitor and measure that reflect the resident's preferences, ethnic, cultural and religious considerations.
8. Contract staff will contribute data and information and collaborate within the QAPI program.
9. QAA meetings will be held at least quarterly and with enough frequency to conduct required QAPI/QAA activities.
10. All facility staff, contracted staff, and volunteers will be educated about the QAPI plan and their role in development and implementation of interventions.
11. A plan will be in place to ensure that agency staff are educated on the facility QAPI plan.
12. The QAPI plan will be reviewed annually and with any significant change at the facility.

References

CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities:

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf>



QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PROGRAM

Preface

Per the QAPI New Brief published by CMS in 2013, Quality Assurance Performance Improvement (QAPI) is the merger of two approaches to monitor and improve quality.

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

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

Regulations require that a facility's QAPI program be ongoing, comprehensive and address the full range of care and services provided by the facility. The program must address all systems of care and management practices. The program utilizes the best available evidence to define and measure indicators of clinical care, quality of life, resident choice. The facility's goals reflect care processes and facility operations that have been shown to be predictive of desired outcomes for residents of SNFs and NFs. The program reflects each facility's complexities, unique residents and care and services provided.

A comprehensive QAPI program involves all staff. Residents and residents' representatives are knowledgeable of the facility's QAPI activities.

Definitions

- **“Quality Assessment”** is an evaluation of a process and/or outcomes of a process to determine if a defined standard of quality is being achieved.
- **“Quality Assurance”** is the organizational structure, processes, and procedures designed to ensure that care practices are consistently applied and the facility meets or exceeds an expected standard of quality. Quality assurance includes the implementation of principles of continuous quality improvement.
- **“Quality Deficiencies”** are potential markers of quality that the facility considers to be in need of investigating and which, after investigation, may or may not represent a deviation from quality that results in a potential or actual undesirable outcome. The term “quality deficiency” in this regulation is meant to describe a deficit or an area for improvement. This term is not synonymous with a deficiency cited by surveyors.
- **“Quality Improvement (QI)”** is an ongoing interdisciplinary process that is designed to improve the delivery of services and resident outcomes

Sample

ABC Facility

Quality Assurance/Assessment and Performance Improvement Plan

Purpose

Example: The Quality Assurance/Assessment and Performance Improvement (QAPI) Program is to utilize an on-going, data driven, pro-active approach to advance the quality of life and quality of care for all residents at ABC Facility. Quality Assurance and Performance Improvement principles will drive our facilities decision making to promote excellence in all resident and staff related areas. All facility staff, families and residents will be encouraged to be involved in identifying opportunities for improvement, partake in QAPI teams, imbed QAPI activities in all core processes and provide ongoing feedback.

Mission

Example: To provide superior quality health care services and to be the facility of choice where our clients see themselves not as patients but rather as members of our extended family

Vision

Example: To be recognized leaders for excellence in healthcare with innovative services for improved resident and client outcomes.

Guiding Principles

Guiding Principle #1: Our organization makes quality improvement decisions based on data analysis with input from residents, families, staff and the community

Guiding Principle #2: Our organization uses quality assurance and performance improvement (QAPI) principles to address systems of care

Guiding Principle #3: In our organization, ...

Guiding Principle #4:

Guiding Principle #5:



Design and Scope

Each facility's program will be on-going, comprehensive and reflect the resident population, staff community, care and services provided by the facility and the resources available and reflect the Service Standards of ABC Facility.

Example: The QAPI program at ABC Facility encompasses post-acute care, long term care and outpatient therapy. The QAPI committee consists of representatives from all departments including nursing, food and nutrition, laundry, maintenance, health information technology, therapeutic recreation, therapy, business office and administration. Involvement will be varied by topic and may include committee, sub-committee or verbal/written input. Our service areas will work together to best meet the needs of the individuals living in our care center. All departments and services along with families, residents, volunteers, board members and contract staff will be educated on the principles of QAPI. All resident directed decisions will be focused on retaining autonomy, encouraging individualized choices and preserving the highest attainable quality of life and quality of care. PIPs will be implemented when an opportunity for improvement is identified. These PIPs may apply to processes or systems at all levels of the organization.

The QAPI program is ongoing, comprehensive and addresses the full range of care and services provided at ABC Facility.

Clinical Care – example: data will be obtained from the following reports: QI/QM, infection, medication error, pressure injuries, falls, health department surveys, CASPER and pain. Licensed nursing staff will receive up-to-date education on best practice and clinical guidelines to promote the highest attainable level of clinical care. The team will meet monthly with the Medical Director to achieve desirable outcomes for the residents. Results will be shared with the QAPI Steering Committee on a quarterly basis.

Quality of Life - example: the best available evidence will be utilized to define and measure indicators of quality including but not limited to resident and family satisfaction surveys, resident council meetings, health department surveys and grievances/concerns. The team will meet monthly to review findings and concerns, and prioritize activities. Results will be shared with the QAPI Steering Committee on a quarterly basis.

Resident Choice – example: individualized plans of care are developed with input from resident and family members. Plans of care are reviewed at care conferences and choices are offered with care options throughout the day. Residents or resident representatives are encouraged to direct their clinical care with staff member guidance to assure safety and informed decision making.



ABC Facility is unique in the population served as we have a ventilator unit with medically complex residents requiring nursing staff with specialized training. Education and competency training are performed on a regular basis. Other service areas include: memory care, short term rehab, long term care, hospice, and respite care.

The services available at ABC Facility include:

Skilled Nursing

Long-Term Care
Post-acute care
Dialysis
Hospice/Palliative Care
Pharmacy

Dietary

Dining
Dietitian

Activities

Housekeeping

Laundry
Janitorial

Health Information Services

Electronic Health Record
Electronic Medical Record
Minimum Data Set

Therapy

Outpatient
Physical
Occupational
Respiratory
Speech Language pathology
Alzheimer's/Memory Care
Skilled Rehabilitation

Social Services

Care Coordination
Mental Health

Maintenance

Building
Landscaping/Grounds keeping
Equipment

Business Office

Staffing
Billing
Human Resources

Organizational Resources include:

Staff Education

On-line LMS
On-boarding and Orientation
Internal Continuing Education
External Continuing Education, (Conferences, Symposiums, etc.)

Governance and Leadership

Example: The Nursing Home Administrator (NHA) and Board of Directors are responsible and accountable for the development, implementation and monitoring of the QAPI program.

- The Quality Assessment and Assurance (QAA) Committee consists of the Director of Nursing Services, the Medical Director, the Administrator, at least two other members of the facility staff, and the infection control and prevention officer.
- The QAA Committee meets at least quarterly to coordinate and evaluate the activities under the QAPI program.
- A QAPI Steering Committee is appointed by the NHA and the Executive leadership team and is interdisciplinary with at least two non-licensed staff who provide direct care or service to the residents. This may include nursing assistants, food and nutrition staff, housekeeping staff, maintenance and laundry staff.
- Non-licensed staff will serve on the Committee for one year and then rotate out so additional staff have the opportunity to service on the Committee.
- The QAPI Steering Committee, which includes the Medical Director as co-chair, meets monthly and is accountable for the continuous improvement in Quality of Life and Quality of Care. Minutes are recorded and shared with staff verbally and posted in staff areas for review.
- The QAPI Steering Committee collects data from sub committees (pain, falls, weight loss) and includes the data in their quarterly reports to the QAA Committee /NHA/Board of Directors.
- The QAA Committee completes an annual assessment of the program with report to the governing body/Board of Directors.
- A Quality Management Coordinator is appointed by the NHA and Executive Leadership team and is responsible for ongoing QAPI activities including development of a facility dashboard to display current goals and progress toward those goals.
- On a quarterly basis, the NHA will report on all current QAPI activities and outcomes to the Board of Directors.
- Annually, Executive Leadership will report on the status of the current QAPI plan and outline plans for the upcoming year. This information will be shared with the Board of Directors, management team, staff, and resident/family councils.
- The Executive Leadership team will support and advise the QAPI Steering Committee.

Budget: The Nursing Home Administrator works with the Board of Directors to create a budget for QAPI to assure that resources are available for the ongoing activities of the QAPI Committee. Resources include but are not limited to time for education, staff time for meetings, equipment, technology needs, software, supplies, improvement projects, etc. The

NHA and Quality Management Coordinator will review the budget on a monthly basis and revise as necessary to assure ongoing success of the QAPI program.

Education: All staff including contracted staff are educated on the principles of QAPI. QAPI is included in orientation of new employees and in the annual education that all staff are required to attend. Education includes the use of visual aide tools, posters, pay-check stuffers, text alerts, small group exercises, department meetings, all staff meetings, change of shift reports, facility newsletter, etc. Staff will be trained on using QAPI principles, identifying areas for improvement, and how they can be involved in the QAPI process including participation on a PIP team. The QAPI program is sustained during transitions in leadership and staffing through all-staff education and involvement in the QAPI process.

Residents and families are also informed of the QAPI plan and are encouraged to share their insights, concerns and opportunities for improvement. QAPI will be discussed at resident council meetings and family council meetings. Involvement of residents and family members on a PIP team may be considered.

Culture: ABC Facility believes in providing a non-punitive environment where managers encourage all staff involvement in bringing forward concerns, areas for improvement, reporting mistakes, and reporting quality issues. Managers will respond respectfully and timely to maintain an environment where staff have no fear of reprisal.

Feedback, Data Systems, and Monitoring

Example: ABC Facility will monitor multiple data sources and performance indicators in determining areas of concern, gaps and opportunities and also to determine effectiveness of system modifications and other interventions. All data will be reviewed against state, national or organization benchmarks or thresholds as appropriate and will be reported to the Board of Directors on a quarterly basis.

Data for adverse events and medical errors will be tracked, causes analyzed and preventative actions and mechanisms put into place. Feedback will be provided to staff and education provided as needed.

Potential sources of data may include:

- Survey outcomes
- Complaints
- Near misses
- Input from staff, residents, families and volunteers
- CMS Quality Measures
- Medication Errors

- Rehospitalization Rates
- Staff hours per day
- Staff retention
- Case Mix findings
- Pharmacist reports
- CASPER report
- Behavioral Health reports
- Satisfaction survey outcomes
- Billing audits
- Five Star report

Data may be collected weekly, monthly or quarterly depending on frequency of data updates from each source. The QAPI Management Coordinator oversees the maintenance of the QAPI dashboard, monthly reports/graphs, QAPI logs, and minutes of all meetings. The QAPI Steering Committee will utilize CMS's [Measure/Indicator Development worksheet](#) and CMS's [Measure/Indicator Collection and Monitoring Plan](#) to assist with program development.

Insert facility specific table here with data source, frequency of data collection, who reviews the information and how the information is disseminated.

Performance Improvement Projects (PIPs)

Example: ABC Facility will review the designated sources of data; identify areas where gaps in performance may negatively affect resident or staff outcomes. Where opportunities for improvement are detected, the QAPI Steering Committee with input from the Leadership Team will prioritize focus areas for PIP development. In prioritizing activities, the team will consider:

- high-risk to residents and/or staff,
- high-volume or problem-prone areas,
- health outcomes,
- resident safety,
- resident autonomy,
- resident choice,
- cost,
- feasibility,
- relevance,
- responsiveness,
- areas not outside of benchmarks but of importance to the resident population we serve.

The CMS publication *Prioritizing Worksheet for Performance Improvement Projects* may be utilized to assist with prioritizing potential areas of concern.

At least annually a project that focuses on high risk or problem-prone areas will be addressed through the QAPI program including PIP development. As defined in the facility assessment required at §483.70(e) our facility's services and resources will be taken into account when determining how many PIPs to support at one time. A minimum of one PIP and a maximum of four PIPs will occur simultaneously.

A *project charter* which establishes the goals, scope, timing, milestones, and team's roles and responsibilities will be developed for each PIP. CMS's form, *Worksheet to Create a Performance Improvement Project Charter* may be utilized by the QAPI Steering Committee to provide guidance to the PIP team.

The *PIP team* will be assembled by the QAPI Steering Committee and the QAPI Quality Manager. The team will be interdisciplinary with staff representing each job role affected by the project and may include resident and/or family representation when appropriate. Direct care staff will be replaced at their work station so that resident care is not interrupted. A *project lead* will be selected and will be responsible for coordinating, organizing and directing the activities of that specific PIP team.

The PIP Team will identify the information needed to evaluate the problem at hand, supplies required, staff participation, and any equipment needs. The project lead will communicate any identified resource needs to the QAPI Quality Manager. The team will utilize root cause analysis to identify the cause of the problem and any contributing factors. PDSA will also be used and is further described in the next section – Systematic Analysis and Systemic Action. The PIP team will develop an action plan with identified problem statement, causes, goals, interventions, staff responsible, and due dates.

The following forms may be utilized for PIP Action Plans:

(Insert facility specific form here)



PIP Action Plan

Problem Statement with Causes (related to)	Goal (Corrected Problem Statement)	Interventions to Address Causes & Achieve Goal	Responsible Staff	Due Date	Completion Date & Comments

The following form may be utilized in developing and monitoring Action Plans:

(Insert facility specific form here)

QAPI ACTION PLAN					
Location			Date:		
Concern					Team Members
Root Cause Analysis					
Goals					
Action Items	Responsible Team Member(s)	Start Date	Estimated Completion Date	Actual Completion Date	Comments

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PIP activities will be reported to residents, families and staff at least one time during the PIP. More frequent communication may be required as determined by the QAPI Quality Manager. Communication may occur via posters, bulletin boards, newsletters, and/or meetings with residents, family, staff and board members. To monitor the status of PIPs within our building, we will utilize CMS Performance Improvement Project (PIP) Inventory.

The project lead will also provide verbal and written documentation at the monthly QAPI Committee meetings. Meeting minutes will include information shared.

Systematic Analysis and Systemic Action

Example: ABC Facility uses a systematic approach to determining the root cause of an issue and any contributing factors. Facility staff and management have been trained on Root Cause Analysis. The PIP team identifies the root cause through utilization of many different tools, including:

- Fishbone Diagram
- Five Whys
- Cause and Effect Diagram
- Healthcare Failure Mode and Effect analysis (HFMEA)

The team considers the implications of any interventions or changes to systems for potential negative outcomes in other areas. The team will determine whether a pilot test or facility wide change is appropriate based on the facts gathered.

We utilize Plan-Do-Study-Act (PDSA) as our rapid-cycle improvement strategy with outcomes reported ongoing to the QAPI Quality Manager and quarterly to the QAPI Steering Committee.

Each PIP team determines the timing for conduction of periodic measurements and reviews to evaluate whether new actions/interventions are being followed/performed consistently. If any backsliding has occurred, the team will continue with the PDSA cycle with changes in processes/procedures as required.

Evaluation

The QAPI program will be evaluated annually by the QAPI Steering Committee with input from the Leadership Team/Executive Leadership. This review will include whether goals were met, if standards of practice are being followed, any training needs will be identified and addressed, and staff opinion on the QAPI process will be obtained via survey. Current trends in long term care will be considered along with strategic plans for ABC Facility. Any variances in systems and processes will be identified and included in the coming year's QAPI plan.

This plan was established on *(insert date)* and will be revisited and revised as needed annually at a minimum.

Source

Measure/Indicator Development Worksheet. (2016). Retrieved December 7, 2016, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndicatDevWksdebedits.pdf>

Measure/Indicator Collection and Monitoring Plan. (2016). Retrieved December 7, 2016, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/MeasIndCollectMtrPlandebedits.pdf>

Prioritizing Worksheet for Performance Improvement Projects. (2016). Retrieved December 7, 2016, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf>

Worksheet to Create a Performance Improvement Project Charter. (2016). Retrieved December 7, 2016, from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPCharterWkshtdebedits.pdf>

CMS PIP Inventory. (2016). Retrieved 2017, January 12 from <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pipinventorydebedits.pdf>



Mission, Vision, Guiding Principles for QAPI

Mission, Vision and Value Statements are standard and critical elements of organizational strategy. Mission, Vision and Value statements serve as foundational guides in the establishment of organizational objectives, and they form the foundation to help guide decision making and setting priorities for Quality Assessment Performance Improvement (QAPI). The organization's mission, vision and values set the quality direction of the organization, and engage staff working toward a common goal. Strong Mission, Vision and Values Statements inspire employee engagement, foster customer engagement, and help boost organizational performance.

Mission Statement

At the heart of any organization is its mission. The mission is the “core”, it is the purpose of the organization. A clear mission captures the essence of the organization and defines what the organization stands for – its purpose, primary objectives and the reason for its existence.

The mission statement should guide the actions of the organization and clearly focus the Quality Assessment Performance Improvement activities. It should spell out the organization's overall goal, provide a path toward achievement, and guide day-to-day decision-making. The Mission provides the framework or context within which the company's strategies are formulated.

Mission statements are set in the present tense. Mission statements tend to be short, clear and powerful, use simple and concise terminology, speak loudly and clearly, and generate enthusiasm for the organization.

Examples of Mission Statements:

Life is Good	Spreading the power of optimism.
Starbucks	Establish Starbucks as the premier purveyor of the finest coffee in the world while maintaining our uncompromising principles while we grow.
Pfizer	We dedicate ourselves to humanity's quest for longer, healthier, happier lives through innovation in pharmaceutical, consumer, and animal health products.
Ritz-Carlton	The Ritz-Carlton Hotel is a place where the genuine care and comfort of our guests is our highest mission. We pledge to provide the finest personal service and facilities for our guests who will always enjoy a warm, relaxed, yet refined ambience. The Ritz-Carlton experience enlivens the senses,

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	instills well-being, and fulfills even the unexpressed wishes and needs of our guests.
Universal Health Service, Inc.	To provide superior quality health care services that: patients recommend to family and friends, physicians prefer for their patients, purchasers select for their clients, employees are proud of, and investors seek for long-term returns.
Nike	To bring inspiration and innovation to every athlete in the world.

Tips for Developing Mission Statements

1. Engage employees in the Mission Statement development process.
2. Developing a mission statement should be culture-specific, i.e., participants may use methods ranging from highly analytical and rational to highly creative and divergent, e.g., focused discussions, divergent experiences around daydreams, sharing stories, etc.
3. When wording the mission statement, consider the organization's, services, markets, values, and public image.
4. Consider any changes that may be needed in wording of the mission statement due to the strategic planning process.
5. Ensure that wording of the mission is to the extent that leadership and employees can infer some order of priorities in how services are delivered.
6. When refining the mission, a useful exercise is to add or delete a word from the mission to realize the change in scope of the mission statement and assess how concise is its wording.
7. Does the mission statement include sufficient description that the statement clearly differentiates the mission of the organization?

Vision Statement

The vision of an organization is the dream, the type of statement that answers the questions “where are we going” and “what can we achieve?”

It is a concise word picture of what the organization strives to be, and should always be the roadmap that drives, inspires, and motivates those affiliated with the organization. This is the real purpose for going to work every day...how the world will be different because of the organization.

Vision statements also define the organization's purpose, but they focus on its goals and aspirations. These statements are designed to be uplifting and inspiring. They're also timeless: even if the organization changes its strategy, the vision will often stay the same.

Vision statements should offer direction and include a perspective of organizational values. A vision might provide a direction for the organization for the next five to 10 years, while also noting a commitment to integrity, transparency, openness and other such values. A vision statement takes the organizational mission and adds an element of human values. It should inspire employees and give them a sense of purpose.

Examples of Vision Statements:

Allstate	To reinvent protection and retirement for the consumer.
Hilton Worldwide	To fill the earth with the light and warmth of hospitality.
Reebok	We all have the potential to do great things, to help consumers, athletes and artists, partners and employees fulfill their true potential and to reach heights they may have thought un-reachable.
CVS	To improve the quality of human life.
Amazon	Our vision is to be earth's most customer-centric company where customers can find and discover anything they might want to buy online....at the lowest possible prices.
Amnesty International	Our vision is of a world in which every person – regardless of race, religion, ethnicity, sexual orientation, or gender identity – enjoys all of the human rights enshrined in the Universal Declaration of Human Rights and other internationally recognized human rights standards.
Ikea	To create a better everyday life for the many people.

Tips for Developing Vision Statements

1. The vision statement includes vivid description of the organization as it effectively carries out its operations.
2. Developing a mission statement should be culture-specific, i.e., participants may use methods ranging from highly analytical and rational to highly creative and divergent, e.g., focused discussions, divergent experiences around daydreams, sharing stories, etc.
3. Developing the vision can be the most enjoyable part of planning, but the part where time easily gets away from you.
4. The vision statement is both a compelling description of the state and function of the organization and a motivational tool, including highly idealistic phrasing and activities which the organization can aspire.

The examples of mission and vision statements are concise, focused and inspiring. Do everything you can to make your statements similarly succinct.

Guiding Principles

Guiding Principles describe the organization's beliefs and philosophy pertaining to Quality Assessment Performance Improvement. The principles should guide what the organization does, why it does it and how.

Examples of Guiding Principles:

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

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

Create a separate document that articulates your mission, vision statements, and guiding principles of QAPI that may be used as a preamble to your QAPI plan. This document will help you articulate the goals and objectives of your organization; QAPI will help you get there. Consider posting for all to see.

Facility Roles and Suggested Job Description Inclusions

Board of Directors/Governing Body/Owner

The facility's Board of Directors (BOD), etc. is responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) within the facility. The BOD delegates responsibilities for oversight of the QAPI program to the _____ (facility name) QAPI Steering Committee. The QAPI Steering Committee will provide annual reports on the QI program to the BOD, etc. at its annual meetings.

Board of Director/Governing Body/Owner Job Description inclusion:

- Oversees the logistics of the Quality Assurance and Performance Improvement (QAPI) program within the facility
- Sets the tone for QAPI work in the facility
- Assumes responsibility for ensuring QAPI is implemented and provided appropriate resources
- Stays informed regarding CMS requirements for QAPI

Education is provided to the Board of Directors/Governing Body/Owner initially with startup of QAPI at the facility and additional education will be provided to new members ongoing. Annual training will be provided to all members.

Facility Leadership

Executive Leadership will assure that time, supplies, equipment and other resources are provided as deemed appropriate for the effective implementation and maintenance of the QAPI program.

Nursing Home Administrator/Executive Director Job Description Inclusion:

- Promote and model behaviors and actions that foster a non-punitive environment where staff is encouraged to voice concerns without fear of reprisal.
- Create and oversee the processes for disseminating information to the entire team, residents, family and BOD including statistics on current projects.
- Develop a program that can be sustained regardless of changes in leadership and facility staff.
- Establish a working environment where QAPI principles are applied to problems on an ongoing basis and not just to problems currently in committee.

QAPI Management Coordinator/Quality Leader/Director of Quality Job Description Inclusion:

- Receive direction from Executive Leadership on the overall objectives for the QAPI program
- Attend educational events to become the QAPI expert for the facility
- Stay current on standards of practice as they apply to QAPI committee projects
- Champion the collection of data, data analysis and display of data over time via charts, graphs, etc.
- Identify and provide staff training for QAPI success
- Encourage staff involvement in QAPI programs
- Lead the development of project charters and performance improvement projects.
- Communicate to the Nursing Home Director any time, supplies, equipment and other resources that are required for the effective implementation and maintenance of the QAPI program.
- Provide reports of project status to the Executive team at mutually agreed upon time frames
- Promote and model behaviors and actions that foster a non-punitive environment where staff is encouraged to voice concerns without fear of reprisal.

Department Directors/Managers

Department Directors/Managers Job Description Inclusions:

- Promote and model behaviors and actions that foster a non-punitive environment where staff is encouraged to voice concerns without fear of reprisal.
- Participate in QAPI activities through identification of opportunities for improvement.
- Provide performance improvement project leadership and develop skills of other staff to be able to actively participate in the facility's QAPI program.

Medical Director

Medical Director Job Description Inclusions:

- Attend monthly QAPI meetings
- Assist with data collection, interpretation, and dissemination of information to support QAPI activities
- Promote system and process modifications to ensure lasting improvements
- Promote and model behaviors and actions that foster a non-punitive environment where staff is encouraged to voice concerns without fear of reprisal.



Resources

Examples of Performance Objectives for Job Descriptions and Performance Reviews. CMS, n.d. Web. 16 Jan. 2017. <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/experformanceobjectivesjobdesc.pdf>

Training Plan: QAPI Overview

Training Name: Overview of QAPI	
	<input type="checkbox"/> Training <input type="checkbox"/> Simulation <input type="checkbox"/> Workshop <input checked="" type="checkbox"/> Presentation
Training Objectives	1. Obtain a basic understanding of the QAPI process and the facility QAPI plan. 2. Understand the roles and responsibilities of the facility team as it relates to QAPI processes - performance improvement.
Connection to Overall Project Goals	The training is part of the overall project to educate and support nursing facility operators and staff regarding the requirements of participation for nursing homes as it relates to the QAPI facility plan, process and roles and responsibilities.
Participants: Who should attend?	<ul style="list-style-type: none"> Governing Body Administrator Director of Nursing Medical Director IDT members
	What training should they attend before this one? <ul style="list-style-type: none"> No pre-requisite
	What training should they attend after this? <ul style="list-style-type: none"> Annually and as needed
Facilitators: (How many trainers should participate and whom?)	One presenter will be needed to facilitate the presentation, discussion and post-test
Logistics Requirements	What is needed? <ul style="list-style-type: none"> Room for training Projector Screen or other blank light colored surface



Training References

CMS: State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities:

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Advance-Appendix-PP-Including-Phase-2-.pdf>

POST TEST FOR QUALITY ASSURANCE PERFORMANCE IMPROVEMENT

Question: True or False?	Answer
1. The QAPI plan must be ongoing, comprehensive and address all systems of care including clinical care, quality of life and resident choice.	
2. Only management team members participate in QAPI and the QAA committee.	
3. Our facility should be aware of any problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	
4. Performance Improvement Projects (PIPs) must be created for every problem identified.	
5. A facility must provide evidence that it has, through the QAA committee, identified its own quality deficiencies, and are making a “good faith attempt” to correct them.	

Employee Printed Name _____ Date: _____

Employee Signature: _____



Five Elements

Element 1: Design and Scope

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

Element 2: Governance and Leadership

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

Element 3: Feedback, Data Systems and Monitoring

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

Element 4: Performance Improvement Projects (PIPs)

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

Element 5: Systematic Analysis and Systemic Action

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



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

API

at a Glance:

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



UNIVERSITY OF MINNESOTA




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Introduction: Why This Guide?

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

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

Effective Quality Assurance and Performance Improvement (QAPI)

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



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

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

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

WHAT IS QAPI?

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

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

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

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

QA + PI = QAPI

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

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

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

WHY QAPI IS IMPORTANT

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

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

Being new at QAPI is like being a new driver...

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



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

QAPI Builds on QA&A

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

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

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

QAPI Features

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

“Not all change is improvement, but all improvement is change.”

*Donald Berwick, MD
Former CMS Administrator*

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

Illustrating QAPI in Action

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

Scenario 1

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

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

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

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

Scenario 2

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

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

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

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

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

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

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

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

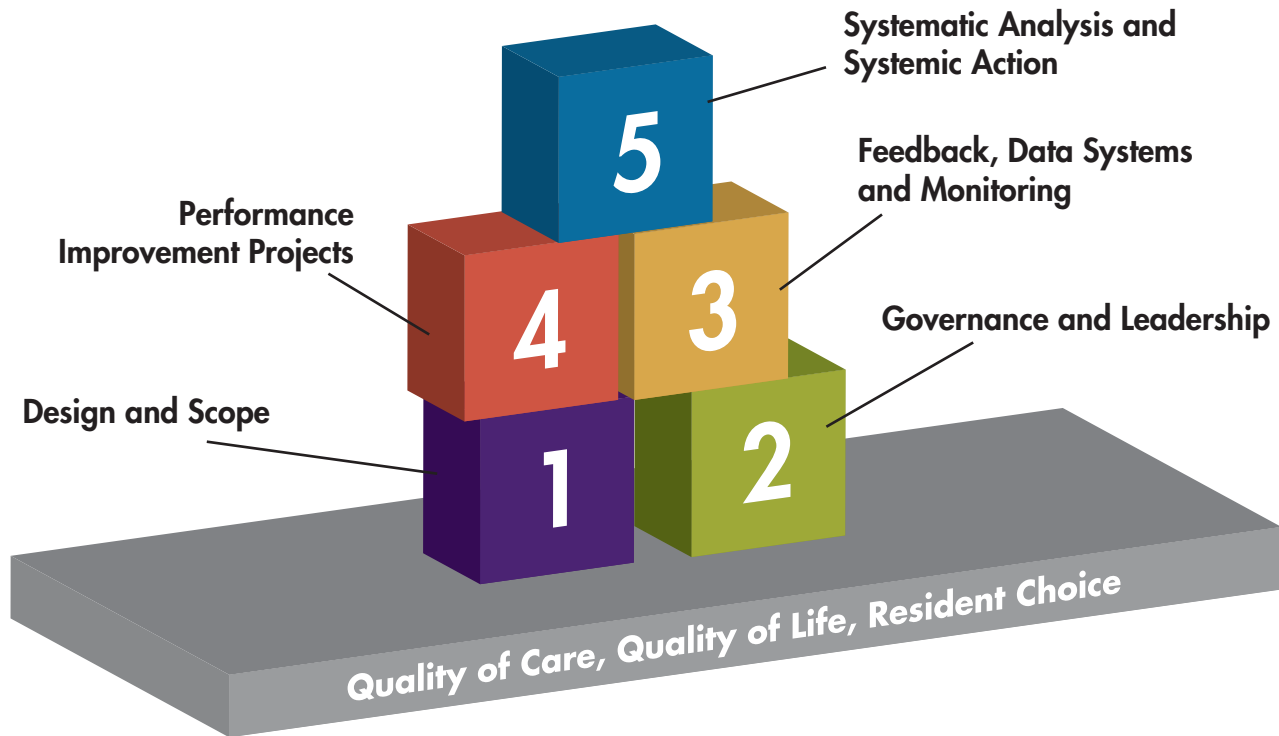
Many of the QAPI action steps discussed in this guide are found in the second scenario. Here are some of the key highlights:

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



Five Elements for Framing QAPI in Nursing Homes

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



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

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

THE FIVE ELEMENTS ARE:

■ Element 1: Design and Scope

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

■ Element 2: Governance and Leadership

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

■ Element 3: Feedback, Data Systems and Monitoring

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

■ Element 4: Performance Improvement Projects (PIPs)

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

■ Element 5: Systematic Analysis and Systemic Action

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

Action Steps to QAPI

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

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

STEP 1: Leadership Responsibility and Accountability

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

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

Put a Personal Face on Quality Issues

Leadership should:

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

Here are some ways leadership can take action:

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

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

STEP 2: Develop a Deliberate Approach to Teamwork

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



Characteristics of an effective team include the following:

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

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

QAPI relies on teamwork in several ways:

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

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

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

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

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

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

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

[Click here to go to the QAPI Self-Assessment Tool in Appendix A](#)



STEP 4: Identify Your Organization’s Guiding Principles

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

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

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

[Click here to go to the Guide for Developing Purpose, Guiding Principles, and Scope for QAPI in Appendix A](#)



STEP 5: Develop Your QAPI Plan

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

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

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

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

[*Click here to go to the Guide for Developing a QAPI Plan in Appendix A*](#)



STEP 6: Conduct a QAPI Awareness Campaign

COMMUNICATE WITH ALL CAREGIVERS

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

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

Try this:

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

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

COMMUNICATE WITH RESIDENTS AND FAMILIES

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



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

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

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

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

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

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

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

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

STEP 8: Identify Your Gaps and Opportunities

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

Potential areas to consider when reviewing your data:

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

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

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

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

STEP 9: Prioritize Quality Opportunities and Charter PIPs

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

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

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

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

Charter PIP teams:

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

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

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

[Click here to go to the Goal Setting Worksheet in Appendix A](#)

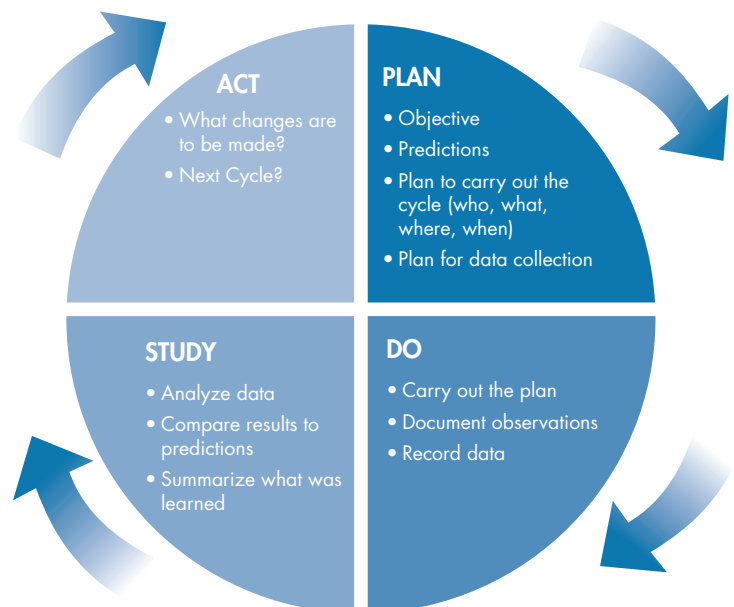


STEP 10: Plan, Conduct and Document PIPs

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

You and your team may:

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



PDSA MODEL

PLAN-DO-STUDY-ACT (PDSA) CYCLE

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

STEP 11: Getting to the “Root” of the Problem

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



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

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

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

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

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

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

STEP 12: Take Systemic Action

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

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

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

Pilot Test:

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

The Department of Veterans Affairs National Center for Patient Safety’s Hierarchy of Actions² 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

²U.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+1>.

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

Examples of strong actions:

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

Prevent future problems by developing and testing strong actions.

QAPI Principles Summarized

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

How to Learn More

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

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

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



QAPI Tools and Related Resources

QAPI PROCESS TOOLS

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

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

QAPI process tools are important to:

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

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

QAPI TOPIC TOOLS

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

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

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

QAPI RESOURCES FOR PROVIDERS

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

RESOURCES AND TOOLS AVAILABLE THROUGH QIOS

Oklahoma Foundation for Medical Quality

Provides tools and resources for nursing homes.

<http://www.ofmq.com/nhtoolsandresources> Improvement basics for nursing homes, Change management, and Facilitating group agreement.

Stratis Health

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

WEBSITES ON SELECTED QUALITY TOPICS

Advancing Excellence in America's Nursing Homes

Supported by CMS, the Commonwealth Fund, and others, The Advancing Excellence Campaign provides tools and resources to improve nursing home care in clinical and organizational areas.

<http://www.nhqualitycampaign.org/>

Agency for Healthcare Research and Quality

The Department of Defense and the Agency for Healthcare Research and Quality developed the Team STEPPS program to optimize performance among teams of healthcare professionals and improve collaboration and communication. The Long-Term Care version addresses issues specific to nursing homes:

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/ltc/index.html>.

Department of Veterans Affairs

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

Getting Better All the Time: Working Together for Continuous Improvement

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

<http://www.susanwehrymd.com/files/gettingbetterall-the-time.pdf>

Interact II

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

Institute for Health Care Improvement (IHI)

IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement. Learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.

<http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx>

WEBSITES ON PERSON-CENTERED CARE

Implementing Change in Long-Term Care: A Practical Guide to Transformation

This resource was prepared by Barbara Bowers and others with a grant from the Commonwealth Fund to the Pioneer Network. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process.

http://www.pioneernetwork.net/Data/Documents/Implementation_Manual_ChangeInLongTermCare%5B1%5D.pdf

Picker Institute Publications

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

<http://pickerinstitute.org/publications-and-resources/>



Appendix A: QAPI Tools



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

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
<p>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.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					

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

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

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems that pose a high risk to residents or caregivers, is frequent in nature, or otherwise impact the safety and quality of life of the residents.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					
<p>For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to assess impact on resident care and quality of life. For example, if making a change, we measure whether the change has actually occurred and also whether it has had the desired impact on the residents.</p> <p>Notes:</p>					
<p>Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis.</p> <p>Notes:</p>					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>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.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					
<p>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.</p> <p>Notes:</p>					
<p>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).</p> <p>Notes:</p>					



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

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

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

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

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

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

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

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

STEP 3. DEVELOP A PURPOSE STATEMENT FOR QAPI

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

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

STEP 4. ESTABLISH GUIDING PRINCIPLES

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

For example:

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

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

STEP 5. DEFINE THE SCOPE OF QAPI IN YOUR ORGANIZATION

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

For example:

Post-acute care
Dementia care and services
Dietary
Dining

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

STEP 6. ASSEMBLE DOCUMENT

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

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



Guide for Developing a QAPI Plan

DIRECTIONS:

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

I. QAPI Goals

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

II. Scope

- a. Describe how QAPI is integrated into all care and service areas of your organization.
- b. Describe how the QAPI plan will address:
 - i. Clinical care
 - ii. Quality of life
 - iii. Resident choice (i.e., individualized goals for care)
- c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).
- d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

- a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).
- b. Describe how QAPI will be adequately resourced.
 - i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
 - ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
 - iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.
 - iv. Indicate how you will determine if resources are adequate for QAPI.
 - v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

c. QAPI Leadership

- i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.
- ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:
 - Establishing a format and frequency for meetings
 - Establishing a method for communication between meetings
 - Establishing a designated way to document and track plans and discussions addressing QAPI.
- iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

- a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.
- b. Identify the sources of data that you will monitor through QAPI
 - i. Input from caregivers, residents, families, and others
 - ii. Adverse events
 - iii. Performance indicators
 - iv. Survey findings
 - v. Complaints
- c. Describe the process for collecting the above information.
- d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.
- e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.
- f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

- a. Describe the overall plan for conducting PIPs to improve care or services.
 - i. Indicate how potential topics for PIPs will be identified.
 - ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.
 - iii. Indicate how and when PIP charters will be developed.
 - iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

- b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.
- c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.
- d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

- a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any “unintended” consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.
- b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.
- c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

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

VIII. Evaluation

- a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)
- b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

- a. Date your plan.
- b. Determine when you will revisit the plan (i.e., at least annually).
- c. Determine how you will track revisions or updates to the plan.

Goal Setting Worksheet



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

Describe the business problem to be solved:

Use the SMART formula to develop a goal:

SPECIFIC

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

What do we want to accomplish?

Who will be involved/affected?

Where will it take place?

MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?

What is the current data figure (i.e., count, percent, rate) for that measure?

What do you want to increase/decrease that number to?

ATTAINABLE

Defend the rationale for setting the goal measure above:

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

RELEVANT

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

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?
--

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

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

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

Appendix B: QAPI Definitions

Performance Improvement (PI)

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

Performance Improvement Project (PIP)

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

Quality Assurance and Performance Improvement (QAPI)

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

Quality Assurance (QA)

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

Root Cause Analysis (RCA)

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

Systems Thinking

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



Guide for Developing a QAPI Plan

DIRECTIONS:

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

I. QAPI Goals

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

II. Scope

- a. Describe how QAPI is integrated into all care and service areas of your organization.
- b. Describe how the QAPI plan will address:
 - i. Clinical care
 - ii. Quality of life
 - iii. Resident choice (i.e., individualized goals for care)
- c. Describe how QAPI will aim for safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or resident's agents).
- d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership

- a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).
- b. Describe how QAPI will be adequately resourced.
 - i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
 - ii. Indicate the plan for developing leadership and facility-wide training on QAPI.
 - iii. Describe the plan to provide caregivers time, equipment, and technical training as needed for QAPI.
 - iv. Indicate how you will determine if resources are adequate for QAPI.
 - v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

c. QAPI Leadership

- i. While everyone in the organization is involved in QAPI, you will likely have a small group of individuals who will provide the backbone or structure for QAPI in your organization. Who will be part of this group? Many of these individuals may be on your current QAA committee.
- ii. Describe how this group of people will work together, communicate, and coordinate QAPI activities. This could include but is not limited to:
 - Establishing a format and frequency for meetings
 - Establishing a method for communication between meetings
 - Establishing a designated way to document and track plans and discussions addressing QAPI.
- iii. Describe how the QAPI activities will be reported to the governing body; i.e., Board of Directors, owner.

IV. Feedback, Data Systems, and Monitoring

- a. Describe the overall system that will be put in place to monitor care and services, drawing data from multiple sources.
- b. Identify the sources of data that you will monitor through QAPI
 - i. Input from caregivers, residents, families, and others
 - ii. Adverse events
 - iii. Performance indicators
 - iv. Survey findings
 - v. Complaints
- c. Describe the process for collecting the above information.
- d. Describe the process for analyzing the above information, including how findings will be reviewed against benchmarks and/or targets established by the facility.
- e. Describe the process to communicate the above information. What types of reports will be used? One way to accomplish this is to use a dashboard or dashboards for individual performance improvement projects.
- f. Identify who will receive this information (i.e., executive leadership, QAPI leadership, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

V. Guidelines for Performance Improvement Projects (PIPs)

- a. Describe the overall plan for conducting PIPs to improve care or services.
 - i. Indicate how potential topics for PIPs will be identified.
 - ii. Describe criteria for prioritizing and selecting PIPs: areas important and meaningful for the specific type and scope of services unique to the facility, requires a concentrated effort on a particular problem in one area of the facility or facility wide.
 - iii. Indicate how and when PIP charters will be developed.
 - iv. Describe the process for reporting the results of PIPs. Identify who will receive this information (i.e., quality committee, resident/family council, and a center's caregivers), in what format, and how frequently information will be disseminated.

- b. Describe how to designate PIP teams and establish and describe a process for assembling teams to work on specific PIPs.
- c. Define the required characteristics for any PIP team. This may include that the team be interdisciplinary (i.e., representing each of the job roles affected by the project), that it include resident representation (as appropriate), and that a qualified team leader is selected (i.e., ability to coordinate, organize and direct all activities of the project team). Describe how PIP teams should document and report their work.
- d. Describe your process for documenting PIPs, including highlights, progress, and lessons learned. For example, what project documentation templates will you use consistently and file electronically in a standardized fashion for future reference.

VI. Systematic Analysis and Systemic Action

- a. Any change that is made has the potential to have broader impact than intended. If you are trying to make a change to a specific system or process, it is important to recognize any “unintended” consequences of your actions. Describe how your organization will identify these consequences which may be either positive or negative.
- b. Describe the process you will use to ensure you are getting at the underlying causes of issues, rather than applying quick fixes that address symptoms only.
- c. Describe how you will monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

VII. Communications

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

VIII. Evaluation

- a. Describe the process for assessing QAPI in your organization on an ongoing basis. (See *QAPI Self-Assessment Tool*.)
- b. Describe the purpose of this evaluation – to help your organization to expand your skills in QAPI and increase the impact of QAPI in your organization.

IX. Establishment of Plan

- a. Date your plan.
- b. Determine when you will revisit the plan (i.e., at least annually).
- c. Determine how you will track revisions or updates to the plan.

QAPI Five Elements	Goals	Tools
Element 1 – Design and Scope	Learn the basics of QAPI <ul style="list-style-type: none"> • Review QAPI five elements • Understand how QAPI coordinates with QAA 	QAPI Five Elements QAPI at a Glance QAPI News Brief - Volume 1
	Assess QAPI in your organization	QAPI Self-Assessment Tool
	Create a structure and plan to support QAPI	Guide to Developing Purpose, Guiding Principles and Scope for QAPI Guide for Developing a QAPI Plan
Element 2 – Governance and Leadership	Understand the QAPI business case	CMS Video: Nursing Home QAPI – What’s in it for you?
	Promote a fair and open culture where staff are comfortable identifying quality problems and opportunities <ul style="list-style-type: none"> • Know your current culture • Assess your individual skills, practice, attitude • Create a learning organization that drives and reinforces a process for organizational change • Distinguish between human error, at risk, and reckless behavior, and respond differently/ appropriately to each 	QAPI at a Glance QAPI News Brief - Volume 1

QAPI Five Elements	Goals	Tools
Element 2 – Governance and Leadership	Create a Culture that embraces the principles of QAPI	QAPI at a Glance QAPI News Brief - Volume 1 QAPI Leadership Rounding Tool
	Promote engagement and commitment of staff, residents and families in QAPI	QAPI at a Glance QAPI News Brief - Volume 1 Examples of Performance Objectives for Job Descriptions and Performance Reviews
	Involve residents and families <ul style="list-style-type: none"> Focus on the customer needs and expectations 	QAPI at a Glance QAPI News Brief - Volume 1
Element 3 – Feedback, Data Systems and Monitoring	Use and make data meaningful <ul style="list-style-type: none"> Identify what you need to monitor Collect, track, and monitor measures/indicators Set goals, benchmarks, thresholds Identify gaps and opportunities Prioritize what you will work to improve Use data to drive decisions 	Measure/Indicator Development Worksheet Measure/Indicator Collection and Monitoring Plan Instructions to Develop a Dashboard Goal Setting Worksheet Prioritization Worksheet for Performance Improvement Projects

QAPI Five Elements	Goals	Tools
Element 4 – Performance Improvement Projects	Implement performance improvement projects <ul style="list-style-type: none"> • Focus on topics that are meaningful and address the needs of residents and staff • Charter PIP teams • Support staff in being effective PIP team members. Use tools that support effective teamwork. • Plan, implement, measure, monitor, and document changes, using a structured PI approach 	Worksheet to Create a PIP Charter PIP Launch Checklist: Helpful hints for project leaders, managers, and coordinators Plan-Do-Study-Act (PDSA) Cycle Template PIP Inventory Sustainability Decision Guide Brainstorming, Affinity Grouping, and Multi-Voting Tool
	Enhance QAPI communications	QAPI at a Glance Communications Plan Worksheet Storyboard Guide for PIPs Improvement Success Story Template
Element 5 – Systematic Analysis and Systemic Action	Understand and focus on organizational processes and systems <ul style="list-style-type: none"> • Model and promote systems thinking • Practice RCA – get to the root of problems • Take action at the systems-level 	Guidance for Failure Mode and Effects Analysis (FMEA) Guidance for Root Cause Analysis (RCA) Flowcharting Five Whys Fishbone Diagram