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CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

QAPI Written Plan How-To-Guide

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QAPI Written Plan: Introduction

Quality Assurance and Performance Improvement (QAPI) is a type of quality management program which takes a systematic, interdisciplinary, comprehensive and data-driven approach to maintaining and improving safety and quality. An interdisciplinary approach encompasses all managerial, and clinical, services, which includes care and services provided by outside (contracted or arranged) providers and suppliers. Each facility must develop, implement and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must maintain and be able to provide documentation and evidence of its ongoing QAPI program, which meets the requirements of §483.75.

The QAPI regulation requires a written plan. A QAPI plan is the written plan containing the process that will guide the nursing home's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved. The plan describes how the facility will conduct its required QAPI and Quality Assessment and Assurance (QAA) committee functions.

The QAPI plan must describe the process for identifying and correcting quality deficiencies. Key components of the process include:

- Tracking and measuring performance.
- Establishing goals and thresholds for performance measurement.
- Identifying and prioritizing quality deficiencies.
- Systematically analyzing underlying causes of systemic quality deficiencies.
- Developing and implementing corrective action or performance improvement activities.
- Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed.

The QAPI plan is intended to be a living document your organization will continue to review and revise. Your written QAPI plan will be made available to a federal and state surveyors at each annual recertification survey and upon request during any other survey, and to The Centers for Medicare & Medicaid Services (CMS) upon request.

To write your organization's written QAPI plan using this how-to-guide, use the numbered sections. These sections reflect the *Reform of Requirements for Long-Term Care Facilities* released by CMS in October of 2016 and information previously published in CMS's QAPI tools and resources. This QAPI Written Plan Guide was updated to reflect revisions to the State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities, updated on Oct. 21, 2022. Under each section, there is a description of what your organization should include in the section, followed by an example. You can begin with this language, but should include language that best describes the unique characteristics of your organization. Use of the *QAPI Written Plan: How-to-Guide* is not mandatory nor does its use guarantee compliance with the regulation. It is intended to provide guidance and structure for writing your organization's written QAPI plan.

An Appendix is available to download for you to write your QAPI plan. This Word format document is intended to allow you to write, copy, paste, edit, etc. When completed, you will have your written QAPI plan.

Purpose of Your Organization's QAPI Plan

The first section will describe the purpose of your QAPI plan. Before writing this section, one suggestion is to review your organization's mission statement, vision statement and/or guiding values. It is not required to include these statements for compliance purposes, however, having them available can guide the development of your QAPI plan.

A. A **vision statement** describes what your organization strives to do and is sometimes referred to as a picture of your organization in the future. The vision statement is what your organization aspires to and is the framework for strategic planning.
B. A **mission statement** describes the purpose of your organization. It guides the decision-making and defines overall goals and actions. The mission statement provides a framework or context for the organization's strategies.

Guiding values or principles are defined actions that all staff will perform. It is guidance for everyone in the organization and frames the culture in the organization.

1. Write the Purpose of Your Organization's QAPI Plan

Describe the purpose and goals the QAPI plan will strive to meet. Describe how your organization works to continuously improve the areas that are of great importance. Describe how often this plan will be reviewed and who will be reviewing it. Keep in mind that any team/committee formed to review QAPI processes is tasked with addressing both Quality Assessment and Assurance (QAA) as well as Performance Improvement (PI). Also describe who will receive communication about any revisions to the plan, and the method of communication.

One suggestion is to include language from your vision statement, mission statement and/or guiding principles. This is not required, but may be helpful in describing how QAPI is integrated into your organization. Describe how the QAPI plan is consistent with and framed on the principles that guide your organization. Provide as much description as possible to show the connectedness between your vision, mission, guiding principles and the quality improvement culture within your organization.

NOTE: In the examples throughout this guide, the team leading the QAPI efforts is referred to as the QAA committee. Regulation requires a QAA committee that plans its work around quality assurance and performance improvement. The committee is responsible for both Quality Assessment and Assurance activities and ongoing, proactive performance improvement activities.

Example

> Our organization's written QAPI plan provides guidance for our overall quality improvement program. Quality assurance performance improvement principles will drive the decision making within our organization. Decisions will be made to promote excellence in quality of care, quality of life, resident choice, person directed care, and resident transitions. Focus areas will include all systems that affect resident and resident representative satisfaction, quality of care and services provided, and all areas that affect the quality of life for persons living and working in our organization.
>
> The administrator will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made to the plan ongoing, as the need arises, to reflect current practices within our organization. These revisions will be made by the QAA committee.
>
> Revisions to the QAPI plan will be communicated as they occur to board members, residents, resident representatives and staff through meetings and newsletters.

Program Design and Scope

Each facility must have a QAPI program that is ongoing, comprehensive and capable of addressing the full range of care and services it provides

2. List of Services You Provide to Residents

List all care and services your organization provides for residents. These service areas will be included in the QAPI plan and involved in QAPI activities. Describe the full range of care and services that are provided both during day-to-day operations and emergencies. On an annual basis, and as needed, the organization must complete a Facility Assessment that includes an overview of the services and/or care areas that are provided. All new services, care areas and/or changes in population must be reflected in the Facility Assessment and QAPI plan. The Facility Assessment determines the unique needs of each organization's population, as well as identifies facility and community risk factors. It is through the QAPI program that the organization ensures the needs and risk factors are addressed. Areas that might be included are: dementia care, hospice, long term care, memory care, post-acute care, rehabilitation services, etc.

Example

QAPI activities will be integrated across all the care and service areas of our organization. Each area will have a representative on the QAA committee. If a representative is not available, the area will still be addressed through committee discussions. Our service areas will work together whenever possible to integrate care and services across our continuum of care to better meet the needs of the people living in our community. Our QAPI activities will cross service areas and departments and we will work together to assure we address all concerns and strive to continuously improve the provided services. On an annual basis, and as needed, a Facility Assessment will be conducted to include an overview of the services and care areas that are provided. Any new service areas or changes in population or service areas identified during the Facility Assessment will be included in our QAPI plan.

Our service areas include:

- Dementia care
- Hospice
- Long-term care
- Palliative care
- Post-acute care
- Rehabilitation services
- Transitional care

3. Describe How Your QAPI Plan Will Address Key Issues

Describe how your QAPI plan will:

- Address all systems of care and management practices.
- Include clinical care, quality of life and resident choice.
- Utilize the best available evidence to define 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.

- Reflect the complexities, unique care and services the facility provides.

The QAPI plan includes the policies and procedures that describe how the organization will:

- Identify and use data to monitor its performance including all departments and based on the facility assessment.
- Establish goals and thresholds for performance measurement.
- Utilize resident, resident representative and staff feedback.
- Identify and prioritize problems and opportunities for improvement including adverse events.
- Systematically analyze underlying causes of systemic problems and adverse events.
- Develop corrective action or performance improvement activities.

Example

Our organization provides services across the continuum of care. These services have an impact on the clinical care and quality of life for residents living in our community. All departments and services will be involved in QAPI activities and the organization's efforts to continuously improve services.

Our QAPI plan includes the policies and procedures used to:

- Identify and use data to monitor our performance including all departments and based on our facility assessment.
- Establish goals and thresholds for our performance measurement.
- Utilize resident, resident representative and staff feedback.
- Identify and prioritize problems, adverse events and opportunities for improvement.
- Systematically analyze underlying causes of systemic problems and adverse events.
- Develop corrective action or performance improvement activities.

The principles of QAPI will be taught to all staff, volunteers and board members on an ongoing basis. QAPI activities will aim for the highest levels of safety, excellence in clinical interventions, resident and resident representative satisfaction and management practices. All organizational decisions involving residents will be focused on their autonomy, individualized choices and preferences, and to minimize unplanned transitions of care.

The organization will partner with each resident and/or resident representative to achieve their individualized goals and provide care that respects their autonomy, preferences and choices. When the need is identified, we will implement corrective action plans or performance improvement projects to improve processes, systems, outcomes and satisfaction.

Our organization strives to employ evidence-based practices related to performance excellence in all management practices, clinical care and resident and resident representative satisfaction. We will solicit and utilize staff, resident and resident representative feedback into all aspects of our QAPI program.

4. Current Quality Assessment and Assurance Activities

Describe how QAPI will integrate and expand current quality assessment and assurance activities. The review of data must continue to assure that systems are being monitored and processes are maintained to achieve the highest level of quality for your organization. Data should be reviewed against benchmarks, such as national, state, corporate or organizational targets. In addition, data must be monitored to identify new areas for improvement. This monitoring and review of data and systems will begin the identification of quality improvement projects.

Example

> The QAA committee will review data from areas the organization believes it needs to monitor on a monthly basis, or as needed, to assure systems are being monitored and maintained to achieve the highest level of quality for our organization.

5. Use of Best Available Evidence

Describe how your organization will utilize the best available evidence (e.g., data, corporate, regional, state and national benchmarks, recognized best practices, clinical guidelines, etc.) to compare your organization against, establish goals for improvement and define measurements to show improvement.

Example

> Our organization will use the best available evidence and data to benchmark our organization, establish goals and define measurements for improvement. The QAA Committee will review data from our corporation, state, and national sources to compare our organization against. When establishing goals, defining measurement and choosing interventions, we will use the best available evidence-based practices and guidelines to guide our decision-making.

Guidelines for Governance and Leadership

6. Responsibility and Accountability

Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management. How does the Governing Body and/or leadership ensure the QAPI program:

- Is defined, implemented and ongoing?
- Addresses identified priorities?
- Is sustained through transitions in leadership and staffing?
- Has adequate resources, including staff time, equipment and technical training as needed?
- Uses performance indicator data, resident and staff input, and other information to identify and prioritize problems and opportunities?
- Implements corrective actions to address gaps in systems and evaluates actions for effectiveness?
- Establishes clear expectations around safety, quality, rights, choice and respect?

Example

> The administrator has responsibility and is accountable to the board of directors and our corporation for ensuring QAPI is implemented throughout our organization. The administrator will assure the QAPI program:
>
> - Is defined, implemented and ongoing.

- Addresses identified priorities.
- Is sustained through transitions in leadership and staffing.
- Has adequate resources, including staff time, equipment and technical training as needed.
- Uses performance indicator data, resident and staff input, and other information to identify and prioritize problems and opportunities.
- Implements corrective actions to address gaps in systems and evaluates actions for effectiveness.
- Establishes clear expectations around safety, quality, rights, choice and respect.

QAPI activities and discussion will be a standing item on our board of director meeting agendas. The administrator will attend all board of director meetings, report on and solicit input on all QAPI activities on a regular basis. The administrator is responsible for assuring all QAPI activities and required documentation are provided to our corporation.

7. Describe How QAPI Will Be Adequately Sourced

QAPI activities need leadership support as well as financial resources to ensure the activities can occur. Performance improvement projects need staff meeting time, as well as time to implement the strategies they develop. Often, nursing assistants, nurses and others involved in direct care activities need to be replaced for meetings so resident care does not suffer. Sometimes performance improvement projects require environmental changes or staffing changes. This takes planning and responsiveness from leadership who control budgets. Describe the process for addressing these issues.

Example

The administrator and financial officer will establish a budget to ensure QAPI activities are supported. These expenses may include, but are not limited to staff time for being involved in performance improvement projects and meetings, monies needed for improvement projects, staff training and education, etc. This budget will be reviewed on a monthly, or as needed basis, by the administrator and revised as necessary. The administrator and QAA committee will work together to review budgetary needs and share decision making regarding performance improvement projects.

8. Determine the Plan for Mandatory QAPI Staff Training and Orientation

Describe how your organization will ensure all staff receive training on QAPI principles and how your organization implements QAPI. Staff responsibilities on how to bring forward opportunities for improvement and participation on performance improvement project teams and the QAA committee should be discussed. This education is mandatory for all employees on an annual basis and is part of new employee orientation.

Example

QAPI principles and staff responsibilities related to QAPI, and ongoing quality improvement will be included in orientation for all new employees. QAPI will be included in the organizational orientation that all new employees are required to attend. All staff will participate in ongoing annual QAPI training which will include quality improvement principles and practices, how to identify areas for improvement, updates on current performance improvement projects and how staff can be involved in performance improvement projects.

9. Framework for QAPI

Determine who the individuals are that will provide the framework or structure for QAPI in your organization and how the QAA committee will work together to communicate and coordinate QAPI activities. The committee should be composed of staff who understand the characteristics and complexities of the care and services delivered by each unit, and/or department. The QAA Committee must be composed of, at a minimum:

- The director of nursing (DON).
- The medical director or his/her designee.
- The infection preventionist (IP).
- At least three other staff, one of whom must be the facility's administrator, owner, board member or other individual in a leadership role who has knowledge of facility systems and the authority to change those systems.
    - The QAA committee must 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.

Determine when it is appropriate for residents and/or resident representatives to be included in QAPI activities. Their input and feedback are always strongly encouraged. When residents and/or resident representatives are included in QAPI activities, safeguards must be taken to protect all resident and staff confidentiality and protected health information.

Example

All department managers, the administrator, the director of nursing, infection control and prevention director, medical director, consulting pharmacist, resident and/or resident representatives (if appropriate), and three additional staff will provide QAPI leadership by being on the QAA committee. The three general staff members will be chosen from staff that have direct care and/or service responsibilities, including nursing assistants, nurses, housekeeping aides, maintenance workers and dietary aides. The three general staff will serve a one-year commitment and the positions will be rotated among staff to ensure as many persons as possible have the opportunity to serve on the committee. Participating residents and/or resident representatives s will receive confidentiality training prior to participating in any QAPI activity.

The QAA committee will meet monthly. QAPI activities and outcomes will be on the agenda of every staff meeting and shared with residents and family members through their respective councils and monthly newsletter. The minutes from all meetings will be posted throughout the organization. The QAA committee will report all activities to the board of directors during their regularly scheduled meetings.

The QAA committee will have responsibility for reviewing data, suggestions and input from residents, staff, resident representative and other partners. The QAA committee will prioritize opportunities for improvement and determine which performance improvement projects will be initiated. When an issue or problem is identified that is not systemic and does not require a

performance improvement project, the QAA committee will decide how to correct the issue or problem. These corrections may include an easy decision, corrective action plan or rapid improvement cycle.

The committee will solicit individuals from the organization to participate in performance improvement projects. The committee will monitor progress, provide input and ensure the individuals involved in the project have the resources they need. The QAA committee will use a charter for all QAPI performance improvement projects.

10. Determine How the QAPI Activities Will Be Reported to the Governing Body

Describe how the QAPI activities will be shared and input solicited from the governing body.

Example

The administrator will facilitate discussion on QAPI activities at the quarterly board of director meetings. QAPI will be a standing agenda item for these meetings. Input will be solicited from board members on QAPI activities. All current projects and outcomes will be reviewed at the board meetings.

11. Describe How a Fair and Just Culture for Staff Will Be Implemented

Describe how leadership will ensure accountability while creating an atmosphere in which staff is comfortable identifying and reporting quality problems.

Example

Our organization is a learning environment. We believe in the practices and principles of a fair and just culture. All managers will promote staff involvement in improving quality. Staff will be encouraged to bring concerns, issues, and opportunities for improvement to any supervisor/manager. The managers will respond in a consistent manner to encourage, and not discourage, staff to bring forward opportunities for improvement. Staff will be encouraged to report errors and near misses to allow the organization to learn from those occurrences and make systemic changes to prevent recurrences. Staff will be held accountable for their behavioral choices and reckless behavior will not be tolerated. Our goal is to improve the systems that drive our actions.

12. Identify Data Sources to Analyze Performance, Identify Areas of Risk and Solicit Feedback/Input

The facility must have policies and procedures in place for developing, monitoring and evaluating performance indicators. Organizations must effectively identify, collect, and use data and information from all departments and the facility assessment. Identify data sources, the frequency of data collection/analysis, targets/benchmarks you will use and establish a plan to communicate data analysis. Choose data sources your organization will use to develop and monitor performance indicators that will track your ongoing performance.

Data Sources*	Data collection frequency		Benchmarks to analyze this data source	Who will analyze the data?	Data analysis frequency	Data will be communicated with	Communicate data analysis via	Frequency of communication
	Suggestions	• weekly • monthly • quarterly • annually	• applicable clinical guidelines • identified best practices • national data • corporate data • state data • facility identified performance indicators/goals/ thresholds/targets	• HR • Leadership Team • QAPI committee	• weekly • monthly • quarterly • annually	• board members • caregivers • community • executive leadership • families • residents • volunteers	• board meetings • bulletin boards • dashboards • newsletters • posters • QAPI interdisciplinary meetings • staff meetings	• weekly • monthly • quarterly • annually
Choose a data source								
Choose a data source								
Choose a data source								

Suggested Data Sources:
This list includes suggestions and is not inclusive of all data sources the organization may use:

- Advanced care planning audits
- CMS Quality Measures (long-stay; short-stay
- Case Mix
- CASPER report
- Community activities
- Consistent assignment
- Discharged resident surveys
- Drug regimen review summary
- Falls
- Family Satisfaction
- Fire safety deficiencies
- Infection Prevention and Control Program
- Info from providers, physicians, contractors, vendors
- Licensed nurse staff hours/resident day
- Medication administration audits
- Medication errors
- Medication room audits
- Near Misses (incidents w/out serious harm)
- Nursing Assistant staff hours/resident day
- Occupancy rates
- Performance Indicators
- Rehospitalization rates
- Resident council minutes
- Resident satisfaction surveys
- Revenue payer sources mix
- Staff retention
- Staff satisfaction
- State survey results
- Staff turnover
- Volunteer hours
- Other

Examples

Data Sources to Analyze Performance, Identify Areas of Risk and Solicit Feedback/Input

Data Sources	Data collection frequency	Benchmarks to analyze this data source	Who will analyze the data?	Data analysis frequency	Data will be communicated with	Communicate data analysis via	Frequency of communication
Suggestions	• *weekly* • *monthly* • *quarterly* • *annually*	• *applicable clinical guidelines* • *identified best practices* • *national data* • *corporate data* • *state data* • *facility identified performance indicators*	• *HR* • *leadership team* • *QAA committee*	• *weekly* • *monthly* • *quarterly* • *annually*	• *board members* • *caregivers* • *community* • *Executive. leadership* • *families* • *residents* • *staff* • *volunteers*	• *board meetings* • *bulletin boards* • *dashboard* • *newsletters* • *posters* • *QAPI meetings* • *staff meetings*	• *weekly* • *monthly* • *quarterly* • *annually*
Abuse, Neglect, Maltreatment reports	weekly	Identified best practices	Leadership team	weekly	Board members, QAPI committee, state reporting agency,	Reporting requirements, meetings	As needed, weekly
CMS Quality Measures (long-stay and short-stay)	monthly	state and national data	Leadership team	monthly	Executive leadership, board members, staff	QAA and IDT meetings	Monthly and quarterly
Complaints	weekly	Identified best practices, organizational date	Leadership team	weekly	Board members, QAPI committee	meetings	As needed, weekly
Falls	weekly	Organizational data	Leadership team, QAA committee	weekly	Residents, families, staff,	Bulletin boards, dashboard, QAA and IDT meetings	Monthly
Medication errors	monthly	Organizational data	Leadership team, QAA Committee	Monthly or asap if adverse drug event	Board members, staff	Staff meetings, dashboard, QAA Meeting	Monthly or sooner if needed
Rehospitalization Rates	monthly	Organizational, state and national data	Leadership team, QAA committee	monthly	Board members, Exec. leadership, staff	Staff meetings, dashboard, QAA meetings	Monthly

Data Sources	Data collection frequency	Benchmarks to analyze this data source	Who will analyze the data?	Data analysis frequency	Data will be communicated with	Communicate data analysis via	Frequency of communication
Suggestions	• *weekly* • *monthly* • *quarterly* • *annually*	• *applicable clinical guidelines* • *identified best practices* • *national data* • *organizational (chain) data* • *state data*	• *HR* • *Leadership Team* • *QAPI committee*	• *weekly* • *monthly* • *quarterly* • *annually*	• *board members* • *caregivers* • *community* • *executive leadership* • *families* • *QAPI committee* • *residents* • *volunteers*	• *board meetings* • *bulletin boards* • *dashboards* • *newsletters* • *posters* • *QAPI interdisciplinary meetings* • *staff meetings*	• *weekly* • *monthly* • *quarterly* • *annually*
Resident/Family Council minutes	monthly	Organizational data	Leadership team, QAPI committee	monthly	QAPI committee, residents families, board members	meetings	monthly
Satisfaction Surveys	annually	Organizational date, national data	Leadership team, QAPI committee	annually	Board members, staff, residents, families, QAPI committee	Meetings, newsletters, board meetings	annually
Suggestion boxes	weekly	Organizational data	QAPI committee, leadership team	weekly	QAPI committee, leadership team	Meetings	monthly

Performance Improvement Projects (PIPs)

13. Describe How Your Organization Will Conduct Performance Improvement Projects

The facility must conduct distinct performance improvement projects, based on the scope and complexity of facility services and available resources, identified as a result of the facility assessment required at §483.70(e). While the number and frequency of improvement projects may vary, each facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis. Describe the overall plan and reasons why your organization will conduct PIPs to improve care and services.

Example

Our organization will conduct at least one Performance Improvement Project (PIP) annually. The PIP will be designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention. We will conduct PIPs that will lead to changes and guide corrective actions in our systems, which cross multiple departments, and have impact on the quality of life and quality of care for residents living in our community. We will conduct PIPs that will improve care and service delivery, increase efficiencies, lead to improved staff and resident outcomes, and lead to greater staff, resident and resident representative satisfaction. An important aspect of our PIPs is a plan to determine the effectiveness of our performance improvement activities and whether the improvement is sustained by regularly reviewing and analyzing data

14. Describe How Potential Topics for PIPs Will Be Identified

Describe how the QAA committee will identify potential topics for PIPs. Topics should be chosen using a systematic approach that considers all the data the organization is monitoring as well as input from residents, staff, resident representatives, partners, etc., including high risk, high volume and/or problem-prone areas, as well as, resident safety, choice, autonomy and quality of care and quality of life outcomes for residents.

Example

The QAA committee will review data and input on a monthly basis to look for potential topics for PIPs. We will monitor and analyze data, and review feedback and input from residents, staff, resident representatives, volunteers, providers and partners. We will look at issues, concerns and areas that need improvement as well as areas that will improve the quality of life and quality of care and services for the residents living and staying in our community. Factors we will consider include high-risk, high-volume, or problem-prone areas that affect health outcomes, resident safety, choice, autonomy, quality of care and services and areas that affect staff.

In addition, we will consider:

- Existing standards or guidelines that are available to provide direction for the PIP
- Measures that can be used to monitor progress
- Quality Measures publicly reported on Care Compare
- Evidence based practices
- Projects that require systemic changes
- Projects that require environmental changes
- Projects affecting staff

15. Describe Criteria for Prioritizing and Selecting PIPs

Choosing an area for improvement is an important step for your organization. Potential areas for improvement are based on the needs of the residents and the organization. Factors such as high-risk, high-volume or problem-prone areas, as well as resident safety, choice, autonomy and quality of care and quality of life will be considered. Other factors to consider are the costs to the organization if the area isn't addressed, how feasible is it to implement a PIP in this area given current resources, and whether the PIP supports organizational goals and priorities. After narrowing topic choices for a PIP, consider which staff will be most affected by the PIP. Are there current resources to support anticipated changes in systems? What training needs will the PIP present? Is there an identified champion(s) to lead the PIP?
There are times an issue or concern comes forward that needs immediate attention and requires corrective action. These issues or concerns will be reviewed by the QAA Committee. Adverse events, issues indicating abuse, neglect or maltreatment are just a few examples of the types of issues that will receive immediate corrective action and systemic review to ensure it is not repeated.

Example

> Our QAA committee will prioritize topics for PIPs based on the current needs of the residents and our organization. Priority will be given to areas we define as high-risk to residents and staff, high-prevalence or high-volume areas, and problem-prone areas. The QAA committee will use the CMS Prioritizing Worksheet for Performance Improvement Projects to prioritize PIPs. Consideration will be given to include staff most affected by the PIP. Anticipated training needs will be discussed as well as other resources to complete the PIP. The QAA committee will provide guidance on how to address issues that arise and need immediate corrective action.

16. Describe How and When PIP Charters Will Be Developed

A project charter is a helpful tool for all PIPs. The charter establishes the goals, scope, timing, milestones, team roles and responsibilities for the PIP. The charter is usually developed by the QAA committee and then given to the team that will carry out the PIP. The charter helps the PIP team stay focused by explaining what they are trying to accomplish. It does not tell them how to get there, that is up to the PIP team.

Example

> A project charter will be developed for each PIP at the beginning of the project that clearly establishes the goals, scope, timing, milestones, team roles, and responsibilities. The PIP charter will be developed by the QAA committee and then will be given to the team that will carry out the PIP.

17. Describe How to Designate PIP Teams

Describe a process for assembling teams to work on specific PIPs. Consider people in a position to explore the problem, including staff closest to the problem, such as nursing assistants and other direct care staff. Consider including residents and resident representatives, if applicable.

Define the required characteristics of any PIP team: perhaps including that the team be interdisciplinary, represent each of the job roles affected by the project, that it includes resident and/or resident representatives as appropriate, and that a qualified team leader is selected who has the ability to coordinate, organize, and direct the work.

Example

When designating a PIP team, the QAA committee will consider and give opportunity to all staff in the organization. The QAA committee will ensure that the team is interdisciplinary, there is representation from each job role that is affected by the project, and resident and/or resident representatives are included, if appropriate. When chosen to participate on a PIP team, staff with direct care responsibilities will be replaced so that the needs of residents continue to be met. A team leader will be selected that has the ability to coordinate, organize, and direct the work. The team will be accountable to the QAA committee.

18. Describe How the Designated Team Will Conduct the PIP

Describe the expectations of the PIP team and how they will conduct their work. Describe the responsibilities of the team. Items to consider include:

- Determine what information is needed for the PIP.
- Determine a timeline.
- Identify and request any needed supplies or equipment.
- Select or create measurement tools.
- Prepare and present results.
- Use a problem-solving model such as Plan-Do-Study-Act (PDSA).
- Other

Example

The PIP teams will consider each PIP a learning process. The team will follow steps and processes that are needed for any quality improvement project. The responsibilities for the PIP teams will be to determine what information is needed for the PIP and how to obtain the information. They will determine a timeline based on the PIP Charter. Requests for needed supplies, staff availability and equipment will be made to the QAA committee. The QAA committee will respond in a timely manner to assure momentum is maintained. The team will develop an action plan using the organization's usual format. Interventions that will make change will be implemented by the team. The team will use root cause analysis to ensure that the root cause and contributing factors are identified. When determining and implementing interventions, PDSA cycles will be used. The team will select and/or create measurement tools to ensure that the changes they are implementing are having the desired effect.

19. Describe Your Process for Documenting and Communicating Performance Improvement and Trends in Performance Measures

Describe how your organization will document the highlights, progress and lessons learned from your PIP. It is important to have a historical record for the organization so that improvement can be built upon past work. What project documentation templates will you use to consistently and electronically inform others about PIPs for review and future reference?

Results of PIPs will be communicated via (choose from these):

- Dashboards
- QAPI interdisciplinary meetings
- Board meetings

- Posters
- Bulletin boards
- Newsletters
- Other

The team will report their progress to the QAPI committee on a regular basis. The QAPI committee will ensure that the following groups are informed of PIPs and other QAPI activities (choose from these)

- Board member
- Staff
- Residents
- Resident representative(s)
- Volunteers
- Community members
- Others

Example

For ongoing monitoring of the PIP, we will use the CMS PIP Inventory to include milestones, PDSAs, outcomes and other lessons learned from the PIP. Information about PIPs will be shared via our quality improvement dashboard, quarterly newsletter provided to all residents, resident representative(s) and staff, and discussed during the QAPI agenda items on all staff, resident and family monthly meetings.

Systematic Analysis and Systemic Action

20. Describe Your Systematic Approach to Quality Improvement

As part of the QAPI program, each facility is responsible for having systems in place and implementing actions intended to improve performance. This includes implementation of corrective actions, measuring success and tracking performance, to ensure improvements are achieved and sustained.

Describe how your organization will use a systematic approach to assist in determining underlying issues and the systems involved. When making any change, there are many tools which teams can use to identify the cause and contributing factors of issues, including:

- Five Whys
- Flowcharting
- Fishbone Diagram
- Failure Mode and Effects Analysis (FMEA)
- Reverse Tracer Methodology
- Other

Example

Our facility uses a systematic approach to determine when in-depth analysis is needed to fully understand identified problems, causes of the problems, and implications of a change. To get at the underlying cause(s) of issue, we bring teams together to identify the root cause and contributing factors using the Five Whys, Flowcharting and the Fishbone Diagram.

21. Describe Your Approach to Preventing Medical Errors and Adverse Events and Promoting Sustained Improvement

In addition to self-identified improvement activities, the facility must also track medical errors and adverse resident events. When medical errors or adverse resident events are identified, the facility must analyze the cause of the error/event, implement corrective actions to prevent future events and conduct monitoring to ensure desired outcomes are achieved and sustained.

Nursing homes must develop and implement written policies and procedures that enable the facility to systematically identify and investigate for medical errors and adverse events, including how the facility will analyze and use data relating to errors/events to develop activities to prevent future occurrences. Corrective actions to address medical errors and adverse events generally involves a written plan that includes:

- A definition of the problem – which includes determining contributing causes of the problem.
- Measurable goals.
- Step-by-step interventions to correct the problem and achieve established goals.
- A description of how the QAA committee will monitor to ensure changes yield the expected results.

Example

> To address medical errors and adverse events and promote sustained improvement, our organization develops actions to address the identified root cause and/or contributing factors of an issue/event that will affect change at the systems level. Our organization then develops corrective actions in a written plan that includes a definition of the problem, measurable goals, and step-by-step interventions to correct the problem and achieve established goals. We use PDSA cycles to test actions and recognize and address "unintended" consequences of planned changes.

22. Describe Your Approach to Ensure Planned Changes/Interventions Are Implemented and Effective

Many organizations choose from the following courses of action to ensure that planned changes/interventions are implemented and effective:

- Choose indicators/measures that tie directly to the new action.
- Conduct ongoing periodic measurement and review to ensure the new action has been adopted and is performed consistently.
- Review some measures more frequently to show incremental changes, which can serve as a reminder for the new action and provide encouragement and reinforcement.
- Based on measurement review, make changes in procedure(s) as needed to help facilitate the change.
- Other

Example

> To ensure the planned changes/interventions are implemented and effective in making and sustaining improvements, our organization chooses indicators/measures that tie directly to the new action and conducts ongoing periodic measurement and review to ensure that the new action has been adopted and is performed consistently.

Resources

- QAPI Five Elements, CMS
- QAPI at a Glance, CMS
- QAPI Self-Assessment Tool, CMS
- Guide for Developing Purpose, Guiding Principles and Scope for QAPI, CMS
- Guide for Developing a QAPI Plan, CMS
- Measure/Indicator Collection and Monitoring Plan, CMS
- Measure/Indicator Development Worksheet, CMS
- Prioritization Worksheet for Performance Improvement Projects (PIPs), CMS
- Guide to Creating a PIP Charter, CMS
- PIP Launch Checklist, CMS
- PIP Inventory, CMS
- Goal Setting Worksheet, CMS
- Adverse Drug Event Trigger Tool, CMS
- Five Whys Tool for Root Cause Analysis, CMS
- Flowchart Guide, CMS
- How to Use the Fishbone Tool for Root Cause Analysis, CMS
- Guidance for Performing Failure Mode and Effects Analysis (FMEA) with PIPs, CMS
- Guidance for Root Cause Analysis, CMS
- Root Cause Analysis Toolkit for Long-term Care, Superior Health
- PDSA Cycles, CMS
- Communication Plan Worksheet, CMS
- Guidance for Reverse Tracer Methodology, Relias Media
- QAPI Meeting Agenda Guide, Superior Health
- QAPI Meeting Agenda, Superior Health

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