This sample was created only to assist nursing homes in developing their own QAPI plan; the content is not intended to describe best practices.

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Quality Assurance Improvement Plan

I. QAPI Goals/Purpose Statement

Our purpose is to provide excellent quality resident/patient care and services. Quality is defined as meeting or exceeding the needs, expectations and requirements of the patients cost-effectively while maintaining good resident/patient outcomes and perceptions of patient care.

Our nursing home has a Performance Improvement Program which systematically monitors, analyzes and improves its performance to improve resident/patient outcomes. It recognizes that value in healthcare is the appropriate balance between good measures, excellent care and services and cost.

II. Scope

a. Our center's full range of services included in our QAPI program are post acute care, long term care, and outpatient therapies. The QAPI committee will consist of representation from nursing, dietary, housekeeping, laundry, maintenance, health information management, activities and staff education. Therapy, music therapy, human resources, resource development, business office and therapy departments will be asked for input or sit on a performance improvement project sub- committee as requested

b. Our QAPI plan addresses:

  i. Clinical Care—monitor existing QI/QM results, internal monitors for falls, medication errors, pressure ulcers, incident reports, infection reports. The QOC Team meets monthly with Medical Director and others to address "care concerns."

  ii. Quality of Life—monitor existing data available through QOL survey, resident/family satisfaction surveys, resident/family concerns brought up at Household/Community Council meetings, concerns from care conferences and individual rounding with residents and family members. The QOL Team meets monthly to address "life concerns."

  iii. Resident Choice—Individualized goals for care are addressed at care conferences, through the formal survey processes, and with rounding.

c. We will use the performance prioritization sheet to identify areas of improvement and rank them by factors such as prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity. From this we will determine our Process Improvement Projects (PIP). Our focus will also be on how we can create innovative best practices while making sure resident's autonomy is maintained.

d. Review of State/National and past facility measures will be used to benchmark for improvement in all areas. These benchmarks will be reviewed at least monthly, and reported to the QAPI Committee on a quarterly basis.

III. Guidelines for Governance and Leadership

a. The community advisory board and administration are responsible and accountable for developing, leading, and closely monitoring a QAPI program.

  i. Input is obtained from facility staff on a monthly basis through the QAPI Council. Department heads are responsible for talking to their employees before reporting into QAPI. Residents and families have input through resident and family council and our satisfaction surveys.

  ii. The input given is acted upon and brings QAPI to life in the facility. Concerns are brought up when a certain department or task is not hitting benchmark. The concern is discussed and an action plan developed. If necessary it will go on the Performance Improvement Project Prioritization sheet.

b. The administrator ensures that the quality program is adequately resourced.

  i. A Quality Management Coordinator is responsible for QAPI processes.

  ii. The Quality Management Coordinator ensures that consistent, appropriate and just-in-time training is provided to facility employees. Quality topics are covered at general orientation and with on-going training.

  iii. Allocation of resources for quality activities such as time, equipment, and technical training are provided as needed by the Administrator in conjunction with the Quality Council.

  iv. A determination of adequacy of resources will be identified by on-going monitoring of quality improvement team progress and the annual completion of our Quality evaluation tool.

  v. Caregivers will become and remain proficient with QI tools and techniques through on-going training and on-going use in day-to-day operations. The caregiver's level of proficiency is assessed by the Quality Council through on-going monitoring of quality data.

  vi. Small group education sessions on QAPI are provided to all caregivers working in the building. The use of visual aide tools describing process improvement is utilized as reminders to keep staff members focused on performance improvement techniques. Paycheck stuffers will contain "Bits of QAPI" designed to provide ongoing information on the commitment to incorporate QAPI in the fabric of our culture and daily operations. QAPI is also part of orientation for new staff members joining our team. Quarterly QAPI focus meetings are in place to ensure that staff members' level of proficiency will remain current. In addition, as part of annual evaluations, staff members are expected to answer questions regarding performance improvement and how QAPI is used in operations of the facility.

c. QAPI Leadership

i. The QAPI Council provides the backbone and structure for QAPI. This group includes all of the Executive Leadership team (list titles of team members including administrator, DON, medical director), plus additional staff members, (physician, contracted pharmacist, etc).

ii. This group of people works together to communicate and coordinate QAPI activities. Currently QAPI Council meets once a month. We also have a bi-weekly QAPI meeting to discuss QAPI, what our next steps are, and how things are going throughout the building. This is where we come up with ideas to communicate new tools to staff.

  1. Existing ongoing committees (e.g., mobility/falls) report their data and activities to the QAPI council.

iii. QAPI activities are reported to the governing body at every Board meeting which is held every other month.

d. The QAPI Steering Committee

i. Steering Committee membership is interdisciplinary with at least 2 non-licensed staff members, and one resident council member.

ii. The QAPI Committee meets monthly and maintains minutes of all activity.

iii. The Committee maintains a QAPI manual that houses meeting minutes, project charters, PIP's, PSDA reviews, data, data analysis and sample performance improvement support tools. Note: *the QAPI manual is different from the QAPI plan*.

iv. Communication about the QAPI activities is shared via staff meetings, trainings, and bi-monthly articles in the Center Newsletter. The administrator also includes QAPI issues in bi-weekly reports to the DOO and the facility ownership.

v. The QAPI Steering Committee will complete an annual self assessment / review of the QAPI program.

IV. Feedback, Data systems and Monitoring

a. a. QAPI is integrated into the responsibilities and accountabilities of all senior management and the Board of Directors.

b. b. The following data is monitored through QAPI:

i. Input from caregivers, residents, families, and others;

ii. Adverse events;

iii. Performance indicators;

iv. Survey findings;

v. Complaints

c. Process for collecting the above information:

i. Gather input from caregivers, residents, families, and others (Surveys, Council Meetings, written evaluations, PCP input)

ii. Adverse events (incident reports, 24 hour report)

iii. Performance indicators (Monthly QM, 5 Star Rating, Advancing Excellence)

iv. Survey findings (2567)

v. Complaints. (input by PCP, surveys, Council Meetings, written comments)

d. The information gathered is analyzed and compared to benchmarks and/or targets established by the facility.

i. Current scores are analyzed against bench marks that have been set – quarterly

ii. Daily interdisciplinary team (IDT) notes are reviewed including adverse events/complaints on a daily basis. We have a mechanism for communicating patterns, trends identified during IDT meetings to the broader QAPI committee.

iii. Consultant reports are compared to goals on a monthly basis.

iv. QAPI teams analyze data regularly as part of their project assignments.

e. A dashboard or dashboards for individual performance improvement projects are used to communicate progress and outcomes of individual QAPI projects.

i. Dashboard(s) – Corporate maintains information on these

ii. Monthly reports / graphs are published – Department managers and/or the QAPI Lead is responsible for cataloging and maintaining these reports

iii. Logs – QAPI Lead is responsible for keeping logs up to date

iv. Minutes of all meetings –QAPI Lead is responsible for maintaining documentation

f. A summary of QA/PI activities and outcomes will be reviewed and approved by the QAPI Committee and the Board regularly with quarterly updates emailed to organizational leadership, staff and key stakeholders. Key information will be posted on the organization's website and in public areas of the facility for viewing by residents, caregivers, and families. Written summaries will be available by request.

V. Guidelines for Performance Improvement Project (PIP) Teams

a. Describe the overall plan for conducting PIPs to improve care or services.

i. Potential topics for PIPs are identified through a prioritization process in the QAPI Committee.

ii. Criteria for prioritizing and selecting PIP's are based on prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity. PIP's involve gathering information to clarify issues or problems, design and implement interventions, assess results, and sustain improvements utilizing the PDSA Cycle.

iii. PIP project charters are developed based on a prioritizing process with a minimum of one project chartered at a time; more than one may be chartered based on the project, available resources and QAPI Committee recommendation.

iv. Results are reported to residents, families, staff and others verbally or in writing at least one time during the performance improvement plan or more often as appropriate.

b. The QAPI committee along with the project lead is responsible for assembling the PIP team(s).

c. The QAPI Committee selects a qualified staff member to lead each project. PIP teams are interdisciplinary with representation of each of the job roles affected by the project and resident representation will be included as appropriate.

d. PIPs are reported by the project lead to the monthly QAPI Committee meeting verbally and documented in the meeting minutes.

VI. Systematic Analysis and Systematic Action

a. Any change that is made has the potential to have broader impact than intended. The impact of all changes to specific systems or processes are reviewed and assessed for both intended and “unintended” consequences/ outcomes. Each PIP is conducted systematically, utilizing a structured format.

   i. Flow charts are used to describe the current process we use, and to identify any areas of breakdown or weakness in the current process

b. The Plan-Do-Study-Act (PDSA) process and Root Cause Analysis (RCA) are used to identify improvement opportunities and to understand how to improve them.

   i. The QAPI Committee makes plans describing what areas of the process we are going to change (where breakdowns were observed), utilizing a Project Plan and Monitoring Tool. (PLAN). Depending on the problem, this section can be expanded. We use structured RCA and/or PDSA depending on the issue/opportunity.

   ii. Implement changes to these areas in the process (DO)

c. The QAPI Committee monitors progress to ensure that interventions or actions are implemented and effective in making and sustaining improvements.

   i. The QAPI Committee monitors the process according to pre-determined time frames, observing if the changes in the process resulted in the desired outcome. (STUDY)

   ii. If the changes to the process have not resulted in the goal of the PIP, further changes are made and monitoring of the process takes place again. (ACT)

   iii. Once the PIP goals have been met, the PIP will be placed on a permanent tracking log for ongoing (but less frequent) measurement, to assure the PIP doesn’t get “forgotten”.

VII. Communications from the quality committee and its subcommittees and their actions will be communicated based on the audience.

a. For staff we plan to communicate via staff newsletters, monthly department meetings, email updates, and memos.

b. For residents we plan to communicate via resident council, neighborhood meetings, newsletters and letters.

c. For families we plan to communicate via newsletters, neighborhood meetings and memos.

VIII. The QAPI program will be evaluated annually by the Steering Committee with input from other staff and stakeholders.

a. The key elements of the program will be reviewed to assure that they are occurring, that the program is efficient, it is accessible to community members and that the results are communicated to the appropriate audience.

i. Performance indicators that are monitored will be reviewed - are they still relevant, do we need to monitor them as frequently, or more frequently? Are our goals, thresholds still relevant, achievable, etc.

ii. Ongoing training needs will be identified and addressed.

iii. Staff will participate in a brief survey about our QAPI program as well as identifying any issues in their individual performance assessment.

b. Describe the purpose of this evaluation- to help your organization to expand your skills and increase the impact of QAPI in your organization.

IX. Establishment of Plan

a. This plan was established on DATE.

b. The plan will be revisited on an annual basis.

c. Substantial changes to the plan will be identified in the following table. Education will be provided regarding any significant changes. The most current version will be available for review at any time on the bookshelf located outside the Director's office.

Revision	Reason for the Change	Date Approved by Quality Council