# Acute Care and Critical Access Quality Assurance/Performance Improvement Guide:

## *What You Need to Know to Establish an Effective QAPI Program*

This companion guide is designed to help your team recognize and understand the major components of the Quality Assurance/Performance Improvement Initiative. It will support your organization's quality improvement efforts. The guide is not intended to replace *QAPI at a Glance*, the Centers for Medicare & Medicaid Services' Conditions of Participation or Missouri Code of State Regulations, but it can be used in conjunction with other materials to help your team stay on track in reaching your quality improvement goals.

This guide primarily is designed for professionals who are new to their current position, organization or level of responsibility. Regardless of your experience in QAPI activities, remembering the systematic approach to sustained improvement is a skill set that requires continual development in any organization.

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MHA
MISSOURI HOSPITAL ASSOCIATION

# 12 Action Steps to QAPI

According to *QAPI at a Glance*, there are 12 action steps on the pathway to QAPI implementation. The steps do not need

to be achieved sequentially; however, the steps do build on one another. Following them sequentially can be a great way to begin your strategic approach to implementing QAPI.

## WHAT'S NEW ABOUT QAPI?

While health care facilities have long-since been required to have quality assessment and assurance programs, regulations and reporting expectations require that a formalized approach to performance improvement is part of ongoing systems improvement.

## QUALITY ASSURANCE

Quality assurance can be characterized as a focus on current outcomes, with a retrospective view of "what happened." Often, this is done out of a need to ensure compliance and proper follow-up of identified issues. While the scope of a quality assurance committee may include such actions as conducting a root cause analysis and developing action plans, current regulations do not require any specific or formal improvement processes to be used.

## PERFORMANCE IMPROVEMENT

Performance improvement can be thought of as a system that makes things better. Unlike quality assurance, which focuses on compliance, performance improvement focuses on "systems issues" that cause poor outcomes. While there are many formalized performance improvement tools, *QAPI at a Glance* refers to the Plan-Do-Study-Act model for improvement.

## PUTTING IT TOGETHER

When QA initiatives and PI efforts are blended together, the result can be significant improvements to important outcomes — patients can experience fewer adverse clinical effects, satisfaction rates can improve and staff can become more engaged as processes are stabilized. All of this can lead to improved operational performance for your organization.

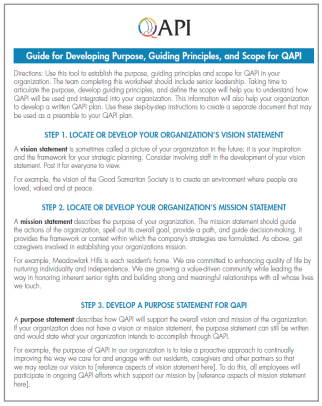
| | QUALITY ASSURANCE | PERFORMANCE IMPROVEMENT |
|---|---|---|
| Motivation | Measuring compliance with standards | Continuously improving processes to meet standards |
| Means | Inspection | Prevention |
| Attitude | Required, reactive | Chosen, proactive |
| Focus | Outliers: "bad apple" individuals | Processes or systems |
| Scope | Medical provider | Resident care |
| Responsibility | Few | All |
| QA + PI = QAPI | | |

*Source: QAPI at a Glance*

# QAPI Tools

## GUIDE TO DEVELOP PURPOSE, GUIDING PRINCIPLES AND SCOPE FOR QAPI

*(QAPI at a Glance, page 31)*


QAPI

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

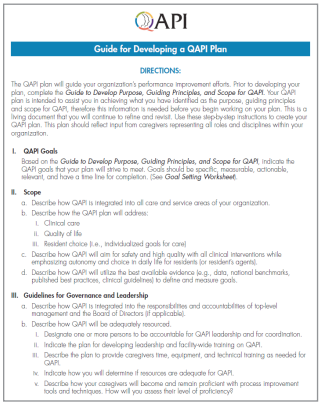
A **mission statement** describes the purpose of your organization. The mission statement should guide the actions of the organization, spell out its overall goal, provide a path, and guide decision-making. It provides the framework or context within which the company's strategies are formulated. As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


QAPI

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*).

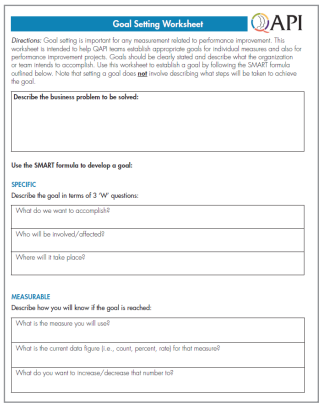
II. **Scope**
a. Describe how QAPI is integrated into all care and service areas of your organization.
b. Describe how the QAPI plan will address:
i. Clinical care
ii. Quality of life
iii. Resident choice (i.e., individualized goals for care)
c. Describe how QAPI will aim for safety and high quality 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?

## GUIDE TO DEVELOPING A QAPI PLAN

*(QAPI at a Glance, page 34)*

This action-based, three-page guide will help your team address the important elements of QAPI, and develop a formal QAPI plan. With concrete examples and actionable steps in a logical progression, the guide will walk you step-by-step through the creation of your plan.


Goal Setting Worksheet

QAPI

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

**Describe the business problem to be solved:**

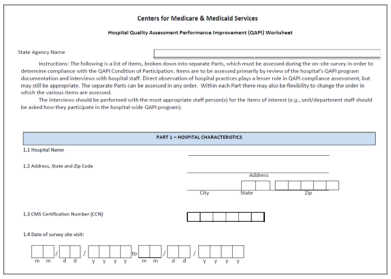
**Use the SMART formula to develop a goal:**

SPECIFIC
**Describe the goal in terms of 3 'W' questions:**
What do we want to accomplish?
Who will be involved/affected?
Where will it take place?

MEASURABLE
**Describe how you will know if the goal is reached:**
What is the measure you will use?
What is the current data figure (i.e., count, percent, rate) for that measure?
What do you want to increase/decrease that number to?

## GOAL-SETTING WORKSHEET *(QAPI at a Glance, page 37)*

This worksheet will help your performance improvement project teams develop SMART performance improvement goals. Effective goals are specific, measurable, attainable, relevant and time-bound.


Centers for Medicare & Medicaid Services

Hospital Quality Assessment Performance Improvement (QAPI) Worksheet

State Agency Name

Instructions: The following is a list of items, broken down into separate Parts, which must be assessed during the on-site survey in order to determine compliance with the QAPI Condition of Participation. Items are to be assessed primarily by review of the hospital's QAPI program documentation and interviews with hospital staff. Direct observation of hospital practices plays a lesser role in QAPI compliance assessment, but may still be appropriate. The separate Parts can be assessed in any order. Within each Part there may also be flexibility to change the order in which the various items are assessed.
The interviews should be performed with the most appropriate staff person(s) for the items of interest (e.g., unit/department staff should be asked how they participate in the hospital-wide QAPI program).

PART 1 – HOSPITAL CHARACTERISTICS

1.1 Hospital Name

1.2 Address, State and Zip Code

Address
City State Zip

1.3 CMS Certification Number (CCN)

1.4 Date of survey site visit:

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## CMS QAPI SURVEYOR ASSESSMENT WORKSHEET

This tool is a part of Step 3. The Self-Assessment Tool is found in the Appendix and will help your team determine the extent to which various QAPI practices are already established in your organization. It is recommended that you complete this self-assessment tool prior to beginning any QAPI planning, and re-assess your organization at routine intervals to show your progress.

## OTHER RESOURCES

- CMS Survey and Certification Website — Policy and Memos to States and Region
- CMS Transmittals and Conditions of Participation for Hospitals
- Acute Care and Critical Access Hospital Quality Reporting Guides
- ASQ Website of Quality Tools

# PDSA Model for Improvement

The success of QAPI and the PIP teams at your organization will depend on everyone's knowledge of the PDSA model for improvement. While there are several different improvement methodologies, PDSA is a simple model that is easy to follow.

To begin, make observations about the system that has been targeted for improvement. Targeted areas could be anything — staff performance, actual processes or service delivery, documentation, quality outcomes, staffing, organizational culture, reportable data, or any other aspect of care or services where the outcomes are not meeting organization expectations or standards.

As a PIP team, answer the following questions.

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

From there, follow the steps below and remember to document your team's process and decision-making.

- PLAN to improve performance.
  - What area(s) are not as strong as you would like? What can you do about it?
- DO carry out your plan.
  - Document what you see when the plan is carried out.
- STUDY the results.
  - Step back and look at the big picture. Has there been improvement?
- ACT on the basis of your findings. Continue with the change, make further changes or stop?

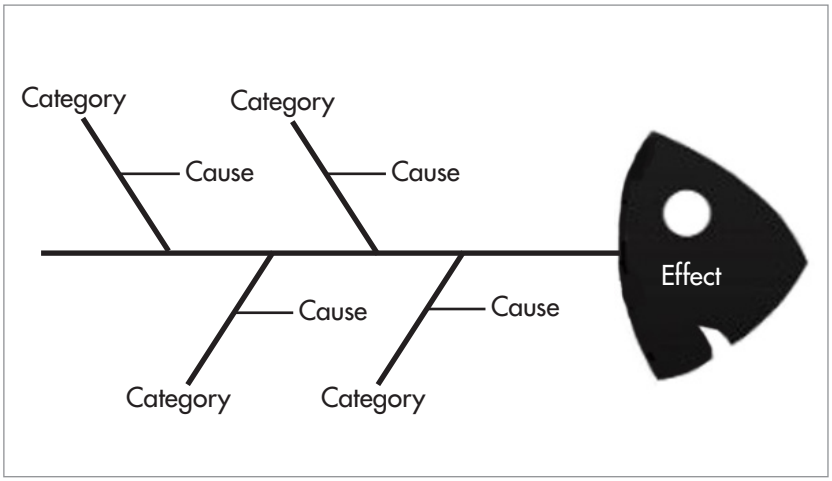
# Root Cause Analysis

## WHAT IS ROOT CAUSE ANALYSIS?

Just as you would pull a weed out of your garden by its root (to ensure that it doesn't grow back), getting to the "root" cause of a systems issue is important to prevent the problem from returning. There are many formalized root cause analysis tools, including the following.

## CAUSE-AND-EFFECT (FISHBONE) DIAGRAM

- The Fishbone diagram starts with the problem at the head of the fish.
- Under each general category of the Fishbone, answer the question, "Why?" for the identified problem.
- Once the diagram is completed, discuss the various causes to determine the root of the problem — or the real reasons why the problem exists. It is from this discussion that the focus for the improvement plan begins.




## FIVE WHYS

The Five Whys tool aids in the identification of the root cause of a problem. Begin by identifying a specific problem and ask why it is occurring. Continue asking "why" until the underlying cause is determined. Each "why" should build from the previous answer. There is nothing magical about the number five. Continue until the root cause is identified.

## STEPS

- Define a problem; be specific.
- Ask why the problem occurs and list the reason(s) in Box 1.
- Select one of the reasons from Box 1 and ask, "Why does this occur?" List the reason(s) in Box 2.
- Continue the process of questioning until you have uncovered the root cause of the identified problem. If there are no identifiable answers or solutions, address a different reason.

The problem: _____

Why does this occur?

1. → Why is that?
2. → Why is that?
3. → Why is that?
4. → Why is that?
5.

# 12 Action Steps Expanded

## QAPI Step 1: Leadership Responsibility and Accountability

Hospital leadership (i.e., CEO, COO, CNO, medical staff, pharmacists, maintenance, radiology, surgical services and other key managers) is responsible for "setting the tone" to help staff identify how to meet the organization's mission, vision, guiding principles, standards and expectations. Without strong leadership, change efforts often fail or are not sustainable.

### ACTION STEPS

- Develop a steering committee/team that will provide QAPI leadership.
- Provide resources for QAPI, including equipment and training for front-line staff.
- Establish a climate of open communication and respect.
- Understand your current culture and how it will promote performance improvement.

### PROBING QUESTIONS FOR TEAM DISCUSSION

- Who is on our QAPI steering committee?
- Is our medical director involved in QAPI?
- How can we provide needed resources for QAPI?
- Is our climate open, respecting and fair? What does our climate look like?
- What resources do we have in place to monitor outcomes?

### SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure success with this step?

### CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Develop a steering committee/team that will provide QAPI leadership. | | |
| Provide resources for QAPI, including equipment and training for front-line staff. | | |
| Establish a climate of open communication and respect. | | |
| Articulate your current culture and how it will promote performance improvement. | | |

# QAPI Step 2: Develop a Deliberate Approach to Teamwork

*QAPI at a Glance* states that QAPI relies on teamwork in several ways. Do teams in your organization have a clear purpose? Do teams have defined roles for each team member? Do teams have commitment and active engagement from each member? While *QAPI at a Glance* was designed for nursing facilities, the framework also applies in the acute care setting.

## ACTION STEPS

- Assess the effectiveness of teamwork in your organization.
- Discuss how PIP teams will work to address QAPI goals.
- Determine how direct care staff, patients and families can be involved in PIPs.
- Identify any communication structures that need to be implemented or enhanced.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- How can physicians be involved in our QAPI efforts?
- Do we have effective teamwork? How do we know? What does it look like?
- How does leadership support the development of effective teams?
- Do we have effective communication in our organization? How do we know?
- Do team members support one another?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Assess the effectiveness of teamwork in your organization. | | |
| Discuss how PIP teams will work to address QAPI goals. | | |
| Determine how direct care staff, patients and families can be involved in PIPs. | | |
| Identify any communication structures that need to be implemented or enhanced. | | |

# QAPI Step 3: Take Your QAPI "Pulse" With a Self-Assessment

Assessing your hospital's current practice is a necessary part of implementing QAPI.

## ACTION STEPS

- Determine a date and time for completing the CMS Surveyor QAPI Worksheet.
- Assemble the right people to complete the worksheet and record your answers for future comparison.
- Determine a date for the next worksheet review.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- Who should be involved in this assessment of our current practices?
- What is our timeline for completion?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Determine a date and time for completing the CMS Surveyor QAPI Worksheet. | | |
| Assemble the right people to complete the worksheet and record your answers for future comparison. | | |
| Determine a date for the next worksheet review. | | |

# QAPI Step 4: Identify Your Organization's Guiding Principles

Is the care provided at your hospital tied to the organization's fundamental purpose or philosophy? How do you determine programmatic priorities? Take time to articulate the purpose. The guiding principles and scope of QAPI will help you integrate these efforts into your organization.

## ACTION STEPS

- Locate or develop your organization's vision and mission statements.
- Develop a purpose statement for QAPI.
- Establish guiding principles.
- Define the scope of QAPI in your organization.
- Assemble the document.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- What beliefs do we have about our purpose and philosophy?
- What beliefs do we have about our approach to QA and PI?
- What is our mission and vision statement?
- What are some of the ways in which we expect care to be provided?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Locate or develop your organization's vision and mission statements. | | |
| Develop a purpose statement for QAPI. | | |
| Establish guiding principles. | | |
| Define the scope of QAPI in your organization. | | |
| Assemble the document. | | |

# QAPI Step 5: Develop Your QAPI Plan

A QAPI plan should be a document that you revisit periodically to ensure that it evolves as your organization grows in its capacity to effectively implement QAPI. This is the main document that will support your QAPI implementation.

## ACTION STEPS

- Determine date(s) and time(s) for writing the QAPI plan.
- Print copies of the "Guide for Developing a QAPI Plan" for all team members.
- Work toward writing the QAPI plan until it is complete.
- Determine a future date for reviewing the QAPI plan.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- What goals do we have for how QAPI will work?
- How will QAPI be integrated into leadership's accountability?
- How will we strive to use data and performance improvement teams?
- How will direct-care staff be involved in QAPI and PIPs?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Determine date(s) and time(s) for writing the QAPI plan. | | |
| Print copies of the "Guide for Developing a QAPI Plan" for all team members. | | |
| Work toward writing the QAPI plan until it is complete. | | |
| Determine a future date for reviewing the QAPI plan. | | |

# QAPI Step 6: Conduct a QAPI Awareness Campaign

Taking time to create a deliberate communication plan about QAPI will help ensure that everyone in your organization is familiar with the plan, goals and their roles and expectations in the process.

## ACTION STEPS

- Inform everyone (staff, physicians, patients, families, consultants, ancillary service providers, etc.) about your organization's QAPI plan.
- Provide training and education regarding QAPI for all caregivers.
- Develop a strategy for communicating with caregivers, patients and families.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- How will we inform staff about QAPI?
- How much education and training will be needed?
- How will we engage patients and families in QAPI efforts?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Inform everyone (staff, physicians, patients, families, consultants, ancillary service providers, etc.) about your organization's QAPI plan. | | |
| Provide training and education regarding QAPI for all caregivers. | | |
| Develop a strategy for communicating with caregivers, patients and families. | | |

# QAPI Step 7: Develop a Strategy for Collecting and Using Data

Effective use of data will help ensure that decisions are made based on fact — not on an assumption of the truth. Just as a physician needs data on a patient to diagnose a condition, QAPI and PIP teams need data to ensure they are targeting the right areas. Data trumps emotions.

## ACTION STEPS

- Determine what data to routinely monitor.
- Set targets for performance in the areas you are monitoring.
- Identify benchmarks for performance.
- Develop a data collection plan, including who will collect applicable data, who will review it, the frequency of collection and reporting, etc.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- What data does our organization routinely monitor? How is the data displayed and used?
- What benchmarks will we use when assessing our performance?
- How can we best make use of the data we have? Do we track and trend our progress throughout time?
- How are data shared with others in the organization (i.e., staff, patients/families, the board, corporate office)?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Determine what data to routinely monitor. | | |
| Set targets for performance in the areas you are monitoring. | | |
| Identify benchmarks for performance. | | |
| Develop a data collection plan, including who will collect applicable data, who will review it, the frequency of collection and reporting, etc. | | |

# QAPI Step 8: Identify Your Gaps and Opportunities

Whether you are reviewing data from quality measure reports, satisfaction surveys, consultant reports, etc., be sure to identify any trends in the data you review. Use the time to observe where processes are breaking down.

## ACTION STEPS

- Review information to determine if gaps or patterns exist in your systems of care, or if opportunities exist to make improvements.
- Discuss any emerging themes with key stakeholders.
- Notice what your organization is doing well in this identified area.
- Set priorities for improvement.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- When reviewing your data, what stands out?
- How strong is your organizational capacity for assessing organization systems (i.e., policies, protocols, actual care delivery, etc.)?
- What are some areas of strength and weakness?
- What opportunities do you see?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Review information to determine if gaps or patterns exist in your systems of care, or if opportunities exist to make improvements. | | |
| Discuss any emerging themes with key stakeholders. | | |
| Notice what your organization is doing well in this identified area. | | |
| Set priorities for improvement. | | |

# QAPI Step 9: Prioritize Quality Opportunities and Charter PIPs

Choose areas that you consider important (i.e., areas of high risk, frequent occurrence or areas that are known problems). Remember that not all identified problems require PIPs, but for those that do, the projects need to be structured or "chartered."

## ACTION STEPS

- Prioritize opportunities for more intensive improvement.
- Consider which problems will become the focus of a PIP.
- Charter PIP teams by selecting a leader and defining the mission.
- The PIP team should develop a timeline and indicate budget needs.
- The PIP team should use the Goal Setting Worksheet to establish appropriate goals.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- How will organizational priorities be determined?
- Who will be responsible for monitoring the overall progress of our PIPs?
- What education is needed for PIP teams?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Prioritize opportunities for more intensive improvement. | | |
| Consider which problems will become the focus of a PIP. | | |
| Charter PIP teams, by selecting a leader and defining the mission. | | |
| The PIP team should develop a timeline and indicate budget needs. | | |
| The PIP team should use the Goal Setting Worksheet to establish appropriate goals. | | |

# QAPI Step 10: Plan, Conduct and Document PIPs

For areas that require PIPs, PIP teams should use a methodical or standardized process for making improvements. PDSA is one well-known model, but there are others that also may work for your organization. The important point is to use a strategic methodology and not a haphazard, "throw it at the wall and see if it sticks" approach.

## ACTION STEPS

- Determine what information is needed 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.
- Prepare and present results.
- Use a problem-solving model (i.e., PDSA).
- Report results to the steering committee.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- According to our data, on what area(s) do we need to work?
- Who should be involved? What is the timeline?
- What resources are needed?
- What ideas can we test?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Determine what information is needed 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. | | |
| Prepare and present results. | | |
| Use a problem-solving model (e.g., PDSA). | | |
| Report results to the steering committee. | | |

# QAPI Step 11: Get to the "Root" of the Problem

Prevent recurring problems by ensuring that all possible root causes have been identified and addressed. Remember to use systematic tools, such as the Cause & Effect Diagram or the "Five Whys" to dig below the surface.

## ACTION STEPS

- Using a methodical approach, determine all potential root cause(s) underlying the performance issue(s).
- Determine which factors are controllable.
- Ensure that the PDSA cycles address the root cause(s).

## PROBING QUESTIONS FOR TEAM DISCUSSION

- What are the obvious and less obvious reason(s) the problem surfaced?
- What is at the root of those factors?
- What systems and processes are involved (not people)?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Using a methodical approach, determine all potential root cause(s) underlying the performance issue(s). | | |
| Determine which factors are controllable. | | |
| Ensure that the PDSA cycles address the root cause(s). | | |

# QAPI Step 12: Take Systemic Action

Just as pulling a weed at the ground level will not prevent it from growing back, weak interventions, such as staff education, new policies or reminders, often do not prevent the recurrence of the original problem. Whenever possible, use strong interventions, such as simplifying a process or making physical or environmental changes, to "hardwire" the change into the existing system.

## ACTION STEPS

- Implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring.
- Target the root cause(s) with strong interventions.
- Test large-scale changes (through PDSA cycles) prior to launching changes organizationwide.

## PROBING QUESTIONS FOR TEAM DISCUSSION

- How strong are the interventions?
- Do the selected interventions address systems issues or individual performance?
- Is what we're doing working? How do we know?
- What are our next steps?

## SURPASSING THE HURDLES

- What barriers do you anticipate with these action steps?
- What additional information does your team need?
- What additional resources would be helpful?
- What structures can you create to help ensure your success with this step?

## CHECKLIST

| ACTION STEP | WHO IS RESPONSIBLE? | DATE COMPLETED |
|---|---|---|
| Implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. | | |
| Target the root cause(s) with strong interventions. | | |
| Test large-scale changes (through PDSA cycles) prior to launching changes organizationwide. | | |

# *Suggestions for Implementing QAPI Steps*

The following strategies were excerpted from the National Nursing Home Quality Care Change Package, available at https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/nnhqcc-package.pdf. They were adapted for the acute care setting.

### STEP 1: LEADERSHIP RESPONSIBILITY AND ACCOUNTABILITY

- Institute an open-door policy for all levels of leadership to establish presence and consistent availability for staff.
- Provide training and gain staff, resident and family member commitment for your QAPI initiatives.
- Routinely spend time in all neighborhoods and during all shifts.
- Talk directly to staff and patients. Establish a practice to ask how they are doing, what they need to do their best work and provide excellent care, and how you can help reduce frustrations that prevent them from doing their best work.
- Follow-through on issues brought to you — keep that commitment.
- Set the example and pitch in.
- Recognize and honor staff and resident opinions. Demonstrate your sincere appreciation.
- Credit others for their contributions that positively affect your performance.
- Ensure necessary equipment is readily available and in good working order.
- Involve all staff in changes and improvement to increase the feeling of ownership and accountability.
- Build leadership skills through training, support and coaching to help staff be effective.
- Openly admit your unintentional errors so people are less afraid to admit theirs.
- As a leader, uphold high expectations of the organization. If you see an issue, take action and set the tone for high expectations.

### STEP 2: DEVELOP A DELIBERATE APPROACH TO TEAMWORK

- Set the expectation for leaders and staff and share ideas for ways to grow and innovate.
- Build trust with and between your staff (do what you say you are going to do). Celebrate successes — it's the "little" things that matter.
- Establish the use of learning circles and huddles to foster relationships and create an opportunity for all to be heard.
- Remove boundaries between departments (hold neighborhood meetings that all disciplines attend, use interdisciplinary teams for problem-solving, etc.)
- Use templates or methods for consistency and to support shared expectations of process (agendas, minutes and a place to share information with the team).
- Encourage and reward staff for supporting each other.
- Expect that the medical director/providers listen to nurses, aides and other staff, and actively seek their suggestions, assessments and recommendations.
- Encourage the medical director and physicians to keep track of opportunities for improvement, and share them with leadership and the QAPI steering committee.

### STEP 3: TAKE YOUR QAPI "PULSE" WITH A SELF-ASSESSMENT

### STEP 4: IDENTIFY YOUR ORGANIZATION'S GUIDING PRINCIPLES

- Use an inclusive process to establish, review and reaffirm your mission. Involve staff, patients and families.
- Ensure values are considered core to the organization and those who work there.
- Translate the mission into action.

### STEP 5: DEVELOP YOUR QAPI PLAN

### STEP 6: CONDUCT A QAPI AWARENESS CAMPAIGN

- Share the mission, vision and guiding principles with all staff, as well as with new staff during orientation.
- Develop communication plans that use multiple approaches (email, verbal, newsletter, etc.) throughout the organization and across all shifts.
- Hold neighborhood meetings.
- Openly and transparently share your performance data with staff, physicians, other key stakeholders, the board, patients and families.
- Set up a scoreboard for staff that monitors progress toward important goals. (Example: days at zero pressure ulcers.) Post progress in common areas, such as halls, staff room, etc.

### STEP 7: DEVELOP A STRATEGY FOR COLLECTING AND USING DATA

### STEP 8: IDENTIFY YOUR GAPS AND OPPORTUNITIES

- Measure important indicators of care that are relevant and meaningful to the patients you serve.
- Guide and empower staff to solve problems. For example, leaders should respond to problems that are raised not by proposing a solution, but instead by asking the team to investigate and determine what they believe would work best.
- Hold short stand-up meetings with managers and staff for each shift to identify concerns, resources, needs, etc.
- Establish a learning organization in which all staff identifies areas for improvement.
- Discuss processes and systems to identify areas for improvement regularly — in meetings and everyday interactions.
- Empower patients to get involved in identifying areas of improvement.

### STEP 9: PRIORITIZE QUALITY OPPORTUNITIES AND CHARTER PIPs

- Get everyone involved in setting goals: patients, staff, family members and board members.
- If practices are not making sense or are frustrating to staff, patients or family, do not settle for "this is just the way it has to be." Challenge and sort out what you have control over and look for ways to address improvements.

### STEP 10: PLAN, CONDUCT AND DOCUMENT PIPs

- Identify and support a change agent for each improvement project (i.e., a cheerleader and/or key facilitator of change in your organization).
- Use an action plan template that defines who and when, to establish timelines and accountability.
- Seek creative ideas from multiple sources within and outside the organization to foster innovation.
- Create a safe environment to test changes to try new ways to meet patient needs.
- Include "all voices" that have a stake in what is being discussed. Use methods that encourage open and honest communication, especially to find out concerns.

### STEP 11: GET TO THE "ROOT" OF THE PROBLEM

- Use the root cause analysis process to look at systems rather than individuals when something breaks down.

### STEP 12: TAKE SYSTEMIC ACTION

- Before initiating a change in the organization, meet with staff and patients who will be impacted by the change to gain their support, buy-in and feedback.



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