



QI and QAPI in Your Facility

Session 3



Announcements

- 1. Didactic Sessions:** begin promptly at 1:30 pm and will be locked after 1:40 pm.
- 2. TNT Program Questions:** please email TNTEducation@ph.lacounty.gov email address only.
- 3. Save the TNT Website:** <http://publichealth.lacounty.gov/acd/TNTProgram.htm>.
- 4. Logging into the sessions** with facility credentials will only provide credit toward facility attendance.
 - For individual attendance credit, each participant must log in with individual credentials (full name)
 - To receive credit, your log in must clearly indicate your name. Anybody that is logged in with a phone number will not be given credit for attendance.
 - Names entered in the chat to identify the phone numbers will not be accepted.
 - Please do not enter your name or facility name in the chat.
- 5. TNT Communication:** Please read in detail.
- 6. Small Group sessions:** Facility assigned session invitations are being sent.

Announcements

7. Chat:

- Again, please do not enter your name or your facility name in the chat.
 - If you have logged in with your full name, your presence will be recorded.
- During the presentation, please listen to the presentation rather than focusing on the content in the chat. All important information will be shared again later.

8. Post-session Evaluation Quiz: only Designated Participants are eligible to take the survey and receive CEUs/Certificates.

- Link will be shared in the chat at the end of the session, AND
- Will be emailed to everyone after each session, AND
- Link will be available on the TNT website within 2 days after each session


Housekeeping


Please do not unmute or start your video.


Click here to raise or lower your hand.

Click here to see the participants list.



 Unmute ▾

 Start video ▾

 Share



Click here to turn captions on.

Please do not share your screen.

Click here to access the chat and choose to send messages to Everyone.

Session Schedule

Topics	Date	Link
1 - Transforming Nursing Home Care Together (TNT) Program - Introduction	Wednesday, July 6th, 10:00-11:00 am	<p>Join using this link: https://lacpublichealth.w ebex.com/lacpublichealt h/j.php?MTID=m4eb4f9c 0019845cbbb6495fedf2a caa6. </p>
2 - QI and QAPI Foundations	Wednesday, July 13th, 1:30-2:30 pm	
3 - QI and QAPI in Your Facility	Wednesday, July 20th, 1:30-2:30 pm	
4 - Leadership, Systematic Analysis, and Systemic Action	Wednesday, July 27th, 1:30-2:30 pm	
5 - System Action Continued - Using a Quality Improvement Framework	Wednesday, August 3rd, 1:30-2:30 pm	
6 - Data Quality and Best Practices	Wednesday, August 10th, 1:30-2:30 pm	
7 - Continuing Your QAPI Journey	Wednesday, August 17th, 1:30-2:30 pm	
8 - Step-by-Step QAPI Performance Improvement Project (PIP)	Wednesday, August 24th, 1:30-2:30 pm	

<http://publichealth.lacounty.gov/acd/docs/TNTProgramSchedule.pdf>

TNT Program Objectives

- Enhance quality improvement and quality assurance performance improvement (QAPI) at LA County SNFs by providing foundational quality improvement education across all roles in SNFs
- Empower SNF staff to initiate performance improvement projects (PIPs) and own QI in their facility
- Improve patient safety and clinical outcomes

Session 3 Objectives

- Learn how to develop a Culture of Safety in your facility.
- Learn how to identify and respond to signals for change and improvement.
- Learn the structure of the A3 and how to use the 5 whys to get to the root cause of problems.



THIS IS QAPI

Things to Consider for this Session

- What do I think about the safety culture in my facility?
- If I had to choose one thing to improve in my facility, where would I start?
- What QAPI/QI projects do I know about in my facility?
- What QAPI/QI tools does my facility use?
- What are the Mission, Vision, and Values of my facility?
- Do I feel comfortable talking about resident safety in my facility?
- Do I know to whom (what individual or what team) to communicate something I identify as unsafe?



Audience Poll Question: What is a "Just Culture"?

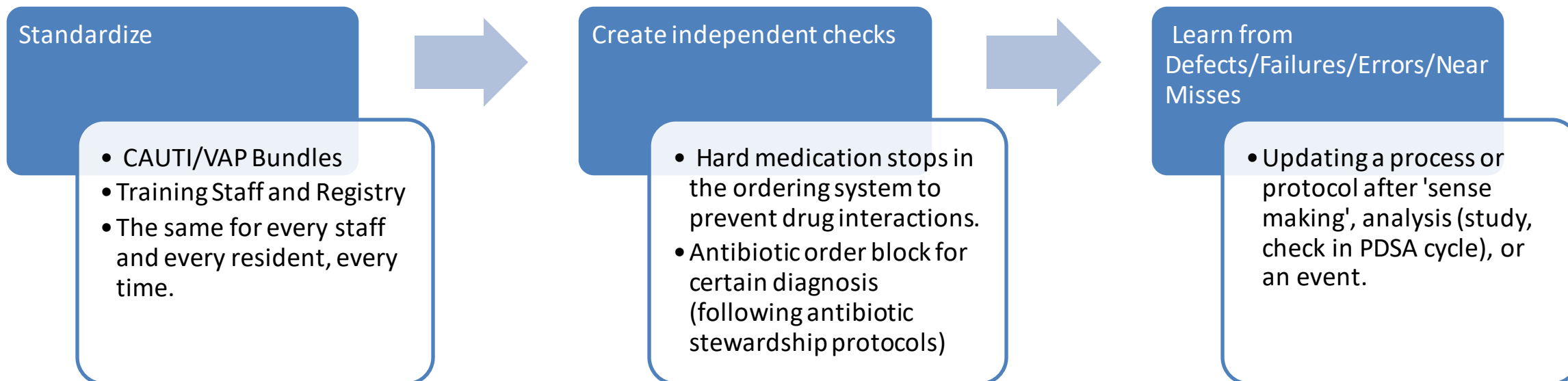
What is a Culture of Safety?

- Acknowledge the high-risk nature of the work
- Just Culture
 - Allows staff to speak up
 - Blame free environment
 - Report errors or near misses
- Collaboration across ranks and disciplines to seek solutions
- Organizational commitment of resources to address safety concerns

The Science of Safety – How do we get to a Culture of Safety?

- Every system is perfectly designed to achieve its end results.
- Understand how the system is designed and how it contributed to the results.
 - Consistent and like errors are designed into processes (Systems fail, not people*)
- Teams make wise decisions when there is diverse and independent input.

Three Principles of Designing Safe Processes





Signals for Improvement and Change



Signals for Improvement and Change

- Resident care event
- External feedback
- Internal feedback
 - Safety Culture Survey results
- CMS Five-Star Quality Rating System (Nursing Home Care Compare)

Improvement Signal – Resident Care Event

- Falls
- CAUTI
- VAP
- Medication Errors

Audience Question: What are some examples of resident care events as signals for improvement and change?

Improvement Signal - External Feedback

- Family notifies that resident:
 - Is not clean
 - Does not have assistive devices
- Ombudsman notifies:
 - Family unable to visit during COVID
 - Multiple/consistent/repeated care complaints

Audience Question: What are some examples of external feedback signals for improvement and change?

Improvement Signal - Internal Feedback

- Resident communicates:
 - Food is cold
 - Call button not answered
- Staff communicates:
 - Hoyer lift unavailable (broken, dirty, in use)
 - Leaks/mold - building failures

Audience Question: What are some examples of internal feedback as signals for improvement and change?

Improvement Signal - Safety Culture Survey

Step 1. What are the clinical or operational problems that have or could have jeopardized patient safety?

Step 2. How might the next resident be harmed in our facility?

Step 3. What can be done to minimize harm or prevent safety hazards?

Nursing Home Survey on Patient Safety

In this survey, **"resident safety"** means preventing resident injuries, incidents, and harm to residents in the nursing home.

This survey asks for your opinions about resident safety issues in your nursing home. It will take about 15 minutes to complete.

If a question does not apply to you or your nursing home or you don't know the answer, please select "Does Not Apply or Don't Know." If you do not wish to answer a question, you may leave your answer blank.

SECTION A: Working in This Nursing Home

How much do you agree or disagree with the following statements?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Does Not Apply or Don't Know
1. Staff in this nursing home treat each other with respect.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
2. Staff support one another in this nursing home.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
3. We have enough staff to handle the workload.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
4. Staff follow standard procedures to care for residents.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9



Audience Poll Question: Does your facility administer a culture of safety survey?

Examples of Resident Safety Failures

Examples of Resident Safety Failures	Root Causes	Solutions
Resident tripped on unattached oxygen tank		
Medication error		
Incorrect disinfectant used		
Critical vital sign was missed		



Audience Poll Question: How often does your facility administer a culture of safety survey?

Improvement Signal – Five-Star Quality Rating System (Nursing Home Care Compare)

Your Skilled
Nursing Home

Overall rating:
★★★★☆

Your address

Your telephone number

[Save to Favorites](#)

RatingsDetailsLocation

RATINGS

Overall rating

★★★★☆

Average

The overall rating is based on a nursing home's performance on 3 sources: health inspections, staffing, and quality measures.
[Learn how Medicare calculates this rating](#)

Health inspections

★★☆☆☆

Below average

Staffing

★★★★☆

Average

Quality measures

★★★★★

Much above average



Introduction to Lean and QI Culture



QI and Patient Safety Methods and Tools

Methods

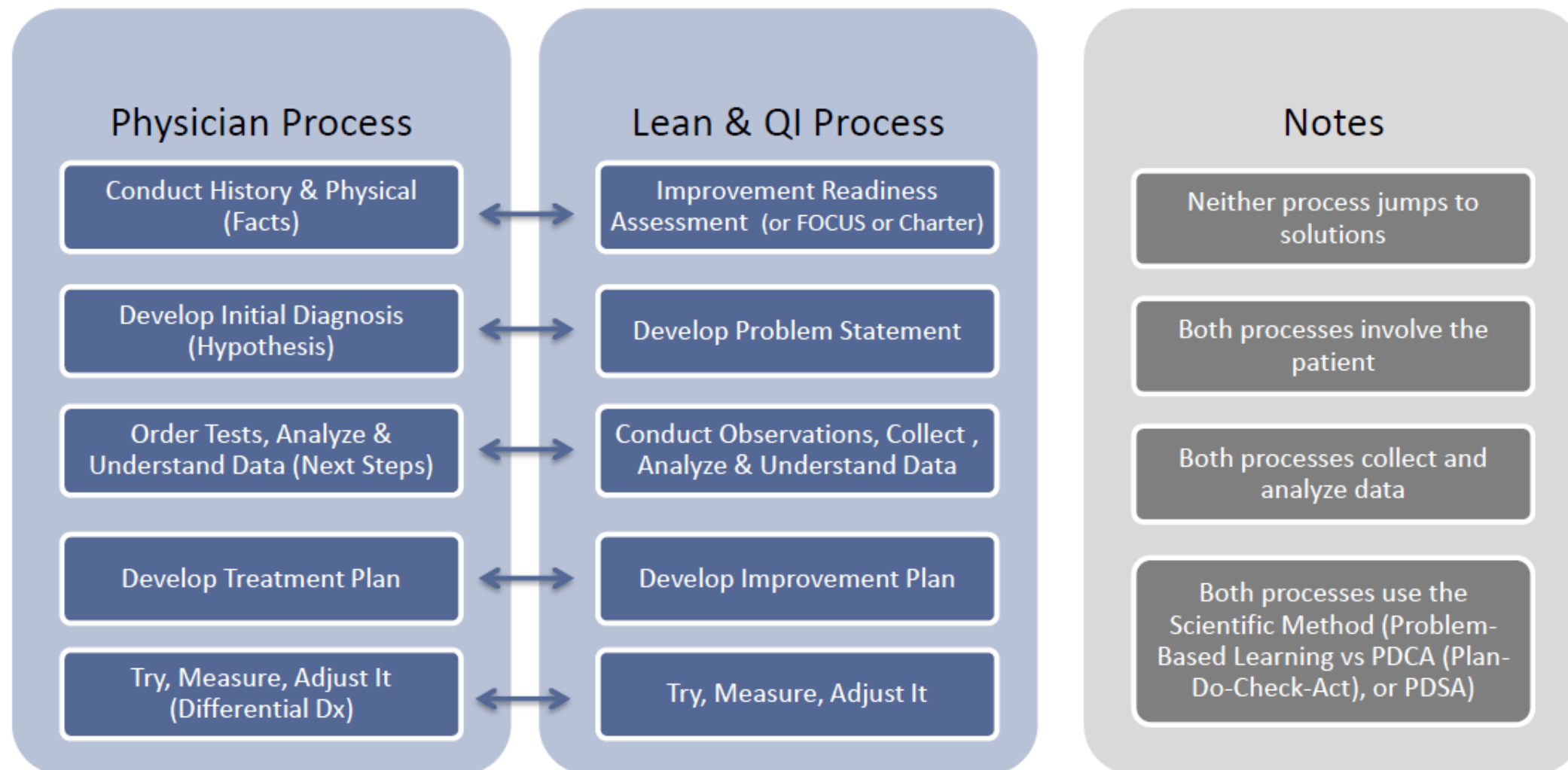
- Comprehensive Unit-based Safety Program - CUSP
- TeamSTEPPS®
- **LEAN**
- Six Sigma
- Institute for Healthcare Improvement (IHI) Model for Improvement

Tools

- **Plan-Do-Study/Check-Act Cycle – The A3**
- **Root Cause Analysis (RCA)**
 - **5 Whys**
 - Fishbone (Ishikawa) Diagram
- Failure Mode Effect Analysis

LEAN & QI "thinking" should be familiar to some health care professionals

Scenario – a resident presents with a problem. What is the Physician's process?



LEAN: Quality Improvement Method

1. Working for your customer (improvement signals).
2. Figure out your problem and focus on it (sensemaking, root cause analysis) .
3. Remove variation and bottlenecks (waiting around = wasted time).
4. Improve communication and train staff (post A3s/A4s, dashboards, registry staff).
5. Be flexible and respond (make change and improve).

The A4 and the A3

A4 Problem Solving (8.5 x 11)

Daily problem solving, consensus & communication tool used by staff

Known root-causes and solutions

Quick and easy to use

Example: Peanut butter and jelly sandwiches in the RR.

A3 Problem Solving (11 x 17)

Complex problem solving, consensus, communication tool

Unknown root-causes and solutions

Requires Planning (**PDCA**) and usually data

Example: A unit wants to improve poor patient satisfaction scores but they do not understand why the scores are so poor or how to improve them

Opportunity:
Impact (Align with OS Pillar):

Date:

Problem Statement

Current Method (Current Conditions)

Suggestion/ New Method

Expectations/ Indicators / Next Steps

Owner(s):
Sponsor:

A3 Project Title

Project Lead:
Facilitator:
Project Champion(s):

Project Team:

Date Updated:

1) Problem Statement: (description of the problem and its effect)

2) Current State: (description of the current state, its processes, and problem(s))

Best Practices/Literature Search:

3) Goal: (How will we know the project is successful, standard/basis for comparison)

4) Root Cause Analysis: (Investigation depicting the problem's root causes)

5) Solutions: (action plan and findings of tested solutions)

Root Cause	Tested Solution	Responsible	Due	Finding

6) Check: (Summary of the solutions' results, overall goal success, and any supporting metrics)

Goal & Metrics	Baseline	Target	Current
Goal			
Supporting Metric			
Supporting Metric			

7) Act: (Action taken as a result of the Check, and the plan to sustain results)

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- 1.
- 2.
- 3.

PDSA/PDCA



Root Cause Analysis and the 5 Whys

Problem: The granite of the Jefferson Memorial is crumbling at an increasing rate

Why?

- Because it was being washed more frequently.

Why?

- Because a larger bird population led to increased waste.

Why?

- Because of the number of spiders for birds to eat.

Why?

- Because there were a large number of midges for spiders to eat.

Why?

Because midges are attracted to the lights, which are turned on before dusk, and they smash into the memorial while swarming.



Keep asking why!

Root Cause Analysis and the 5 Whys

Problem: Mr. Johnson fell at 0200 on 4/12/22

Why?

- Because he got up at 0200, in the middle of night.

Why?

- Because he was hungry.

Why?

- Because he did not eat an evening snack during regular snack time.

Why?

- He was documented as sleeping when snacks were passed out.

Why?

Resident's usual routine was affected when his daughter took him out on pass.

Keep asking why!

Why?

- Because he got out of bed without his walker.

Why?

- Because it wasn't in its usual place.

Why?

- It was moved when his room was cleaned.

Why?

- Because the room was cleaned by a new EVS staff member, and they are not familiar with Mr. Johnson's preferences.

Why?

Because new EVS staff member did not know there are documented resident preferences for items in rooms.

Audience Question: What are some possible solutions to the missing walker being the cause of Mr. Johnson falling?

Embed QAPI and QI/LEAN into Your Culture



PDCA/PDSA Problem-Solving Approach

PDCA – Plan Do Check Act

- A3 methodology
- A4 methodology



Visual Systems

- Performance Boards: visual Systems to see performance
- Standards/Metrics- Trended Dashboards & Daily Metrics



Huddles & Rounds

- Daily Huddles, Huddles with Performance Boards
- Rounding, etc.

Standard Work & Processes

- Evidence-based Standard Work (designed by staff, with training)
- Bundles



THIS IS ALL QAPI

Homework

- Review the different sources of information (signals for improvement and change) at your disposal.
- Identify areas in your facility that could use improvement to enhance your quality of care.

Resources

- Nursing Home Survey on Patient Safety Culture
 - <https://www.ahrq.gov/sops/surveys/nursing-home/index.html>
- PDCA Cycle
 - <https://asq.org/quality-resources/pdca-cycle>
- CMS QAPI Resource – Using the 5 Whys for Root Cause Analysis
 - <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/fivewhys.pdf>
- CMS QAPI Resource – Using a Storyboard in PIPs
 - <https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/pipstorybdguide.pdf>

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Questions?