QAPI *news brief*

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

WHAT IS QAPI?

QAPI is the merger of two complementary approaches to quality management, Quality Assurance (QA) and Performance Improvement (PI). QA and PI combine to form QAPI, a comprehensive approach to ensuring high quality care. Both involve seeking and using information, but they differ in key ways:

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

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

5 ELEMENTS OF QAPI

1. Design and Scope
2. Governance and Leadership
3. Feedback, Data Systems and Monitoring
4. Performance Improvement Projects (PIPS)
5. Systematic Analysis and Systemic Action

The articles in this issue introduce you to some of the important aspects of each of the 5 elements.

ELEMENT 1 - Design and Scope of QAPI in your Facility

Involving All Staff in QAPI

For successful implementation, QAPI cannot be imposed from the "top down." Rather, all levels of staff in nursing homes must be involved in planning and improving systems and processes in order to get effective results. Direct care staff have valuable and unique input which are vital to the success of performance improvement. It's easy to say all levels of staff should be involved, but harder to put into practice.

All staff must know they contribute as individuals to the big picture: the successful achievement of the resident's goals for quality of life and quality of care. Involving all levels of staff in QAPI can be challenging. "I don't have time to leave the floor" is a commonly heard sentiment from nursing assistants in response to a request to attend meetings. Organizations need to have adequate levels of staffing in order to cover the absence of a direct care staff member to attend meetings. This is even more of a challenge in homes that are facing shortages of staff.

Nursing assistants may not be accustomed to voicing their opinions in the company of directors, supervisors, physicians, and other senior nursing home staff. Let direct care staff know that their experiences with the residents are invaluable to the QAPI process. Their hands-on knowledge of the resident and the day-to-day processes of the nursing home are necessary to the QAPI discussion and planning.

ELEMENT 2 – Governance and Leadership

How to Engage Residents and Families in QAPI

Residents should have control over their lives, influence decisions which affect them, and know that their opinions and preferences matter. The autonomy, individuality, and dignity inherent in this goal are all part of quality of life.

The opinions and priorities of individual residents and family members should guide QAPI. Residents and families can identify quality of life and care issues important to them, and provide feedback on their experiences.

Residents and families may also have structural roles in QAPI—they can serve on performance improvement project (PIP) teams and Steering Committees. Residents and families have unique perspectives and can facilitate communication with staff and bring in new ideas.Consider using your Resident Council as a source of input for QAPI.

The following questions may be helpful as you consider how to involve residents and families in QAPI:

- How do you regularly ask for feedback from residents and families? Remember that QAPI Element 3—Feedback, Data Systems, and Monitoring—requires that some of your data are derived from feedback from residents and families.

- Do you investigate resident and family complaints and generate action plans if validated?

- How do you create a climate where residents and families are comfortable raising issues?

- Do you have a resident and/ or family council that can help individuals speak in a shared voice to effect change?

- Do you address the concerns raised in resident and family council?

- Do you have, or would you consider having a resident and/ or family member on your Quality steering committee?

Creating an Environment for QAPI

For QAPI to thrive, nursing homes need to create an environment that balances safety and accountability with fairness and openness. Nursing homes should facilitate communication by adopting a nonpunitive response to medical errors and near misses. They should not adopt a blameless system where no one is held accountable for reckless or careless behavior or intentional rule breaking. Rather, employees should feel comfortable coming forward with useful information in the interest of system safety.

ELEMENT 3 – Feedback, Data Systems and Monitoring

Making Data Meaningful

How do you know if you are doing well? Without a baseline or point of comparison, it is hard to judge your own performance. A strong approach to quality management, such as QAPI, uses performance indicators to monitor a wide range of care processes and outcomes. Then it reviews findings against benchmarks or targets the facility has established for performance.
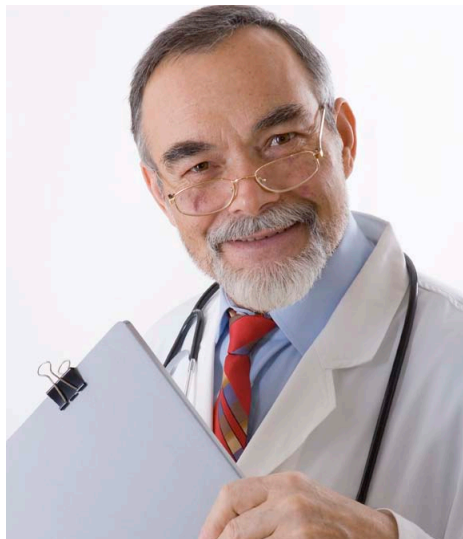
Benchmark refers to a standard against which other things can be measured or judged. You can use external results that represent best practices and performances, often around quality, time, and cost as the standards for setting benchmarks. Benchmarking is the process of comparing a set of results to these best practices and performances. For example:

- A benchmark for physical restraints in nursing homes might be zero, as many homes have achieved this rate.

- A benchmark for consistent nursing assistant assignment has been set by the Advancing Excellence in America's Nursing Homes campaign as no more than 8 nursing assistants for one resident over a four week period, since organizations that have focused on consistent assignment have been able to achieve this result.

Good sources for benchmarks are Nursing Home Compare and Advancing Excellence . Other sources are literature from researchers and data analysis from industries that have similar processes, and data from nursing home organizations that have been recognized for leadership in a specific process area.

A **target** refers to an internal goal that refers to a specific level of performance that an organization is trying to reach. Options to determine targets include:

- Determine a target based on internal improvement over time as an organization tracks its progress while implementing changes.

- Base target on an intermediate, more achievable goal, if current performance is considerably worse than the benchmark. For example, if a home's current high risk pressure ulcer rate is 12%, and the benchmark was 6%, they might choose to reduce the gap by 50% and set their intermediate target at 9%.

- Base target on the current national or their state's average, if they are currently below those targets. For example, if a home's current high risk pressure ulcer rate is 12%, they might set their target at the national average rate of 8%, or their state's current rate of 7%.

Discussing targets is a good team exercise.

Thresholds are a measure of quality performance that the facility feels must be achieved or their facility is at risk. A threshold is a level which performance results must not go above or below.

- For example, a facility sets a level for medication errors meaning that errors should not exceed this level. If errors exceed this level, the facility should analyze why they exceeded the threshold.

- If data suggests the threshold is missed, a full evaluation and root cause analysis is indicated.

ELEMENT 4 – Performance Improvement Project: Keys to Success

Conducting PIPs allows the nursing home to examine performance and make improvements in any area identified as needing attention, or that is found to be a high priority based on the needs of the residents.

Draft a Charter – Clarify Team Purpose and Goals

A charter is typically a documented plan that identifies the problem, goals, and the team members' roles and responsiblilities. The purpose of the charter is to provide the PIP team with key information that will allow them to have a clear understanding of what they are being asked to do. The charter helps a team stay focused by setting timelines and displaying milestones. Note that the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish. Chartering can help teams get off to a good start, avoid misunderstandings, and gain organizational support.

Get the Right People on the Team; Provide Clarity about Team Membership and Roles

- Designate a team sponsor. Typically, this is someone in a leadership role who can help the project director and/or manager and the team by providing resources, focus, and problem solving. The sponsor can also work with the team to identify and recruit new team members who would care about the topic.

- Designate a person to lead and manage the day-to-day activities of the project. This person should have the necessary training and

skills, as well as access to any tools to successfully manage a project (e.g., computers, data management, etc.).

- Make sure the team has representation from all departments and roles that are involved in the work being improved. Identify and recruit enthusiastic members who are invested in the PIP topic. For example, involve the medical director and nurses if a clinical topic is the focus, involve activities staff if activities are being discussed, and involve nursing assistants if the topic has an impact upon their work.

- Consider having a resident or family member on some teams. For example, if you are working to improve an aspect of food or dining based on resident or family input, you might consider including them on the PIP team.

ELEMENT 5 – Systematic Analysis and Systemic Action

Getting to the Root of the Problem (Systematic Analysis)

Root cause analysis (RCA) provides a structure for evaluating events (e.g., adverse event, incident, near miss, unsafe condition, or complaint). The RCA process looks at events and incidents from a systems perspective. RCA avoids focusing on individual performance as a cause of errors or events, and instead focuses on the underlying breakdowns or gaps in the systems or processes in which individuals are working. The key question in RCA is "why?" The goal of RCA is not to describe what happened, but to understand why things happened or are done a certain way. If the underlying root causes of performance can be identified, changes can be made to improve current performance and prevent future occurrences.

Steps of the RCA process include:

- Describing the details of the event so everyone can picture the steps that occurred and where decisions were made. This includes who, what, where, and when.

- Looking for root causes and their preceding factors as well as any contributing factors that added to the likelihood of the problem or event occurring. This may require flowcharting processes to see where there are gaps or breakdowns. The most important thing to do in this step is to keep asking "why" or "why did the process fail" until you just can't go any further. Failure to do this can lead to corrective actions that do not address true underlying causes and you may not decrease your risk of the problem or event recurring.

- Sorting identified gaps or breakdowns into categories such as:

  - Human factors such as communication, training, distraction, or bias

  - Rules, policies, or procedures. Was there a problem with current policies or procedures or are there no policies or procedures to address an issue?

  - Environment/equipment

  - Barriers – was this a breakdown in a barrier or defensive mechanism that was intended to prevent the problem?

- Clearly identifying the root cause(s) and contributing factor(s).

- Identifying corrective actions to address the root causes and put a plan in place to measure the impact of these interventions.

Focus on a specific problem. One of the challenges when you first start using RCA is defining the problem or the event in such a way that it is not too broad. For example, RCA on medication errors will quickly get too big. Instead, identify the various types of medication errors that are occurring and use the RCA process to better understand each type. By looking at several types of medication errors you will start to see common causes or contributing factors that can be addressed with a broader intervention.

Sustaining the Gains (Systemic Action)

Root Cause Analysis is an excellent tool for performance improvement because it helps identify the root causes and contributing factors that led to an event or that if changed can improve performance. However, identifying root causes is only the first step. Next you will need to implement changes or corrective actions at the system level. This will result in improvement or reduce the chance of the event recurring. Often this step is the weakest link in the process, as solutions often center on training/ education or asking clinicians to "be more careful."

These common solutions do not impact the system, and are based on two assumptions: lack of knowledge contributed to the event, and if a person is educated or trained the mistake won't happen again. Solutions that rely on vigilance or memory are equally problematic because they create expectations for staff to remember more or be more careful. This is not always realistic when staff are in stressful situations or when multi-tasking.

To be effective, interventions or corrective actions should target elimination of root causes, offer long term solutions to the problem, and be achievable, objective, and measurable.

The Department of Veterans Affairs National Center for Patient Safety's Hierarchy of Actions classifies corrective actions as:

WEAK: Actions that depend on staff to remember their training or what is written in the policy. Weak actions enhance or enforce existing processes.

Examples of Weak Actions:
- Double checks
- Warnings/labels
- New policies/procedures/ memoranda
- Training/education

INTERMEDIATE: Actions that are somewhat dependent on staff remembering to do the right thing, but they provide tools to help staff to remember or to promote clear communication. Intermediate actions modify existing processes.

Examples of Intermediate Actions:
- Decrease workload
- Software enhancements/ modifications
- Checklists/cognitive aids/ triggers/prompts
- Read back
- Enhanced documentation/ communication

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

Examples of Strong Actions:
- Physical changes: grab bars, nonslip strips on tubs/showers
- Forcing functions: design of gas lines so that only oxygen can be connected to oxygen lines;
- Electronic medical records – cannot continue charting unless all fields filled in; need to step on brake before car can be put into reverse
- Simplifying: unit dose