SUBJECT: ORGANIZATIONAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PROGRAM	REFERENCE #9001
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DEPARTMENT: HOME HEALTH	OF: 15
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

- The HHA's Quality Assessment and Performance Improvement (QAPI) program shall be designed to:
  - Delineate expectations and plan and manage processes to measure, assess and improve the HHA's governance, management, clinical and support activities
  - Promote positive patient outcomes through the application of optimal patient care, treatment and services based on clinically sound principles and current knowledge
  - Identify, on an ongoing basis and in a coordinated and collaborative manner, areas for improvement in the quality of care, treatment and services
  - Evaluate, monitor, improve and resolve areas of concern

- The QAPI plan, established by the senior management of the organization in collaboration with staff members and the interdisciplinary QAPI committee, with the support and approval of the Governing Body shall be comprehensive in scope and provide a vehicle to monitor patient care, treatment and services with the goal of identifying and resolving any processes, functions and services that may adversely impact patient care, treatment and services, while striving to continuously facilitate positive patient outcomes.

POLICY:

- The Administration of_____HHA shall be committed to and support a planned, systematic and data-driven organizationwide QAPI plan that encompasses well-designed processes and performance measurement, analysis and improvement.

- The HHA's Governing Body has ultimate responsibility to ensure the QAPI program reflects the complexity of its organization and services.

- The HHA's QAPI plan shall be evaluated at least annually and revised as necessary.

- The QAPI activities shall be planned in a collaborative, interdisciplinary manner throughout the organization and include all services provided by the HHA, including those services provided under contract or arrangement.

- As organizational Quality Assessment and Performance Improvement is a coordinated and collaborative effort, the approach to improving performance involves multiple departments and disciplines in establishing the plans, processes and mechanisms that comprise QAPI activities.

- In keeping with the organization's mission of providing quality, cost-effective patient care, treatment and services, the QAPI plan allows for a systematic, coordinated and continuous approach to improving performance, focusing upon the process and functions that address these principles.

- The HHA shall maintain documentation of its QAPI program and related activities.

GOALS:

- The primary goals of the organizational QAPI program shall be to continually and systematically plan, design, measure, assess and improve performance of organizationwide key functions and processes relative to patient care, treatment and services.

- To achieve this goal, the program strives to:

  - Incorporate quality planning throughout the organization.

  - Collect data to monitor performance

  - Provide a systematic mechanism for the organization's appropriate individuals, departments and professions to function collaboratively in their QAPI efforts providing feedback and learning throughout the HHA.

  - Provide for an organizationwide program that assures the HHA designs processes (with special emphasis on design of new or revisions in established services) well and systematically measures, assesses and improves its performance to achieve optimal patient health outcomes in a collaborative, cross-departmental, interdisciplinary approach. These processes include mechanisms to assess the needs and expectations of patients and their families, staff and others.

- Process design contains the following focus elements:
  - Consistency with the organization's mission, vision, values, goals, and objectives and plans
  - Meets the needs of individuals served, staff and others
  - Fosters the safety of patients and the quality of care, treatment and services
  - Supports a culture of safety and quality
  - Shows measurable improvement in indicators that improve health outcomes, patient safety and quality care
  - Use of clinically sound and current data sources, i.e., use of practice guidelines, information from relevant literature and clinical standards
  - Is based upon sound business practices
  - Incorporates available information from internal sources and other organizations about the occurrence of medical errors and sentinel events to reduce the risk of similar events in this organization
  - Utilizes reports generated from OASIS data, including the following OASIS reports:
    - Outcome-Based Quality Monitoring (OBQM) Potentially Avoidable Events Report and Patient Listing
    - Outcome-Based Quality Improvement (OBQI) Outcome Report
    - Patient/Agency Characteristics Report
    - Submission Statistics by Agency Report
    - Error Summary Report by HHA

- Utilizes collected data to:
  - Monitor the effectiveness and safety of services and quality of care
  - Identify opportunities for improvement
- The frequency and detail of the data collection as approved by the Governing Body
- Utilizes the results of quality assessment and performance improvement, patient safety and risk reduction activities
- Management of change and performance improvement supports both safety and quality through the HHA

- The organization incorporates information related to these elements, when available and relevant, in the design or redesign of processes, functions or services.
- Assure that the improvement process is organizationwide, monitoring, assessing and evaluating the quality and appropriateness of patient care, treatment and services, patient safety practices and clinical performance to resolve identified problems and improve performance.
- Appropriate reporting of information to the Governing Body to provide the leaders with the information they need in fulfilling their responsibility for the quality of patient care, treatment and services, and safety is a required mandate of this plan.

☐ Necessary information is communicated among departments/services when opportunities to improve patient care, treatment and/or services and patient/staff safety practices impact more than one (1) department/service.

☐ The status of identified problems is monitored to assure improvement or resolution.

☐ Information from departments/services and the findings of discrete QAPI activities shall be analyzed to detect trends, patterns of performance or potential problems that may impact more than one (1) department/service.

- The objectives, scope, organization and mechanisms for overseeing the effectiveness of monitoring, assessing, evaluation and problem-solving activities in the QAPI program shall be evaluated at least annually and revised as necessary.

- Important key aspects of care to the health and safety of patients are identified. Included are those that occur frequently or affect large numbers of patients; place patients at risk of serious consequences of deprivation of substantial benefit if care is not provided correctly or not provided when indicated; or care provided is not indicated, or those tending to produce problems for patients, their families or staff.

- Internal structures can adapt to changes in the environment.

SCOPE OF ACTIVITIES:

- The scope of the organizational QAPI program shall include an overall assessment of the efficacy of QAPI activities with a focus on continually improving care, treatment and services and patient and staff safety practices. The program consists of these focus components: performance improvement, patient/staff safety, quality assessment, and quality control activities.

- Collaborative and specific indicators of both key processes and outcomes of care shall be designed, measured and assessed by appropriate departments/services and disciplines in an effort to improve patient/staff safety and organizational performance.

- These indicators are objective, measurable, based on current knowledge and experience and are structured to produce statistically valid performance measures of care, treatment and services provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time.

- The HHA's QAPI activities must:
  - Focus on high risk, high volume or problem-prone areas
  - Consider incidence, prevalence and severity of problems in identified areas
  - Lead to an immediate correction of any identified problem that directly or potentially threatened the health and safety of patients
- QAPI activities must track adverse patient events, analyze their courses and implement preventative actions.
- QAPI activities shall include monitoring of administrative/operational activities (i.e., in-service hours, performance evaluations, billing audits)
- Assessment of the performance of the following patient care and organizational functions shall be included:
  - Environment of Care
  - Emergency Management, including:
    - Review of the annual emergency management planning reviews
    - Review of emergency response exercises
    - Review of response to actual emergencies
    - Prioritization of emergency management improvements
  - Human Resources
  - Infection Prevention and Control
  - Information Management
  - Leadership

- Medication Management
- Provision of Care, Treatment and Services
- Performance Improvement
- Record of Care, Treatment and Services
- Rights and Responsibilities of the Individual
- Waived Testing

PERFORMANCE IMPROVEMENT PROJECTS:

- The HHA shall conduct Performance Improvement Projects as part of its organizationwide QAPI program.

- Performance Improvement Projects shall be conducted and documented at least annually (See Performance Improvement Projects Policy).

ORGANIZATION:

- To achieve fulfillment of the objectives, goals and scope of the organizational QAPI plan, the organizational structure of the program shall be designed to facilitate an effective system of monitoring, assessment and evaluation of the care, treatment and services provided within the HHA.

    - The Governing Body shall ultimately be responsible for the quality of patient care, treatment and services provided.

        - The Governing Body shall require staff, through the QAPI Committee and Administration, to implement and report on the activities and the mechanisms for monitoring, assessing and evaluating patient safety practices and the quality of patient care, treatment and services, for identifying and resolving problems and for identifying opportunities to improve patient care, treatment and services or performance throughout the organization. This process addresses those departments/disciplines that have a direct or indirect effect on patient care, treatment and services, including management and administrative functions.

- The Governing Body, through the HHA Administrator, shall provide for resources and support systems for the quality assessment and performance improvement functions and risk management functions related to patient care, treatment and services and safety.

- The Governing Body shall have a responsibility to evaluate the effectiveness of the QAPI activities performed throughout the HHA and the organizational QAPI program as a whole.

- The Governing Body shall have a responsibility to ensure that clear expectations for patient safety are established, implemented and maintained.

- The Governing Body shall have a responsibility to ensure that any findings of fraud or waste are appropriately addressed.

- With designated responsibility from the QAPI Committee, the Safety Committee shall operate as a standing quality assessment and performance improvement subcommittee dedicated to implementation and monitoring of the effectiveness of the Patient Safety Program. The scope of the Patient Safety Program includes an ongoing assessment, using internal and external knowledge and experience, to prevent error occurrence, and to maintain and improve patient safety.

- Patient safety occurrence information from aggregated data reports and individual incident reports shall be reviewed by the Safety Committee to prioritize organizational patient safety activity efforts. Included in the duties of the Safety Committee shall be a review of these data reports and, through use of performance improvement priority criteria grid, the committee shall select at least one (1) high-risk safety process for proactive risk assessment annually. The proactive risk assessment shall be performed through the following methodology:

  - Assessment of the intended and actual implementation of the process to identify the steps in the process where there is, or may be, undesirable variation. Identify the possible effects of the undesirable variation on patients and how serious the possible effect on the patient could be.

  - For the most critical effects, conduct a root cause analysis to determine why the undesirable variation leading to that effect may occur.

- Redesign the process and/or underlying systems to minimize the risk of that undesirable variation or to protect patients from the effects of that undesirable variation.
- Test and implement the redesigned process.
- Identify and implement measures of effectiveness of the redesigned process.
- Implement a strategy for maintaining the effectiveness of the redesigned process over time.

- The Safety/Risk Management Committee shall report committee findings, determinations and actions to the QAPI Committee for review. Information reporting shall contain concurrent data related to ongoing patient safety and medical error issues, as well as information related to the proactive risk assessment and improvement endeavor. The QAPI Committee shall serve as the oversight committee for the Safety Committee, however the two (2) committees will work jointly to provide for optimal patient safety practices throughout the organization.

METHODOLOGY:

- The **Plan, Do, Check, Act (PDCA)** methodology shall be utilized to plan, design, measure, assess and improve functions and processes related to patient care and safety throughout the organization.

  - **Plan:**

    - Objective and statistically valid performance measures are identified for monitoring and assessing processes and outcomes of care, including those affecting a large percentage of patients, and/or place patients at serious risk if not performed well, or performed when not indicated, or not performed when indicated; and/or have been or likely to be problem prone.
    - Performance measures are based on current knowledge and clinical experience and are structured to represent cross-departmental, interdisciplinary processes, as appropriate.

- Data shall be collected from internal sources (staff) and external sources (patients, referral sources, etc.). The following data sources shall be reviewed for use in the development of performance measures:
  - Staff opinions and needs
  - Staff perceptions of risks to patients and suggestions for improving patient safety
  - Staff willingness to report medical/health care errors
  - Behavior management procedures, if used
  - Outcomes of processes or services, including adverse events
  - Performance measures from organization approved internal and external databases
  - Infection control surveillance and reporting
  - Patient medical records
  - Patient and family perceptions of care, treatment and services (satisfaction surveys)
    - Data collected includes the specific need and expectations of the patients
    - Patients' perceptions on how well the organization meets these needs and expectations
    - Patient suggestions regarding improvement of patient safety
    - Patients' perceptions of effectiveness of pain management
    - Timely response to questions and/or concerns
  - Satisfaction surveys

- ♦ Risk management
- ♦ Utilization management
- ♦ Quality control
- ♦ Customer demographics and diagnoses
- ♦ Business practice

- Performance measures for processes that are known to jeopardize the safety of patients or associated with sentinel events shall be routinely monitored. At a minimum performance measured related to the following processes, as appropriate to care and services provided, shall be monitored with the approval and at the suggested frequency of the QAPI Committee:

  - ♦ Management of hazardous conditions
  - ♦ Medication management
  - ♦ Blood and blood product use
  - ♦ Wound care
  - ♦ IV therapy
  - ♦ Appropriateness and effectiveness of pain management
  - ♦ Care, treatment or services to high-risk populations
  - ♦ National Patient Safety Goals

- Benchmarks or thresholds that trigger intensive assessment and evaluation shall be established. Undesirable patterns or trends in performance shall be analyzed for all of the above; however, an in-depth analysis is conducted for the following when the levels of performance, patterns or trends vary substantially from those expected:
  - All confirmed transfusion reactions
  - All serious adverse drug events
  - All significant medication errors
  - Home care associated infections
  - Hazardous conditions
  - Staffing effectiveness
  - All adverse events

- **Do:**
  - Data is collected to determine:
    - Whether design specifications for new processes were met
    - The level of performance and stability of existing processes
    - Priorities for possible improvement of existing processes

- **Check:**
  - Assess care when benchmarks or thresholds are reached in order to identify opportunities to improve performance or resolve problem areas

- **Act:**
  - Take actions to correct identified problem areas or improve performance
  - Evaluate the effectiveness of the actions taken and document the improvement in care
  - Communicate the results of the monitoring, assessment and evaluation process to relevant individuals, departments or services

 Information Management:

- QAPI activities throughout the organization are dependent upon the management of information function. This function shall be performed in an interdisciplinary collaborative approach throughout the organization. As the management of information is a function that is comprehensive, impacting all services within the organization, the review of this function shall be performed as a collaborative process when QAPI activities are conducted. Outcomes shall be reflected through the auspices of the QAPI Committee's review and analysis of quality assessment and performance improvement data.
- This function shall be performed to obtain, manage and use information to enhance and improve individual and organizational performance in effective communication, patient care and safety, governance, management and support processes.
- The quality of the medical record shall be reviewed for accuracy, timeliness, completeness and legibility.

REPORTING FORMAT:

- The findings, conclusions, recommendations, actions taken to improve performance and the results of actions taken shall be documented and reported through established channels.
    - Results of the outcomes of quality assessment and performance improvement activities and patient safety activities shall be reported to the QAPI Committee on a monthly/ bimonthly/quarterly basis as designated.
    - The QAPI Committee shall submit a report of their analysis of the quality of patient care, treatment and services provided to the Administrator and Patient Care Services Director on a monthly basis.
    - The QAPI Committee shall provide the Governing Body with a report of the relevant findings from all QAPI activities performed throughout the organization at least on a quarterly basis.

ANNUAL EVALUATION AND APPROVAL:

- The organizational QAPI program shall be evaluated for effectiveness at least annually and revised as necessary to assure appropriateness of the approach to planning processes of improvement: setting priorities for improvement; assessing performance systematically; using statistically valid methods; implementing improvement activities on the basis of assessment; and sustaining achieved improvements.
- The annual evaluation of the HHA's total program is part of the HHA's QAPI Plan.

CONFIDENTIALITY:

- All information related to QAPI activities in accordance with this plan is confidential.
    - Confidential information may include, but is not limited to, staff committee meetings, QAPI Executive Report, electronic data gathering and reporting, medical record reviews and untoward incident reporting.
    - Some information may be disseminated on a “need to know basis” as required by agencies such as federal review agencies, regulatory bodies or any other organization with a proven “need to know basis” as approved by the HHA Administration and/or the Governing Body.

ORGANIZATIONAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) PLAN APPROVAL

ADOPTION:

The organizational QAPI Plan has been reviewed, approved and adopted by the Governing Body and by the HHA Administration as attested to by the signatures below:

_____ _____
Governing Body Signature Date

_____ _____
Medical Director Signature Date

_____ _____
HHA Administrator Signature Date

_____ _____
Patient Care Services Director Signature Date

_____ _____
Chairperson, QAPI Committee Signature Date

SUBJECT: PERFORMANCE MEASUREMENT	REFERENCE #9002
	PAGE: 1 OF: 6
DEPARTMENT: HOME HEALTH	
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Measurement of process outcomes shall facilitate improvement in the quality of patient care.

- _____ HHA shall select and utilize a performance measurement system that meets accrediting organization requirements for inclusion in the accreditation process and simultaneously best promotes attainment of the HHA's strategic measurement goals.

- Performance measures shall be selected by_____based on their impact on patient care, services offered, clinical practice, fiscal accountability and cost effectiveness.

- Areas targeted for improvement shall include, but are not limited to, those that are high-cost, high-risk, high-volume and problem-prone. Additionally, these areas offer genuine opportunities to improve the quality of care.

- The HHA shall also collect data on evaluation and improvement of conditions in the environment, infection prevention and control, and the medication management systems.

PROCEDURE:

- Data shall be collected and evaluated to ensure that the selected measures fulfill the criteria of high-volume, high-risk, high-cost and/or problem-prone.

- Data shall be collected to measure performance of each of the following:

  - Significant medication errors
  - Significant adverse drug reactions
  - Infections and communicable diseases
  - Patient perception of the safety and quality of care, treatment, or services delivered by the HHA
  - Patient satisfaction with and complaints about products and services
  - The timeliness of response to patient questions, problems and concerns

- The impact of the organization's business practices on the adequacy of patient access to equipment, items, services and information
- Adverse events involving patients due to inadequate or malfunctioning equipment, supplies, or services, i.e., injuries, accidents, signs and symptoms of infection, hospitalizations
- All injuries, including psychological injury
- Any act of violence
- Any unexpected patient death, including suicide
- Staff opinions and needs
- Staff perceptions of risk to individuals
- Staff suggestions for improving patient safety
- Staff willingness to report adverse events (conditions in the organization or patient environment that are related to care, treatment or services)

□ The HHA shall also establish data priorities particular to its needs.

□ Multiple internal/external data sources shall be organized to monitor and assess home health services for quality of healthcare.

□ Internal data sources shall include, but not be limited to, the following:

- Patient clinical records
- Patient accident/incident reports
- Medication error reports, including reports of near misses
- Infection prevention and control reports
- Patient perception of care/satisfaction questionnaires
- Patient letters and/or comments regarding services

- Staff competency assessments
- Cost benefit analysis
- QAPI activity form
- Staff orientation, inservice and continuing education records
- Inter/Intradepartmental committee meeting minutes
- Patient case conferences
- Utilization Review reports
- Risk Management activities
- Structure, process and outcome study data
- Accreditation/licensure/certification survey requirements
- Patient classification data
- Patient care standards
- Observations
- Financial reports
- Other data relating directly/indirectly to patient care

□ External Data sources include, but are not limited to, the following:

- Professional organizations
- Regulatory agencies
- Review agencies
- Insurers
- Continuing education conferences

- Professional conferences
- Professional literature

- Valid and relevant structures, processes and outcomes of patient care and/or clinical practice criteria that shall:
  - Be developed to define the focus for monitoring and assessing quality of healthcare services
  - Be appropriately implemented to monitor and assess quality of healthcare services

- Corrective action plans shall be developed and implemented.

- Developed corrective action plans shall describe:
  - All corrective actions required to resolve knowledge, performance and systems areas of concern.
  - Measurable objectives for each corrective action, including degree of expected change in patient care and/or clinical practices.
  - Person(s) responsible for implementing, monitoring, evaluating and reassessing corrective actions.
  - Date corrective action is to be implemented.
  - Date corrective action is to be evaluated for effectiveness.
  - Names/titles of staff responsible for overseeing implementation of the outlined corrective actions.

- Appropriate and valid study methods shall include, but not be limited to, the following:
  - Audits
  - Patient admission interviews
  - Submitted patient concerns

- Patient survey forms
- Staff survey forms
- Community analysis survey forms
- Individual patient and staff interviews by telephone and in person
- Patient discharge/transfer interviews
- Group interviews
- HHA staff exit interviews
- HHA staff discipline meetings
- Patient/family case conferences
- Direct/indirect observations
- Patient education surveys

- Data regarding the effectiveness, i.e., the ability to achieve positive outcomes, of the action plans shall be collected, compiled and analyzed on a monthly basis. Samples shall be of sufficient size to provide an adequate representation of the areas/issues being studied. Monitored corrective actions shall be evaluated for actual or potential effectiveness in improvement in the delivery of healthcare.

- Confidentiality of patient information shall be maintained in a manner that is consistent with applicable HIPAA regulations and HHA policies and procedures to preserve any confidentiality or privilege of information.

- The data shall be displayed graphically within the HHA and analyzed by the Quality Assessment and Performance Improvement (QAPI) Committee at least on a quarterly basis to ensure that targeted outcomes are being achieved.

- Statistically valid (± 0.10) variances shall be analyzed immediately upon detection to facilitate improvement of processes, structure or outcomes.

- Performance measurement data shall be submitted to the Governing Body for review and evaluation at least annually and more often if necessary.

SUBJECT: PERFORMANCE IMPROVEMENT PROJECTS	REFERENCE #9003
DEPARTMENT:	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

NOTE:

Beginning January 13, 2018, HHAs will be required to conduct and document performance improvement projects per CMS regulations.

POLICY:

- _____HHA shall conduct performance improvement projects as part of its organizationwide Quality Assessment and Performance Improvement (QAPI) program.
- Performance improvement project(s) shall be conducted at least annually.
- Performance improvement projects shall be documented and maintained.

PROCEDURE:

- Performance improvement projects shall be selected based on indicators related to improved patient safety and quality outcomes (See Organizational Quality Assessment and Performance Improvement (QAPI) Program Policy).

- The number and scope of distinct improvement projects conducted annually shall be based upon the HHA's:
  - Scope
  - Complexity
  - Past performance of services and operations

- Performance improvement projects may include (**Examples only** - Performance improvement projects should be identified based upon individual HHA's performance data):
  - Decreasing medication errors
  - Reducing hospital admissions and re-admissions
  - Decreasing rate of UTIs contracted while on service

- Documentation of performance improvement projects shall include, at minimum:
  - Name of the performance improvement project undertaken
  - Reasons for conducting the project(s)
  - Actions taken toward performance improvement
  - Measurable progress achieved on the project(s)

ADDITIONAL TOOLS:

- See Centers for Medicare and Medicaid Services (CMS) for additional tools, including:
  - Worksheet to Create a Performance Improvement Project Charter, https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pipcharterwkshtdebedits.pdf
  - Performance Improvement Project (PIP) Inventory, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPInventorydebedits.pdf
  - Performance Improvement Project (PIP) Launch Check List: Helpful hints for project leaders, managers, or coordinators, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PIPLaunchChecklistdebedits.pdf

SUBJECT: PROBLEM CONCLUSION	REFERENCE #9004
	PAGE: 1 OF: 1
DEPARTMENT: HOME HEALTH	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

- To present study/problem topic results in the context of the specific topic.
- To formulate judgment or opinions based on the study/problem topic.
- To explain formulated study/problem topic conclusions and the rationale for the same.
- To answer the study/problem topic question problem or hypothetical.

POLICY:

- Conclusions shall be based on analyzed and interpreted study and problem topic data.
- Patient confidentiality shall be maintained per HHA policy and procedure.

PROCEDURE:

- Conclusions shall be derived from analyzed and interpreted data.
- Conclusions shall focus on:
  - Presentation and interpretation of topic/problem results
  - Implications of study topic/problem results within broader context
  - Application of conclusions to study/problem topic question problem or hypothesis
  - Generalization of study/problem topic results to comparable situation
- Conclusions shall be documented on a Quality Assessment and Performance Improvement (QAPI) Activity Form.
- Conclusions shall be communicated to appropriate individuals and committees as necessary.

SUBJECT: ACTION PLAN MONITORING	REFERENCE #9005
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

To assess the effectiveness of process modifications on outcomes.

POLICY:

- Data shall be collected and analyzed at a predetermined frequency to evaluate the effectiveness of the implemented changes and to ensure that improvement is sustained.

- _____ HHA shall initiate an evaluation when undesirable performance is suspected or known as evidenced by comparisons that show that:

  - Important single events, levels of performance, patterns or trends vary significantly
  - (±5%) and undesirably from those expected
  - Performance varies significantly and undesirably from that of other organizations
  - Performance varies significantly and undesirably from recognized industry standards

PROCEDURE:

- Corrective action plans shall be monitored on an ongoing basis after it has been implemented according to policy and procedure "corrective actions".

- Implemented corrective action shall be monitored on an ongoing basis to assess actual or potential effectiveness of problem resolution.

- Monitored corrective action that is determined to be actually or potentially ineffective in problem resolution shall be modified or discontinued in a timely manner, as appropriate.

- Revised corrective action shall be monitored on an ongoing basis to assess actual or potential effectiveness of problem resolution.

SUBJECT: ACTION PLAN MONITORING	REFERENCE #9005
DEPARTMENT: HOME HEALTH	PAGE: 2 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

- Implemented corrective action shall be monitored and appropriately discontinued/revised as often as necessary, in a timely manner to improve process outcomes.

- Monitoring information shall be documented, aggregated, analyzed and displayed in a manner that maintains the confidentiality of information according to HHA policy and procedure while simultaneously providing valuable information to individuals, departments or committees as appropriate.

SUBJECT: CONDUCTING ROOT CAUSE ANALYSIS	REFERENCE #9006
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- In response to a sentinel event occurrence, healthcare associated infection outbreak, or identification of undesirable patterns, trends or variations in its performance related to the safety or quality of care, the Administrative team shall appoint an event analysis team, who shall conduct a root cause analysis.

- Objectives of the root cause analysis shall include:

  - To identify those causative issues, systems or processes that represent core reasons for occurrence of the event
  - To develop an action plan that will prevent recurrence of the event
  - To implement the action plan, monitoring the plan's effectiveness periodically
  - To assure the event will not be repeated

PROCEDURE:

- A root cause analysis contains the following characteristics:

  - Primarily focuses on systems and processes, not individual performance
  - Progresses from special causes in clinical process focus to common causes in system and/or organizational processes
  - Consistently focuses on basic, core rationale for causative factor(s), that is the analysis consistently searches deeper, ever questioning the core rationale (asking why)
  - Identifies necessary redesign efforts and/or revisions in systems and processes, either through redesign or development of new systems or processes intended to improve performance levels and reduce the risk of event recurrence
  - The analysis is thorough and credible

- To be viewed as credible, the root cause analysis must consist of the following elements:
  - Be internally consistent, i.e., not contradict itself or leave obvious questions unanswered
  - Provide an explanation for all findings of "not applicable" or "no problem"
  - Include consideration of any relevant literature
- The members of the analysis team, as appointed by the organizational Administrative team, shall be known as the core members. The analysis team may request additional members, as appropriate to the identified issues, for either long or short term membership. The administrative team shall appoint the team facilitator.
- The analysis team, at the time of the initial meeting, shall determine meeting length, frequency and reporting (format and frequency) structure to the administrative team.
- The analysis team shall formulate a “work plan” with established objectives and target dates.
- The analysis team shall include participation by the leadership of the HHA and by the individuals most closely involved in the processes and systems under review.
- To conduct a ***thorough*** root cause analysis, analysis team meetings shall contain the following elements:
  - A clear definition of the issue(s) pertaining to the sentinel event; that is, a determination of the human and other factors most directly associated with the sentinel event or other safety-related event, and the process(es) and systems related to its occurrence, will be made.
  - Brainstorming all real or potential contributing causes, which includes analysis of the underlying systems and processes through a series of "why?" questions to determine where redesign might reduce risk.

- Inquiry into all areas appropriate to the specific type of event as described in the current Joint Commission table of *Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events* located in the Joint Commission accreditation manual.
- Identification of risk points and their potential contributions to this type of event.
- Organization and analysis of causative factors, listing these factors in identified cause/effect priority.
- Identify those systems or processes related to the causative factors, determining the relationship of each cause to the system or process as special or common.
    - Common causes within a system(s) shall receive emphasis as identified from special causes within a process(es), i.e., special cause variations found to be within a process often result from variation in a larger system to which the process has a relationship.
    - Adequacy of staffing, including nurse staffing, shall always be evaluated as a possible cause:
        - Evaluation of the adequacy of staffing shall include number, skill mix and competency of all staff. Issues such as processes related to workflow, competency assessment, credentialing, supervision of staff, and orientation, training and education shall also be evaluated.

☐ The analysis team shall make a determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination after analysis that no such improvement opportunities exist. Implement the identified actions as soon as possible, regardless of the progress point of the analysis team.

☐ A time line shall be established to assess team progress.

- The Analysis Team shall:

  - Emphasize improvement actions on identified larger systems, as it is through redesigning the larger system that receives the most concrete and permanent benefit from eliminating common causes of the variation.
  - Focus improvement plans on redesigning processes and systems to eliminate identified root causes of the sentinel event.
  - Submit the improvement plan to the administrative team for approval.
  - Implement the action plan after approval is received from the administrative team.
  - Function as resource staff during action implementation.
  - Establish time frames and methodology to assess and evaluate effectiveness of the action plan.
  - Follow the evaluation time line through data collection and aggregation. Measure, assess and evaluate effectiveness of the plan, in accordance with the time line, reporting results as determined by the analysis team and the administrative team.

A FRAMEWORK FOR A ROOT CAUSE ANALYSIS AND ACTION PLAN
IN RESPONSE TO A SENTINEL EVENT

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why"?	Take Action?
What happened? ↓	Sentinel Event	What are the details of the event? (Brief description)				
		When did the event occur? (Date, day of week, time)				
		What area/service was impacted?				
Why did it happen? **What were the most proximate factors?** (Typically "special cause" variations) ↓	The process or activity in which the event occurred.	What are the steps in the process, as designed? (A flow diagram may be helpful here)				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influenced this outcome?				
		What other areas of services are impacted?				

This three-page template is provided as an aid in organizing the steps in a root cause analysis. Not all possibilities and questions will apply in every case, and there may be others that will emerge in the course of the analysis. However, all possibilities and questions should be fully considered in your quest for "root causes" and risk reduction.

As an aid to avoiding "loose ends," the three columns on the right are provided to be checked off for later reference.

"Root cause?" should be answered "yes" or "no" for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding that is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a "Why?" question. Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.

"Ask "Why?"" should be checked off whenever it is reasonable to ask why the particular finding occurred (or didn't occur when it should have) -- in other words, to drill down further. Each item checked in this column should be addressed later in the analysis with a "Why?" question. It is expected that any significant findings that are not identified as root causes themselves have "roots."

"Take action"? should be checked for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan. It will be helpful to write the number of the associated Action Item on the third page in the "Take Action?" column for each of the Findings that requires an action.

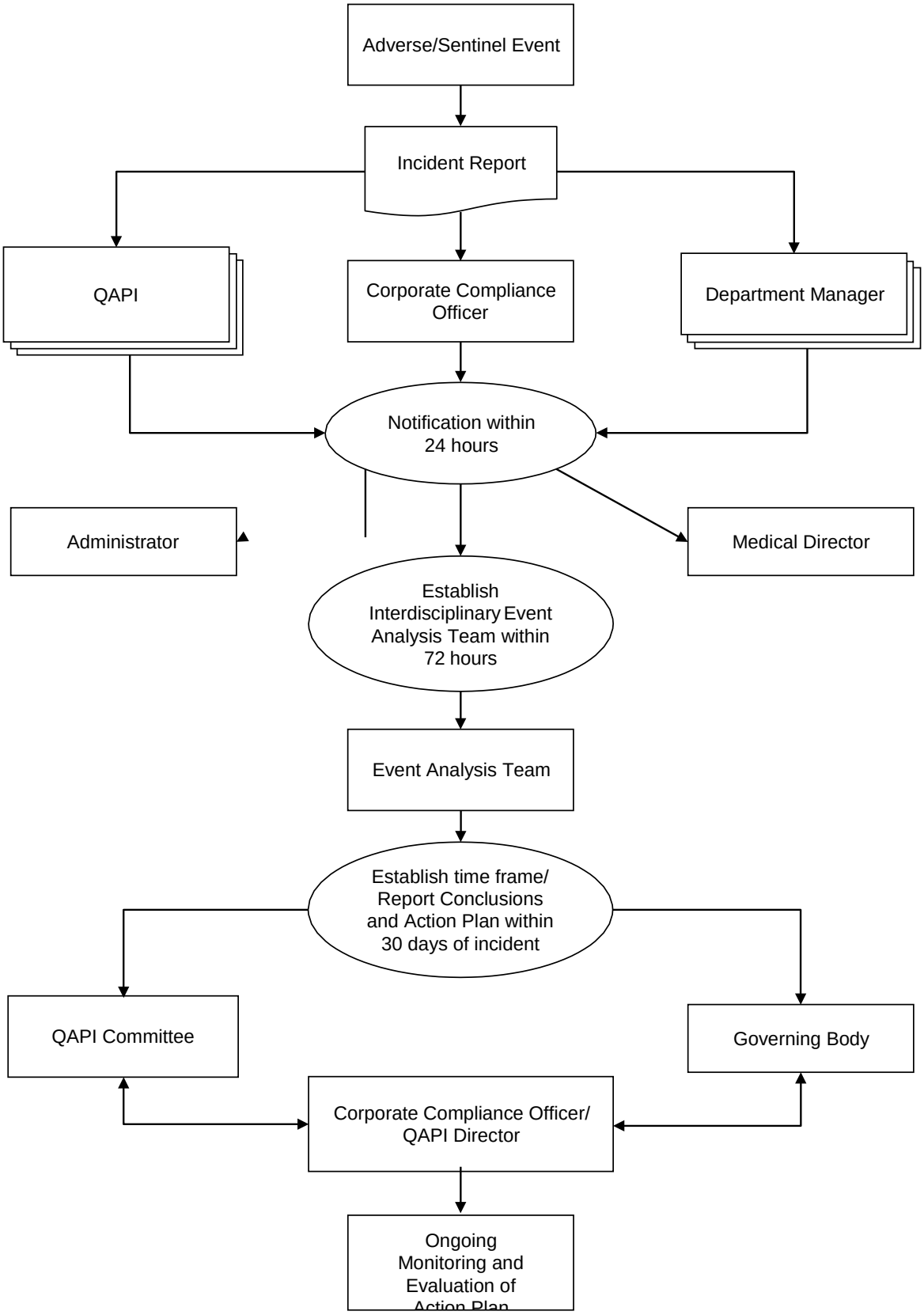
A FRAMEWORK FOR A ROOT CAUSE ANALYSIS AND ACTION PLAN (continued)

Level of Analysis		Questions	Findings	Root Cause?	Ask "Why"?	Take Action?
Why did that happen? What systems and processes underlie those proximate factors? (Common cause variation here may lead to special cause variation in dependent processes.)	Human resource issues	To what degree are staff properly qualified and currently competent for their responsibilities?				
		How did actual staffing compare with ideal levels?				
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				
		To what degree is staff performance in the operant process(es) addressed?				
		How can orientation and inservice training be improved?				
	Information management issues	To what degree is all necessary information available when needed? Accurate? Complete? Unambiguous?				
		To what degree is communication among participants adequate?				
	Environmental management issues	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
		What emergency and failure-mode responses have been planned and tested?				
	Leadership issues: Corporate culture	To what degree is the culture conducive to risk identification and reduction?				
	Encouragement of communication	What are the barriers to communication of potential risk factors?				
	Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?				
	Uncontrollable factors	What can be done to protect against the effects of these uncontrollable factors?				

A FRAMEWORK FOR A ROOT CAUSE ANALYSIS AND ACTION PLAN (continued)

	Risk Reduction Strategies	Measures of Effectiveness
For each of the findings identified in the analysis as needing an action, indicate the planned action, expected implementation date and associated measure of effectiveness, OR . . .	**Action Item #1:**	**Measure:**
If, after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time.	**Action Item #2:**	**Measure:**
Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action.	**Action Item #3:**	**Measure:**
Consider whether pilot testing of a planned improvement should be conducted.	**Action Item #4:**	**Measure:**
Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	**Action Item #5:**	**Measure:**
	Action Item #6:	**Measure:**
	Action Item #7:	**Measure:**
	Action Item #8:	**Measure:**
Cite any books or journal articles that were considered in developing this analysis and action plan:		

ROOT CAUSE ANALYSIS FLOWCHART



SUBJECT: INCIDENT REPORTS	REFERENCE #9009
DEPARTMENT: HOME HEALTH	PAGE: 1 OF: 2
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- The Incident Report form shall be used as part of the_____HHA's integrated risk management and Quality Assessment and Performance Improvement (QAPI) program.

- The Incident Report form must be completed for ALL unusual occurrences involving patients, staff or family. An unusual occurrence is defined as any occurrence involving a patient, staff or family member which is not consistent with regular routine, regardless of whether or not there was an apparent injury or other damage. Also, all occurrences of significant patient complaint or criticism, including complaints from a patient's relative or friend, should be the subject of an Incident Report.

- All incidents shall be reported in accordance with State and Federal regulatory requirements, as applicable.

PROCEDURE:

- All staff shall be responsible for submitting Incident Reports as appropriate. Appropriate follow-up shall be initiated by the QAPI Director.

- When an event occurs, an Incident Report shall be completed by staff aware of the occurrence.

  - The form shall be completed in its entirety.

  - The narrative portion of the Incident Report form should NOT contain opinions or conclusions, but rather, consist of facts, direct observations and witnesses' statements.

  - No photocopies of the Incident Report are to be made at any time.

  - If the occurrence involves a patient, document precisely the necessary information on the patient's medical record. **Do not document that an "error" or "mistake," etc., was made or that an Incident Report was completed.**

- The staff member completing the report form shall immediately forward the report to his/her Supervisor for review and countersignature. Thereafter, the form shall be forwarded to the Patient Care Services Director for review and follow-up. The information obtained from the reports shall be categorized in a "patterns over time" manner and submitted to the appropriate committees and departments for the purpose of:

  - Improving the management of patient care, treatment and services by assuring that appropriate and immediate intervention occurs for the patient's safety and to assure the prevention of occurrences.

  - Providing a database for the HHA so that the care, treatment and services being given can be analyzed, evaluated and acted upon.

- All Incident Reports shall be filed by month. The file shall contain the original Incident Report, follow-up report and the interventions taken to prevent a recurrence.

INCIDENT REPORT

CONFIDENTIAL: Place into sealed envelope and route to Patient Care Services Director within 24 hours.
Note: Staff Injuries send to Human Resources Department.

Patient/Person Involved:_____ MR#:_____ DOB:_____ Sex: _____

Address:_____ City/State/Zip: _____

Date of Occurrence:_____ Time of Occurrence: _____

Person Completing Report:_____ Date Report Filed: _____

❑ Patient ❑ Staff ❑ Family Member ❑ Other: _____

Check Applicable Event:

- ❑ Hospital Admission
- ❑ AMA
- ❑ Cardiopulmonary Arrest
- ❑ Abusive Behavior:
  - ❑ Patient
  - ❑ Family Member
- ❑ Medication Problem:
  - ❑ Missed Dose
  - ❑ Incorrect Dose
  - ❑ Incorrect Medication
  - ❑ Reaction to/Toxic Effect
- ❑ Equipment Failure
  Lot #_____ Tracking # _____
- ❑ Fall ❑ Staff in home ❑ No staff present
- ❑ Infusion Equipment Problems
- ❑ Staff Injury
- ❑ Staff Property Missing/Damaged
- ❑ Patient Injury
- ❑ Patient Property Missing/Damaged
- ❑ Surgical Complication/Infection
- ❑ Untoward Reaction to Treatment/Procedure
- ❑ Wound Disruption
- ❑ Other: _____

Describe the event, effects, outcome and potential risk issue (name equipment, drug, procedure, treatment, etc., if applicable).

_____

_____

_____

_____

_____

For PI Director Use Only: Date Received: _____

Effect:

❑ Trending Medical Legal: Date Filed: _____

❑ Inconsequential ❑ Consequential ❑ Non-existing/Unknown

Comments: _____

_____

_____

_____

_____

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Assessment and Care/Service Management of Patient with CHF:	Nursing Staff (Employee and Contract) and Nursing Mgrs. Referring Physician Medical Director		IM, PC													
- Assessment of diuresing as evidenced by weight documentation on each nursing visit	As above		As above													
- Assessment of response to diuretic medications by documented review of lab work and communication with physician	As above		As above													
- Adequate assessment of lung sounds and edema with documentation, and any change reported to physician	As above		As above													
- Documented patient/family understanding of CHF teaching (signs/symptoms to report)	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Assessment and Care/Service (continued) <u>Management of Patient with CHF (continued)</u> - Discharge instructions provided to patient/family address all of the following:	Nursing Staff (Employee and Contract) and Nursing Mgrs. Referring Physician Medical Director		IM, PC													
• Activity level	As above		As above													
• Diet	As above		As above													
• Medications	As above		As above													
• Follow-up appointments	As above		As above													
• Weight monitoring	As above		As above													
• Signs and symptoms to report	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Assessment and Care/Service (continued) Pain Management:	Clinical Staff (SN, PT, ST, OT) and Managers Referring Physician Risk Management Medical Director		IM, MM, PC, RI													
- All patients are assessed for the presence of pain on admission to the organization according to an objective pain scale	As above		As above													
- All patients with diagnoses that have the potential for causing pain will have their pain level assessed and documented according to an objective pain scale during each skilled visit	As above		As above													
- Effectiveness of pain medication, if used by the patient, will be assessed and documented during each skilled visit	As above		As above													
- Effectiveness of pain management techniques will be assessed and documented during each skilled visit	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Assessment and Care/Service (continued) Pain Management (continued)																
- Documented communication with patient's physician and other team members providing care/service when change in patient's pain level/response to medications/other pain management techniques	Clinical Staff (SN, PT, ST, OT) and Managers Referring Physician Risk Management Medical Director		IM, MM, PC, RI													
Management of Patients with Open Wounds	Nursing Staff (Employees and Contract) and Nursing Mgmt. Medical Director Referring Physician		IC, IM, MM. PC													
- Open wounds are assessed and measured during admission and subsequent skilled nursing visits	As above		As above													
- Open wounds are photographed one time weekly	As above		As above													
- Wound care management coincides with physician orders	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Assessment and Care/Service (continued) Management of Patients with Open Wounds (continued)	Nursing Staff (Employees and Contract) and Nursing Mgmt. Medical Director Referring Physician		IC, IM, MM. PC													
- Aseptic/clean technique/ Standard Precautions followed during wound care procedure	As above		As above													
- Documented patient/family understanding of wound care management	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Assessment and Care/Service (continued) - Patient/family education needs and level of understanding are assessed and documented at each skilled visit	All Clinical Staff (SN, PT, OT, ST) and Managers		LD, PC, RI													
- Education materials appropriate to the level of understanding and language are provided and reviewed with the patient/family	As above		As above													
PFA: Patient Safety - Basic home safety assessment is conducted and documented at the time of the initial visit	Clinical Staff (Employee and Contract SN, PT, OT, ST) and Managers Risk Management Medical Director		EC, IM, MM. PC													
- Fall assessment is conducted and documented on every patient during each skilled visit	As above		As above													
- Documented patient/family level of understanding of fall prevention precautions	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Patient Safety (continued) - Patients are identified using two (2) identifiers before all procedures, medications and treatments	All Clinical Staff, i.e., SN, PT, OT, ST, MSS (employees and contractors) and Managers Risk Management Billing Department		IM. PC													
- On admission the patient's name, spelling and number is visually confirmed with information on the health insurance card	As above		As above													
- Upon arrival at the patient's place of residence, staff members address the patient by his/her first and last names	All Clinical Staff, i.e., SN, PT, OT, ST, MSS (employees and contractors) and Managers Risk Management Billing Department		IM. PC													
- During admission and all subsequent visits each staff member confirms with the patient and documents the correct site(s) for treatment, i.e., wounds, IV/phlebotomy sites, mastectomy sites, shunts, treatment of any extremity	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Communication - All verbal/telephone orders and critical test results are read back for verification by the person taking the order; verification is documented	All Clinical Staff (Employees and Contract) and Managers Risk Management Medical Director Referring Physician		IM, LD, MM, PC													
- All home care staff and physicians use only the HHA approved list of abbreviations, acronyms and symbols when documenting	As above		As above													
PFA: Communication (continued) - Plans of treatment and verbal/telephone orders are reduced to writing and submitted to the physician within___days of the start of care/receipt of the verbal/telephone order	Medical Records Department Data Entry Department Billing Department All Clinical Staff (Employees and Contract) and Managers Risk Management Medical Director		IM, LD, MM, PC													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
- Plans of treatment and verbal/telephone orders are returned to the office within ___ days of the start of care date/receipt of the verbal/ telephone order and contain the ordering physician's original signature	As above		As above													
PFA: Infection Control - CDC hand hygiene guidelines will be adhered to by all staff	All Clinical Staff (Employee and Contract) and Managers Risk Management Medical Director Referring Physician		IC, LD, PC													
- All clinical staff will have alcohol-based handwashing solution available during each patient visit	As above		As above													
- Personal protective equipment will be used appropriately by all staff	As above		As above													
- Standard Precautions will be adhered to by all home care staff	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Information Management - Personal health information is protected during home visits	All Clinical Staff (Employees and Contract) and Managers		IM, LD, PC, RC, RI													
- Home chart information is returned to the Agency office upon patient discharge and destroyed appropriately	As above		As above													
- Every entry into the patient record is dated and signed with the staff member's full name and professional designation	As above		As above													
- Computers are turned off when not in use	As above		As above													
PFA: Orientation and Training - All home care staff complete a structured orientation program prior to providing care, treatment and/or services	Human Resources Clinical Staff and Managers Contractors		HR, LD													
- Competency evaluations are completed for all home care staff at time of hire, within 90 days of hire and annually	As above		As above													
- Staff training is provided and competency assessed whenever job responsibilities/ duties change	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) TRENDING SHEET

Department/Committee: Home Health **Date:** _____

*PFA = Priority Focus Area

Performance Measures/Outcomes	Interdepartmental Collaboration	Benchmark Goal	Function	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
PFA: Orientation and Training (continued) - Annual education plan includes at least the following topics:	All Clinical Staff (Employees and Contract) and Managers Contractors		EC, EQ, HR, LD, PC													
• Emergency Management	As above		As above													
• Fire Safety	As above		As above													
• Infection Prevention and Control Measures	As above		As above													
• Ethics	As above		As above													
• Performance improvement	As above		As above													
• Body Mechanics and Transfer Safety	As above		As above													
• Basic Home Safety Measures	As above		As above													
• Patient Safety	As above		As above													
• Staff Safety	As above		As above													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) OUTCOME EVALUATION

Department: Home Health Person Making Report: _

Month/Quarter Reviewed: _____

Priority Focus Area (PFA)	Conclusions	Action	Evaluation of Effectiveness and Collaboration with Other Services
Assessment and Care/Service			
Patient Safety			
Communication			
Infection Control			
Information Management			
Orientation and Training			

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) VOLUME MEASURES/STATISTICS

Department/Committee: Home Health **Year:** _____

Volume Measures/Statistics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
# of completed Plans of Care/Treatment sent to physician within ___ days of the start of care visit													
# of physician verbal orders signed and returned to HHA office within ___ days of receipt of the order													
# of patients admitted within 48 hours of referral/patient's return home/physician ordered start of care													
# of patients readmitted to hospital/transferred to another level of care													
# of patients readmitted to hospital for exacerbation of admission diagnosis													
# of medication errors													
# of medication adverse reactions													
# of patient falls													
# of patients assessed at risk of falls due to medications													
# of patients assessed at risk of falls not due to medications													
# of patients assessed as being at nutritional risk are provided a referral to a Registered Dietitian													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) VOLUME MEASURES/STATISTICS

Department/Committee: Home Health **Year:** _____

Volume Measures/Statistics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
# of infections acquired following admission to HHA													
# of patients admitted for parenteral therapy													
# of patients with improved ambulation													
# of patients recertified													
# of visits													
# of scheduled visits (all disciplines)													
# of missed visits													
# of unscheduled (extra) visits													
# of visits by HHA staff (all disciplines)													
# of visits by contracted staff													
# of staff sick calls													
# of days per diem staff used													
# of patient complaints													
# of admissions to HHA													

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) VOLUME MEASURES/STATISTICS

Department/Committee: Home Health **Year:** _____

Volume Measures/Statistics	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
# of total discharges from HHA with all goals met													
# of patients assessed for pain													
# of patients requiring pain management modalities													
# of acquired wound infections following admission to HHA													
# of wound care patients													
# of Medication Profiles completed according to HHA policy													
# of supervisory visits completed within appropriate time frames													
# of staff competence evaluations completed during probationary period													
# of staff annual competency evaluations completed													

SUBJECT: HEALTH SERVICES QUESTIONNAIRE	REFERENCE #9015
	PAGE: 1
DEPARTMENT: HOME HEALTH	OF: 1
	EFFECTIVE:
APPROVED BY:	REVISED:

PURPOSE:

The results of the questionnaire provide organization management with feedback about the quality of care and services provided as perceived by the patients.

POLICY:

The organization shall provide a Health Services Questionnaire to all active patients within two (2) weeks following admission to the organization and upon discharge from the organization.

PROCEDURE:

- The Health Services Questionnaire Form shall be mailed to all new active patients within two weeks of admission to the organization and within one week of discharge from the organization.
- All employees providing care/services to the patient shall be responsible for verifying that the patient received the form and that the form is returned to the organization within one (1) week of receipt by the patient.
- If the form is not returned to the organization within the specified time frame, a designated clerical staff member shall contact the patient and elicits a verbal response to the questions from the patient and/or family.
- The results of the questionnaires shall be tabulated on a monthly basis. The monthly summary shall be submitted to the Patient Care Services Director/Administrator, the Quality Assessment and Performance Improvement (QAPI) Director and the Compliance Officer.
- Any negative trends shall be evaluated and investigated and a plan of correction shall be developed and instituted.

HOME HEALTH SERVICE QUESTIONNAIRE

To continuously improve the quality of care received by our home health patients, we conduct an ongoing review of the service provided. To help us identify problem areas and/or concerns, we have developed a questionnaire/survey for you to complete. Please answer all questions and document any concerns in the space provided below. An envelope has been provided for your convenience. Thank you for your participation.

	Strongly Agree	Agree	Somewhat Agree	Strongly Disagree
1. When you were discharged from the hospital or left the physician's office, did you receive adequate information regarding your home care?	❑	❑	❑	❑
2. When you have telephone contact with the _____ HHA staff, are you treated in a courteous manner?	❑	❑	❑	❑
3. When_____HHA staff (i.e., nurse, therapist, social worker) come into your home, are they dependable?	❑	❑	❑	❑
4. Are you given clear instructions and education regarding your home care?	❑	❑	❑	❑
5. Do you feel that the _____ HHA staff is accessible to answer your questions?	❑	❑	❑	❑
6. Were your pain management issues addressed adequately?	❑	❑	❑	❑
7. Were you treated in a respectful and supportive manner by our staff during your home care visit(s)?	❑	❑	❑	❑
8. Were mutual goals of treatment discussed at the time of admission?	❑	❑	❑	❑

Comments: _____

INCIDENT REPORTING STAFF QUESTIONNAIRE

Position: _____
(Nurse, Pharmacist, Physical Therapist, etc.)

This is an anonymous survey, designed to elicit honest answers to incident reporting issues. It is the goal of the Patient Safety Program to improve incident reporting through the adoption of a non-punitive reporting approach. Your truthful answers to the following questions will assist in this goal. Any additional comments are appreciated.

I feel that I can report a medical/health care error that I discover without fear of reprisal by responsible staff ❒ Yes ❒ No ❒ N/A

Comments: _____

I feel that I can report a medical/health care error that I have caused without fear of reprisal by my superiors ❒ Yes ❒ No ❒ N/A

Comments: _____

I feel that blame is placed on individuals that report medical/health care errors ❒ Yes ❒ No ❒ N/A

Comments: _____

I feel that there are negative consequences to reporting medical/ health care errors (fear of legal actions, challenges to licensure, personal reputation, etc.) ❒ Yes ❒ No ❒ N/A

Comments: _____

INCIDENT REPORTING STAFF QUESTIONNAIRE (continued)

I feel that reporting of medical/health care errors does not change the situations that may have led to the error occurrence ❒ Yes ❒ No ❒ N/A

Comments: _____

_____

_____

_____

I feel the error reporting process is problematic (cumbersome, too lengthy, etc.) ❒ Yes ❒ No ❒ N/A

Comments: _____

_____

_____

_____

I feel that I am supported by my supervisor and/or department if I am involved in a medical/health care error ❒ Yes ❒ No ❒ N/A

Comments: _____

_____

_____

_____

I feel there are systems, processes and/or equipment in my department that lead to medical/health care errors ❒ Yes ❒ No ❒ N/A

Comments: _____

_____

_____

_____

Rate your willingness to report medical/health care errors: (Circle your answer)

Score: 1 very willing - 10 extremely unwilling

1 2 3 4 5 6 7 8 9 10

Date Completed:_____ Date Reviewed by Administrator/Governing Body: _____

EMPLOYEE SAFETY INFORMATION FORM

This form is for use by employees who wish to provide a safety suggestion or to report an unsafe workplace condition or practice. Turn in completed form to Safety Officer.

Description of Unsafe Condition or Practice: _____

Causes or Other Contributing Factors: _____

Employee's Suggestion for Improving Safety: _____

Has this matter been reported to the Area Supervisor? ❑ Yes ❑ No

Employee Name (optional): _____

Department: _____ Date: _____

Employees are advised that use of this form, or other reports of unsafe conditions or practices, is protected by law. It would be illegal for the employer to take any action against an employee in reprisal for exercising rights to participate in communications involving safety.

The employer shall investigate any report or question as required by the Injury and Illness Prevention Program Standard and advise the employee who provided the information, or the workers in the area, of the employer's response.