

# Quality Assurance & Performance Improvement Clinician's Resource Guide



A guide to assist in  
interpreting the complex  
healthcare regulatory  
environment



## PDQWC mission

PDQWC elevates the importance of critical thinking and educates to improve the practice of skin and wound care



The Quality Assurance & Performance Improvement: Clinician's Resource Guide was developed with input from the Professionals Dedicated to Quality Wound Care (PDQWC).

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This “Quality Assurance & Performance Improvement: Clinician’s Resource Guide” was developed by the Professionals Dedicated to Quality Wound Care (PDQWC). All members of the PDQWC have experienced the challenges associated with integrating the major components of the Quality Assurance & Performance Improvement (QAPI) Initiative into their facilities. PDQWC members have reviewed all of the key components of the QAPI Initiative, and have identified several areas related to pressure ulcer prevention and treatment where guidelines, checklists and sample forms could be of benefit. They developed this resource guide to provide a framework to assist clinicians in developing their own sets of guidelines and checklists for their facilities. This guide is not intended to replace any of the materials provided by the Centers for Medicare & Medicaid Services (CMS).

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QAPI is an essential tool to evaluate, improve, and document quality care. Pressure ulcers are an important patient care issue especially considering that many pressure ulcers may be deemed avoidable. Using QAPI to evaluate pressure ulcers and the care processes associated with pressure ulcers is considered essential. This guide will provide an overview of Nursing Facility CMS guidelines associated with pressure ulcers, QAPI data collection, pressure ulcer root cause analysis, and use of pressure ulcer QAPI for CMS survey management. A PIP template is also provided. This guide is provided only as an overview and template. Patient centered care, state and federal requirements, standards of practice must always be considered.

## Background

Improving and demonstrating quality patient care is essential in any healthcare setting. This is especially true in nursing facilities with the challenges of the Centers for Medicare & Medicaid Services' (CMS) compliance and Five Star Rating, Accountable Care Organizations, and Bundled Payments. Quality Assurance and Performance Improvement (QAPI) programs have proven to be successful in improving and demonstrating quality care. QAPI merges Quality Assurance (QA) with Performance Improvement (PI), typically with a synergetic outcome. QAPI is data driven and proactive.

The nursing facility requirement for Quality Assessment and Assurance (QAA) is referenced in the Code of Federal Regulations 42 CFR, Part 483.75(o), which indicates that a nursing facility should have a QAA committee, and specifies the composition and frequency of meetings. It requires nursing facilities to develop and implement appropriate plans of action to correct identified quality deficiencies. While it provides a rule, it does not go into detail as to the means and methods of actually implementing the QAA requirement. CMS has been reinforcing the critical importance of nursing facilities establishing and maintaining accountability for QAPI processes in order to sustain quality of care and quality of life for nursing home residents.

Congress passed the Patient Protection and Affordable Care Act in March, 2010, commonly referred to as the Affordable Care Act. It contains provisions to provide the opportunity for CMS to outline best practices for nursing facilities and to identify technical assistance including development of standards relating to Quality Assurance and Performance Improvement (QAPI). This new provision significantly expands the level and scope of required QAPI activities to ensure that nursing facilities continuously identify and correct quality deficiencies and to sustain performance improvement. CMS launched a prototype QAPI program in a small number of nursing homes in September 2011. The demonstration provided best practices for helping nursing facilities to upgrade their QA programs. CMS combined results from the demonstration with consumer, provider and stakeholder feedback to establish QAPI tools and resources.

## QA versus PI

Quality Assurance (QA) is a process of measuring defined aspects of care against an established standard and assuring that these aspects reach an acceptable level. Nursing facilities typically set QA thresholds that are higher than regulations. QA is a reactive and retrospective effort to examine aspects of care and quality that failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standards are met.

Performance Improvement (PI) is a pro-active and continuous measurement and evaluation of processes with the intent to prevent or decrease potential issues by identifying areas of opportunity and testing new approaches to improve underlying causes of less than optimum outcomes. PI in nursing facilities aims to improve processes involved in health care delivery and quality of life. PI initiatives can aid with improving quality.

The following chart adapted from the Health Resources and Services Administration (HRSA) summarizes some key differences between QA and PI efforts:

	Quality Assurance	Performance Improvement
Motivation	Measuring compliance with standards	Continuously Improving processes to meet standards
Means	Inspection	Prevention
Attitude	Required, reactive	Chosen, proactive
Focus	Outliers: "bad apples" Individuals	Processes or systems
Scope	Medical provider	Resident care
Responsibility	Few	All

# Five key elements of QAPI

## Element 1 – Design and scope

A QAPI program must be written, ongoing and comprehensive, dealing with nursing facility services including all departments. The QAPI program should include clinical care, quality of life and resident choice and address all systems of care and management practices. It utilizes the best available evidence and standards of care to define and measure goals.

## Element 2 – Governance and leadership

The governing body and/or administration of the nursing facility should develop a culture that involves leadership seeking input from staff, residents and their families and/ or representatives. It assures adequate resources exist to conduct QAPI efforts including designating one or more person(s) to be accountable, developing leadership and facility-wide training, ensuring staff time, equipment, and technical training as needed. The governing body should foster a culture where QAPI is a priority by ensuring that policies are developed to sustain QAPI regardless of changes in personnel or staff turnover and their responsibilities include, setting expectations around safety, quality, rights, choices and respect by balancing safety with resident-centered rights and choice. The governing body ensures staff accountability, while creating an atmosphere where staff is comfortable identifying and reporting quality problems as well as opportunities for improvement.

## Element 3 – Feedback, data systems and monitoring

The nursing facility implements systems to monitor care and services by drawing data from multiple sources with feedback systems to obtain input from staff, residents, families, and others as appropriate. This element includes using Performance Indicators to monitor various care processes and outcomes, and reviewing findings against benchmarks and/or targets the nursing facility has established for performance. It also includes tracking, investigating, and monitoring negative sentinel outcomes that must be investigated whenever they occur, and action plans implemented to prevent recurrences.

## Element 4 – Performance Improvement Plan (PIPs)

A Performance Improvement Plan (PIP) concentrates on a particular problem in one area of the nursing facility or facility-wide. It involves gathering information systematically to clarify issues or problems, and intervening for improvements. The nursing facility conducts PIPs to examine and improve care or services. The areas that need attention will vary depending on the type of Nursing Facility and their unique services.

## Element 5 – Systematic analysis and systemic action

The nursing facility uses a systematic approach to determine when analysis is needed to fully understand the issue, its causes, and implications of a change. The nursing facility uses a thorough and highly organized and structured approach to determine how identified problems may be caused or exacerbated by the mechanism by which care and services are organized or delivered. Additionally, Nursing Facilities will be expected to develop policies and procedures and demonstrate proficiency in the use of Root Cause Analysis when needed. Systemic Actions evaluate comprehensively all involved systems to prevent future events and promote sustained improvement. This element includes a focus on continual learning and continuous improvement.

## Summary

QAPI is an essential tool to evaluate, improve, and document quality care. Pressure ulcers are an important patient care issue especially considering that many pressure ulcers may be deemed avoidable. Using QAPI to evaluate pressure ulcers and the care processes associated with pressure ulcers is considered essential. This guide will provide an overview of Nursing Facility CMS guidelines associated with pressure ulcers, QAPI data collection, pressure ulcer root cause analysis, and use of pressure ulcer QAPI for CMS survey management. A PIP template is also provided. This guide is provided only as an overview and template. Patient centered care, state and federal requirements, standards of practice must always be considered.

**F314 42 CFR 483.25(c) §483.25(c) Pressure Sores (the nomenclature widely accepted refers to pressure ulcers.)**

**State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 149, 10-09-15)**

**According to tag 314 based on the comprehensive assessment of a resident, the facility must ensure that:**

- 1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
- 2) Intent: (F314) 42 CFR 483.25(c) The intent of this requirement is that the resident does not develop pressure ulcers unless clinically unavoidable and that the facility provides care and services to:
  - Promote the prevention of pressure ulcer development;
  - Promote the healing of pressure ulcers that are present (including prevention of Infection to the extent possible); and
  - Prevent development of additional pressure ulcers.

## Overview

**A pressure ulcer can occur wherever pressure has impaired circulation to the tissue. Critical steps in pressure ulcer prevention and healing include:**

- Identifying the individual resident at risk for developing pressure ulcers
- Identifying and evaluating the risk factors and changes in the resident's condition
- Identifying and evaluating factors that can be removed or modified
- Implementing individualized interventions to attempt to stabilize
- Reducing or removing underlying risk factors
- Monitoring the impact of the interventions
- Modifying the interventions as appropriate

It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure.

**A complete assessment is essential to an effective pressure ulcer prevention and treatment program. A comprehensive individual evaluation helps the facility to:**

- Identify the resident at risk of developing pressure ulcers, the level and nature of risk(s); and
- Identify the presence of pressure ulcers.

This information allows the facility to develop and implement a comprehensive care plan that reflects each resident's identified needs

The care process should include efforts to *stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.*

**The facility should have a system/procedure to ensure:**

- assessments are timely and appropriate;
- interventions are implemented, monitored, and revised as appropriate; and
- changes in condition are recognized, evaluated, reported to the practitioner, and addressed.

The QAPI may help the facility evaluate existing strategies to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and ensure that facility policies and procedures are consistent with current standards of practice.

**The following are components of the care process expected by CMS within the federal guidance for pressure ulcer prevention and treatment.**

**Admission assessment**

Ensure admission assessment identifies the resident at risk of developing a pressure ulcer, and the resident with existing pressure ulcer(s) or areas of skin that are at risk for breakdown.

**Identification of risk factors**

Ensure risk factors for pressure ulcers are identified. Multiple factors, including pressure intensity, pressure duration, and tissue tolerance, significantly affect the potential for the development and healing of pressure ulcers. An individual may also have various intrinsic risks due to aging, for example: decreased subcutaneous tissue and lean muscle mass, decreased skin elasticity, and impaired circulation or innervation. While a standardized risk assessment may be used, an overall risk score indicating the resident is not at high risk of developing pressure ulcers does not mean that existing risk factors or causes should be considered less important or addressed less vigorously than those factors or causes in the resident whose overall score indicates he or she is at a higher risk of developing a pressure ulcer.

**Pressure points and tissue tolerance**

Ensure evaluation/assessment of pressure points and of tissue tolerance. Assessment of a resident's skin condition helps define prevention strategies. The skin assessment should include an evaluation of the skin integrity and tissue tolerance (ability of the skin and its supporting structures to endure the effects of pressure without adverse effects) after pressure to that area has been reduced or redistributed.

## Nutrition and hydration

### (Cross reference to 42 CFR 483.25 (i), F325, Nutrition, and 483.25(j), F327)

Ensure adequate nutrition and hydration to the extent possible as they are essential for overall functioning.

Nutrition provides vital energy and building blocks for all of the body's structures and processes. Any organ or body system may require additional energy or structural materials for repair or function. The skin is the body's largest organ system. It may affect, and be affected by, other body processes and organs. Skin condition reflects overall body function; skin breakdown may be the most visible evidence of a general catabolic state.

Water is essential to maintain adequate body functions. As a major component of blood, water dissolves vitamins, minerals, glucose, amino acids, etc.; transports nutrients into cells; removes waste from the cells; and helps maintain circulating blood volume as well as fluid and electrolyte balance. It is critical that each resident at risk for hydration deficit or imbalance, including the resident with a pressure ulcer or at risk of developing an ulcer, be identified and that hydration needs be addressed.

## Moisture and its impact

### (Cross reference to 42 CFR 483.25 (d) (2) F315, 42 Urinary Incontinence)

Manage moisture. Both urine and feces contain substances that may irritate the epidermis and may make the skin more susceptible to breakdown. Some studies have found that fecal incontinence may pose a greater threat to skin integrity, most likely due to bile acids and enzymes in the feces. Irritation or maceration resulting from prolonged exposure to urine and feces may hasten skin breakdown, and moisture may make skin more susceptible to damage from friction and shear during repositioning.

## Interventions

The assessment provided the basis for defining approaches to address residents at risk of developing or already having a pressure ulcer. After completing a thorough evaluation, the interdisciplinary team should develop a relevant patient-centered care plan to include prevention and management interventions with measurable goals. Many clinicians recommend evaluating skin condition (e.g., skin color, moisture, temperature, integrity, and turgor) at least weekly, or more often if indicated, such as when the resident is using a medical device that may cause pressure.

In the context of the resident's choices, clinical condition, and practitioner input, the resident's plan of care should establish relevant goals and approaches to stabilize or improve co-morbidities, such as attempts to minimize clinically significant blood sugar fluctuations and other interventions aimed at limiting the effects of risk factors associated with pressure ulcers. Alternatively, facility staff and practitioners should document clinically valid reasons why such interventions were not appropriate or feasible. Repeated hospitalizations or emergency room visits within a 6-month period may indicate overall decline or instability.

**Based upon the assessment and the resident's clinical condition, choices and identified needs, basic or routine care should include interventions to:**

- a) Redistribute pressure (such as repositioning, protecting heels, etc.);
- b) Minimize exposure to moisture and keep skin clean, especially of urine and fecal contamination;
- c) Provide appropriate, pressure redistributing, support surfaces;
- d) Provide non-irritating surfaces; and
- e) Maintain or improve nutrition and hydration status, where feasible.

## **Resident choice**

### **(Cross reference to at 42 CFR 483.10(b)(3) and (4), F154 and F155)**

In order for a resident to exercise his or her right appropriately to make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment.

## **Advanced directive**

If a resident has a valid Advance Directive, the facility's care must reflect a resident's wishes as expressed in the Directive, in accordance with state law. However, the presence of an Advance Directive does not absolve the facility from giving supportive and other pertinent care that is not prohibited by the Advance Directive. If the facility has implemented individualized approaches for end-of-life care in accordance with the resident's wishes, and has implemented appropriate efforts to try to stabilize the resident's condition (or indicated why the condition cannot or should not be stabilized) and to provide care to prevent or treat the pressure ulcer (including pertinent, routine, lesser aggressive approaches, such as, cleaning, turning, repositioning), then the development, continuation, or progression of a pressure ulcer may be consistent with regulatory requirements.

## **Repositioning**

Repositioning is a common, effective intervention for an individual with a pressure ulcer or who is at risk of developing one. Assessment of a resident's skin integrity after pressure has been reduced or redistributed should guide the development and implementation of repositioning plans.

## **Support surfaces**

Pressure redistribution refers to the function or ability to distribute a load over a surface or contact area. Redistribution results in shifting pressure from one area to another and requires attention to all affected areas. Pressure redistribution has incorporated the concepts of both pressure reduction (reduction of interface pressure, not necessarily below capillary closure pressure) and pressure relief (reduction of interface pressure below capillary closure pressure).

## **Infection**

### **(Cross reference to §42 CFR 483.65 (Tag F441) Infection Control)**

Prevent infection. Current literature reports that all Stage II, III, and IV pressure ulcers are colonized with bacteria but may not be infected. Identification, diagnosis and treatment of infection, when present, are critical to healing a pressure ulcer.

## **Pain management**

### **(Cross reference to 42 CFR 483.25, F309, Quality of Care)**

Control pain. The assessment and treatment of a resident's pain are integral components of pressure ulcer prevention and management. "The goal of pain management in the pressure ulcer patient is to eliminate the cause of pain, to provide analgesia, or both." Pain that interferes with movement and/or affects mood may contribute to immobility and contribute to the potential for developing a pressure ulcer or for delayed healing or nonhealing of an already existing ulcer

## Assessment and treatment of pressure ulcer(s)

It is important that each existing pressure ulcer be identified, whether present on admission or developed after admission, and that factors that influenced its development, the potential for development of additional ulcers or for the deterioration of the pressure ulcer(s) be recognized, assessed and addressed. Any new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers.

**When assessing the ulcer itself, it is important to:**

- Differentiate the type of ulcer (pressure-related versus non-pressure-related) because interventions may vary depending on the specific type of ulcer;
- Determine the ulcer's stage;
- Describe and monitor the ulcer's characteristics;
- Monitor the progress toward healing and for potential complications;
- Determine if infection is present;
- Assess, treat and monitor pain, if present; and
- Monitor dressings and treatments

## Monitoring

At least daily, staff should remain alert to potential changes in the skin condition and should evaluate and document identified changes. The resident should be monitored for condition changes that might increase the risk for breakdown and the defined interventions should be implemented and monitored for effectiveness.

## Other potential tags associated with pressure ulcers

During the investigation of F314, the surveyor may have determined that concerns may also be present with related outcome, process and/or structure requirements. Some examples of related requirements that should be considered include the following:

### **42 CFR 483.10(b)(11)(i)(B)&(C), F157, Notification of Changes**

Determine if staff notified the physician of significant changes in the resident's condition or failure of the treatment plan to prevent or heal pressure ulcers; or the resident's representative (if known) of significant changes in the resident's condition in relation to the development of a pressure ulcer or a change in the progression of healing of an existing pressure ulcer.

### **42 CFR 483.20(b)(1), F272, Comprehensive Assessments**

Determine if the facility comprehensively assessed the resident's skin condition, including existing pressure ulcers, and resident-specific risk factors (including potential causative factors) for the development of a pressure ulcer or non-healing of the ulcer.

### **42 CFR 483.20(k)(1), F279, Comprehensive Care Plans**

Determine if the facility developed a care plan that was consistent with the resident's specific conditions, risks, needs, behaviors, and preferences and current standards of practice and included measurable objectives and timetables, specific interventions/services to prevent the development of pressure ulcers and/or to treat existing pressures ulcers.

**42 CFR 483.20(k)(2)(iii), F280, Comprehensive Care Plan Revision**

Determine if the care plan was periodically reviewed and revised as necessary to prevent the development of pressure ulcers and to promote the healing of existing pressure ulcers.

**42 CFR 483.20(k)(3)(i), F281, Services Provided Meet Professional Standards**

Determine if pressure ulcer care was provided in accordance with accepted professional standards.

**42 CFR 483.25, F309, Quality of Care**

Determine if staff identified and implemented appropriate measures for the management of pain as indicated as related to pressure ulcers and pressure ulcer treatment.

**42 CFR 482.30(a), F353, Sufficient Staff**

Determine if the facility had qualified staff in sufficient numbers to assure the resident was provided necessary care and services, based upon the comprehensive assessment and care plan, to prevent or treat pressure ulcers.

**42 CFR 483.40(a)(1), F385, Physician Supervision**

Determine if the physician has assessed and developed a treatment regimen relevant to preventing or healing a pressure ulcer and responded appropriately to the notice of changes in condition.

**42 CFR 483.75(i)(2), F501, Medical Director**

Determine whether the medical director assisted the facility in the development and implementation of policies and procedures for pressure ulcer prevention and treatment, and that these are based on current standards of practice; and whether the medical director interacts with the physician supervising the care of the resident if requested by the facility to intervene on behalf of the resident with a pressure ulcer(s).

# Pressure ulcers: Critical thinking strategies to determine Root Cause

## Starting points

- There is no “silver bullet” remedy for prevention or treatment of pressure ulcers. Successful pressure ulcer management requires a sound understanding of causative factors and an individualized plan of care that is routinely monitored for on-going effectiveness.
- New pressure ulcers can be disturbing for all and often emotion and fear result in knee-jerk reactions in hopes of a fast remedy. Knee-jerk reactions rarely result in an effective remedy.
- Understanding of the medical, physical, and psychosocial attributes of the human body and those interconnected relationships that result in homeostasis and subsequent overall integumentary health is necessary to determine true causative factors, identify accurate wound type, and provide appropriate and realistic anticipated wound outcomes.
- Pressure ulcer knowledge including ongoing pressure ulcer processes and expected standards of care amongst all leadership and care staff is required for sustainable outcomes.

## Groundwork knowledge

- In some cases, a new pressure ulcer on a human body can be a ‘symptom’ of absent or decreasing homeostasis; whether it is medical, psychosocial, and/or function compromise. In other words, the human body is on a downward cascade with dwindling reserve. Fit, healthy, mobile individuals in a state of homeostasis will not develop a pressure ulcer.
  - Although some pressure ulcers may be ultimately medically unavoidable, the facility should have sound documentation to support that the pressure ulcer is unavoidable\* based on risk assessment(s), individualized interventions and on-going monitoring of interventions.
- It is well understood that those residing in institutions such as Nursing Facilities often have a myriad of co-morbid conditions and subsequent medications that impact health, mobility, and psychosocial well-being. The facility is responsible to recognize the lack of homeostasis (risk) and employ specific interventions and strategies to prevent impairments in skin integrity (pressure ulcer). New pressure ulcers within a facility may represent a ‘symptom’ of facility processes. This may include lack of staff knowledge, leadership oversight of processes, existing processes for basic interventions like turning or heel off-loading, skin checks, risk assessment, monitoring interventions for tissue tolerance, effective or adequate equipment (beds, surfaces, seat cushions, heel off-loading devices, turning devices) and effective communication strategies. **It is important to note that avoidable pressure ulcers do not occur in facilities with appropriate equipment and sound established processes that are consistently performed by a competent interdisciplinary professional team with strong leadership support.**

## Step 1: Determine whether the issue was patient specific and isolated or facility specific and systemic.

### Systemic

2 or more pressure ulcers on 1 unit within 2 weeks

### Isolated

1 new In-House Acquired (IHA) pressure ulcer on 1 patient within 2 weeks

## Steps to determine if event is more likely 'Isolated': Select sample of 5-10 residents on same unit that are immobile, non-ambulatory, or limited mobility

- Audit Treatment Administration Records (TAR) or Electronic Medical Records (EMR) for consistency and compliance of skin checks.
- Perform skin checks on a sample of residents
- Interview direct caregivers such as Certified Nursing Assistants (C.N.A.) caring for the sample residents to determine their knowledge level. An example of a questionnaire is provided.
- Audit compliance of turning/repositioning for the sample residents during a 24–48 hour period.
- Audit incontinence care. Either assist at bedside to observe skin care, or conduct an interview session as appropriate.
- Audit heel off-loading compliance
- Audit Risk Assessment/Braden for completion and accuracy

If the above findings are satisfactory, the IHA pressure ulcer was more likely an isolated patient event rather than a systemic process issue.

If event was deemed isolated, the patient's medical record should be reviewed to aid in ensuring the plan of care is appropriate.

### Isolated event: Next step

#### Question 1: Was the ulcer caused by pressure or pressure and shear?

- Is or was patient or the patient's body part immobile?
- Evaluate location of the ulcer. Is it directly from positioning in bed? Chair? Shoe? Device?
- Observe the patient in actual supine, side lying, sitting, and with their devices (splints, braces, etc). Is the specific area of breakdown consistent with applied external force?
- Determine if the patient had a recent period of immobility, including just prior to admission. Consider falls at home, rhabdomyolysis, and surgical procedures > 4 hours.

#### No/unsure

- **Rationale:** Not all ulcers are from pressure. If the cause was clearly not from pressure, do NOT label as pressure.
- **Determine wound type:** Review with the patient's physician, nurse practitioner. In the case that the wound type is unclear, a wound consultation by a Certified Wound Specialist (CWS) may be helpful to determine wound type. Obtain final wound type diagnosis by the patient's physician, nurse practitioner.
- **Document:** In cases where a wound is deemed to be NOT pressure, but has characteristics of pressure, the rationale should be documented.
- **Communicate:** Provide education on wound type, plan of care, prognosis, interventions, treatments, etc. with interdisciplinary team, patient and responsible party

#### Yes

- **Rationale:** In the case that wound type is deemed pressure, a full evaluation should be completed to determine the extent of the issue, mitigate the pressure cause, determine plan of care and wound type prognosis and communicate effectively with the interdisciplinary team, the patient, and the family.

- **Next steps:**
  - **What stage was the pressure ulcer found?**
  - **Medical Evaluation:** A medical evaluation should be completed to determine contributing factors of both the breakdown of the integumentary system as well as to determine the potential wound prognosis. This may include laboratory findings, vascular exam, biopsy, medication review, review of current disease states, kidney function, and blood sugars.
  - **Nutritional evaluation**
  - **Functional evaluation**
  - **Behavioral evaluation**
  - **Plan of Care** Interventions such as bed, surface, seat cushion, splints, devices, turning schedules, and continence products.
- **Determine any changes to the Plan of Care.** Obtain necessary orders and update as appropriate.
- **Determine medical causation of the pressure ulcer.** Based on overall findings, determining if the ulcers were medically avoidable.
- **From a regulatory perspective, determine whether the pressure ulcer was *avoidable*\* or *unavoidable*\*\*.** Consider if risk factors were identified properly before breakdown and appropriate interventions provided, monitored and re-evaluated.
- **Communicate and educate:** to the inter-disciplinary team, the patient, and responsible party.
- **Document findings:** Update orders and Care Plan as needed. Report findings to supervisor/director and contact risk management if needed.

## Systemic event

### Step 1: Full house skin review to identify the baseline of wound status

- A full skin review includes inspections/skin assessments of every resident to determine any new or unknown skin conditions.

### Step 2: Evaluate findings

- How many pressure ulcers reported prior to skin review?
- How many new from skin review?
- Any trends noted?
  - Number found on each unit
  - Number on heels vs. number on sacrum
  - Severity/stages
- **For each patient with an existing pressure ulcer**
  - Review the previous skin check documentation including whether it was completed, when it was completed, and the person who completed it.
  - If found at a stage 3 or 4, interview direct caregivers for more information on skin findings.
  - Review specific risk assessments for accuracy.
  - Review specific care plans for appropriate interventions.
  - Observe interventions in practice.

- **For each patient with a new pressure ulcer**
  - Certified Wound Specialist, physician, or nurse practitioner to evaluate with interdisciplinary team to ensure
    - Wound type
    - Wound prognosis
    - Contributing factors
    - Appropriate treatment and interventions
    - Guide in communication and education
    - Provide and/or guide in documentation

### **Step 3: Evaluate center-wide processes**

- Does facility have a turning program?
- Does leadership routinely audit turning?
- To whom does direct caregiver report skin findings?
- Does direct caregivers have consistent residents?
- How does the direct caregiver know how and when to turn?
- How does the direct caregiver know how and when to off-load a heel?
- What products are available for heel off-loading? Where are they stored? Who can get them?
- What are the basic skin products used and where are they found?
- Evaluate all standard surfaces, are they viable?
- Evaluate for specialty surfaces, are they working? How are they set? How are they obtained?
- Evaluate mobility: is it encouraged? Who is on RNP for ambulation? Review RNP, observe to validate program.
- Evaluate for wheelchair cushions, are they used 100%? Are they viable?
- Observe meals, determine if residents receive the time and assistance required.
- Does the facility have consistent weekly wound rounds?
  - Observe rounds: are nurses able to accurately determine wound type and stage?
  - Observe treatments. Is pain managed? Privacy provided? Treatment performed as per order and manufacturers insert? Aseptically as per policy?

### **Step 4**

- Summarize findings and discuss with the Interdisciplinary Team
- Establish a process improvement plan (Refer to PIP)
- Set goals and time-line
- Determine action plan for implementation
- Review progress (daily or weekly)
- Determine long term strategy to sustain improvements

# QAPI Performance Improvement Plan: Skin concerns form

	Date	Problem	Interventions	Responsible party	Comments	Resolution date
<b>S.A.F.E.R. Method</b>						
<b>Select – performance measure</b>		In house acquired pressure areas.				
<b>Analyze – data</b>		Review actual data for accuracy and benchmark.	1. Complete skin review for a baseline skin statistics.			
			2. Compile and review skin statistics for trends and patterns.			
			3. What issues were identified? Examples: lack of nutrition, turning and repositioning not completed, lack of frequent assessment, heels not floated, lack of restorative program or therapy, lack of incontinence program, lack of preventative skin integrity program, appliances not in place for bed and chair. These are examples and not all inclusive.			
<b>Find – opportunities for improvement</b>			Based on analysis of data identify the area or areas for improvement.			
<b>Execute – actions</b>			1. Initiate root cause analysis and investigative tool for all skin areas identified.			
			2. Reevaluate all residents for risk factors (AMFA).			
			3. Implement a turning and repositioning program.			
			4. Monitor weekly skin assessments.			
			5. Reeducate staff on skin integrity program.			
			6. Review all at risk residents for devices such as mattresses and chair cushion.			
			7. RD review. Evaluate nutritional needs and need for further supplements.			
			8. Wound specialist assessment and orders.			
			9. Evaluate all treatments for appropriateness based on the wound assessment.			
			10. Review for appropriate staging.			
			11. Review for formulary compliance for appropriate treatment.			
			12. Review the products for enough product in house to provide treatment.			
			13. Review lifting and position of residents. Education may be needed.			
			14. Review incontinence program.			
			15. Competencies on wound treatments.			
			16. Review treatment if no improvement in two weeks for change if appropriate.			
			17. Monitoring program based on individual intrinsic risk factors.			
<b>Reevaluate – improvement or requires additional changes</b>			Review statistics monthly in QAPI meeting for improvement. Reevaluate if the facility continues to develop new pressure areas.			

Date	Problem:	Interventions	Responsible party	Comments	Resolution date
<b>Prevention</b>					
	1. Practitioner assessment for nonmodifiable comorbid conditions and risk factor unaviodability).				
	2. Get an accurate preadmission summary/history to prepare for prevention of the resident on admission.				
	3. Risk assessment on admission				
	4 Weekly skin assessments by licensed nurse.				
	5. Daily skin checks by nurse aides.				
	6. Individualized turning and repositioning.				
	7. Therapy program				
	8. Skin program including cleansing and barriers.				
	9. Incontinence program.				
	10. Nutritional review by registered dietitian.				
	11. Wound specialist on staff or contract for expertise and treatment recommendations.				
	12. Medication review				
	13. Laboratory testing as appropriate.				
	14. Ensure skin team training is appropriate. No one nurse can prevent pressure ulcers. It is a team program.				
	15. Utilize wound providers to ensure appropriate treatment for all pressure ulcers.				
	16. Assure there is an agenda for the wound meeting.				
	17. Communication system for any skin areas – assure that this communication is timely for early intervention.				
	18. Care plan individualized interventions for skin integrity.				
	19. Daily skin checks by certified nursing assistance.				
	20. Weekly skin assessment by licensed staff.				
	21. Monitoring program for all prevention.				

## Pressure ulcers: Data collection guidelines

Data collection related to any quality assurance program is key to the success of your performance improvement plan (PIP). In relationship to pressure ulcers, specific parameters should be utilized for baseline comparative data.

- Initially, it is important to determine whether there is a potential issue with facility acquired pressure ulcers. Recommendations include completing an entire house skin review to validate that the in house pressure ulcers are accurate. Then, clarify that the areas identified are actually pressure ulcers, and that they are staged appropriately. The competency of the staff staging ulcers should be validated to ensure accurate and consistent staging. A standard skin tracking tool should be utilized at least weekly to review the statistics.
- Validate that in-house developed pressure ulcer statistics are accurate. If accurate, set the benchmark for your organization of the threshold number of ulcers. That will be your goal for your PIP. Review the in house pressure ulcers for avoidable and unavoidable areas related to disease process and comorbidities.
- Develop your PIP. Collect the same data weekly to evaluate the effectiveness of the performance improvement plan. If your statistics are not improving, you must reevaluate your plan and adjust for further interventions for meeting your goal.

See Appendix IV for a sample data collection form.



## CMS compliance templates

The following templates were developed by members of the Professionals Dedicated to Quality Wound Care (PDQWC). Having reviewed the key components of the QAPI initiative, PDQWC members identified several areas where checklists and guidelines could be of benefit. The following templates were designed to provide examples of the types of documents that may be used to collect and measure data. Effective data collection can help to ensure that decision-making is based on statistics rather than thoughts or opinions. These forms should be customized to reflect the unique needs of your facility.

- I. QAPI meeting minutes template**
- II. QAPI Performance Improvement Projects (PIPs) template**
- III. QAPI attendance record template**
- IV. QAPI data collection template**
- V. QAPI self-assessment tool template**

# Appendix I: QAPI meeting minutes template

Internal use – Quality Assurance purposes only.

## I. Approval of previous minutes

Motion to accept minutes as presented by \_\_\_\_\_

Motion seconded by \_\_\_\_\_

## II. Old business

	System	Issue	Start date	Progress	Date resolved
PIP # 1					
PIP # 2					
PIP # 3					
PIP # 4					
PIP # 5					
PIP # 6					

System	Bench Mark	In Compliance		If No – PIP in place Date put into Place	Comments
		Yes	No		
State reportables					
Grievances					
Pressure ulcers					
Falls					
Incident reports					
Restraint reduction					
Weight loss					
Drug regimen review					
Medication errors					
Dietary consultant report					
Anti-psychotic drug reduction					
Return to acute					
Documentation compliance					
Education					
Survey					
<b>Infection control (identified trends brought to QAPI from infection control meeting)</b>					
Healthcare acquired infection					
UTI					
UTI with catheter					
MDRO's including C-Diff					
Environmental and dietary surveillance					
<b>Safety (identified trends brought to QAPI from safety meeting)</b>					
Fire drills					
Elopement drills					
Disaster drills					
Monthly safety inspection reports					
Generator testing					
Other					

# Appendix II: QAPI Performance Improvement Projects (PIPs) template

Internal use – Quality Assurance purposes only.

## S.A.F.E.R. – Select, Analyze, Find, Execute, Reevaluate

**Select performance measures.** Requires identifying top priorities for improvement, data to be collected and individuals responsible for various performance improvement.

System \_\_\_\_\_ Date identified \_\_\_\_\_

Department responsible \_\_\_\_\_

Scope of priority for improvement

Priority 1  Priority 2  Priority 3  Priority 4

Insert goal/objective here:

**Analyze the data.** Requires gathering and analyzing data to determine if a process is producing the desired results. Is the facility following policies, procedures and meeting internal and organizational benchmarks.

Insert information here:

Number of residents affected \_\_\_\_\_ Number of residents that have the potential to be affected \_\_\_\_\_

**Find opportunities for improvement.** Requires identifying the processes that need to be corrected or redesigned and determine possible causes of identified issues in these processes. Utilize **Root Cause Analysis**.

Insert information here:

**Execute actions.** Requires developing action plan, assigning responsibility providing education and executing actual improvements. Implementation of changes or corrective action to the system must be made for improvements. Implementation of changes or corrective action to the system must be made resulting in improvement or reduction of risk for the event to reoccur. This is often the most challenging step in the QAPI process. Choose interventions that are closely tied to the root cause. These interventions should lead to an overall change in the system or process. Remember the goal is to make changes that will lead to lasting improvement. The interventions or corrective actions should target the elimination of the root cause, offer long term solutions, and have a greater positive effect on the system or process. Interventions must be achievable, objective and measurable.

Action 1 \_\_\_\_\_ Due date \_\_\_\_\_

Person responsible \_\_\_\_\_

Action 2 \_\_\_\_\_ Due date \_\_\_\_\_

Person responsible \_\_\_\_\_

Action 3 \_\_\_\_\_ Due date \_\_\_\_\_

Person responsible \_\_\_\_\_

Action 4 \_\_\_\_\_ Due date \_\_\_\_\_

Person responsible \_\_\_\_\_

**Reevaluate performance.** Requires monitoring improvement and validating that the improvement is effective and may involve making additional changes to achieve the desired outcome.

Reevaluation date \_\_\_\_\_

Resolved?  Yes  No

Continue with plan?  Yes  No

If No, what is new plan? \_\_\_\_\_

Reevaluation date \_\_\_\_\_

Resolved?  Yes  No

Continue with plan?  Yes  No

If No, what is new plan? \_\_\_\_\_

# Appendix III: QAPI attendance record template

Internal use – Quality Assurance purposes only.

Facility name \_\_\_\_\_ Date \_\_\_\_\_

The Quality Assurance Performance and Improvement meeting was called to order \_\_\_\_\_ am/pm  
on \_\_\_\_\_ in the year of \_\_\_\_\_

Title	Signature
Medical Director	
Administrator	
Director of Nursing	
Assistant Director of Nursing	
Assistant Director of Nursing	
Dietary Supervisor	
Housekeeping Supervisor	
Activity Director	
Maintenance Supervisor	
Social Services	
Nurse Assessment Coordinator	
Staff Development Coordinator	
Direct Care Staff	
Direct Care Staff	
Direct Care Staff	
Other	
Other	
Other	

Motion to adjourn by \_\_\_\_\_ Motion to seconded by \_\_\_\_\_

Adjourned at \_\_\_\_\_ am/pm

# Appendix IV: QAPI data collection template

Internal use – Quality Assurance purposes only.

Please insert the number or percentage for the appropriate month.

System	January	February	March	April	May	June	July	August	September	October	November	December
State reportables												
Grievances												
Staff turn over												
<b>Incident reports</b>												
Falls												
Skin tears												
Bruises of unknown origin												
Medication errors												
In-house acquired pressure ulcers												
Return to acute												
Point of care compliance												
Silver chair compliance												
<b>Infection control</b>												
Healthcare acquired infection												
UTI												
UTI with catheter												
LRI/pneumonia, VAP's												
C-Diff infections												
MDRO's (from IC report)												

# Appendix V: QAPI self-assessment tool template

**Directions:** Use this tool as you begin work on QAPI and then for annual or semiannual evaluation of your organization’s progress with QAPI. This tool should be completed with input from the entire QAPI team and organizational leadership. This is meant to be an honest reflection of your progress with QAPI. The results of this assessment will direct you to areas you need to work on in order to establish QAPI in your organization. You may find it helpful to add notes under each item as to why you rated yourself a certain way.

Date of review \_\_\_\_\_ Next review scheduled for \_\_\_\_\_

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
Our organization has developed principles guiding how QAPI will be incorporated into our culture and built into how we do our work for example we can say that QAPI is a method for approaching decision making and problem solving rather than considered as a separate program. Notes:					
Our organization has identified how all service lines and departments will utilize and be engaged in QAPI to plan and do their work. For Example, we can say that all service lines and departments use data to make decisions and drive improvements and use measurement to determine if improvement efforts were successful. Notes:					
Our organization has developed a written QAPI plan that contains the steps that the organization takes to identify, implement and sustain continuous improvements in all departments: and is revised on a ongoing basis. For example, a written plan that is done purely for compliance and not referenced would not meet the intent of a QAPI plan. Notes:					
Our board of directors and trustees (if applicable) are engaged in and supportive of the performance improvement work being done in our organization. For example, it would be evident from meeting minutes of the board or other leadership meetings that they are informed or what is being learned from the data and they provide input on what initiatives should be considered. Other examples would be having leadership (board or executive leadership) representation on performance improvement projects or teams and providing resources to support QAPI. Notes:					
QAPI is considered a priority in our organization. For example, there is a process for covering caregivers who are asked to spend time on improvement teams. Notes:					
QAPI is an integral component of new caregivers orientation and training. For example, new caregivers understand and can describe their role in identifying opportunities for improvement. Another example is that new caregivers expect that they will be active participants on improvement teams. Notes:					
Training is available to all caregivers on performance improvement strategies and tools. Notes:					
When conducting performance improvement projects, we make a small change and measure the effect of that change before implementing more broadly. An example of a small change is pilot testing and measuring with one nurse, one resident, on one day, or one unit, a and then expanding the testing based on the results. Notes:					
When addressing performance improvement opportunities, our organization focuses on making changes to systems and processes rather than focusing on addressing individual behaviors. For example, we avoid assuming that education or training of an individual is the problem, instead we focus on what was going on at the time that allowed a problem to occur and look for opportunities to change the process in order to minimize the chance of the problem recurring. Notes:					
Our organization has established a culture in which caregivers are held accountable for their performance, but not punished for errors and do not fear retaliation for reporting quality concerns. For example, we have a process in place to distinguish between unintentional errors and intentional reckless behavior and only the later is addressed through disciplinary actions. Notes:					
Leadership can clearly describe, to someone unfamiliar with the organization, our approach to QAPI and give accurate and up-to-date examples of how the facility is using QAPI to improve quality and safety of resident care. For example, the administrator can clearly describe the current performance improvement initiatives, or projects and how the work is guided by caregivers involved in the topic as well as input from residents and families. Notes:					

Rate how closely each statement fits your organization	Not started	Just starting	On our way	Almost there	Doing great
<p>Our organization has identified all of our sources of data and information relevant to our organization to use for QAPI. This includes data that reflects measures of clinical care; input from caregivers, residents, families and stakeholders, and other data that reflects the services provided by or organization. For example, we have listed all available measures indicators or sources of data and carefully selected those that are relevant to our organization that we will use for decision making. Likewise, we have excluded measure that are not currently relevant and that we are not actively using in our decision making process.</p> <p>Notes:</p>					
<p>For the relevant sources of data we identify, our organization sets targets or goals for desired performance, as well as thresholds for minimum performance. For example, our goal for resident ratings for recommending our facility to family and friends is 100% and our threshold is 85% (meaning we will revise the strategy we are using to reach our goal if we fall below this level).</p> <p>Notes:</p>					
<p>We have a system to effectively collect, analyze; and display our data to identify opportunities for our organization to make improvements. This includes comparing the results of the data to benchmarks or to our internal performance targets or goals. For example, performance improvement projects or initiatives are selected based on facility performance as compared to national benchmarks, identified best practice to applicable clinical guidelines.</p> <p>Notes:</p>					
<p>Our organization has or supports the development of , employees who have skill in analyzing and interpreting data to assess our performance and support our improvement initiatives. For example, our organization provides opportunities for training and education on data collection and measurement methodology and caregivers involved in QAPI.</p> <p>Notes:</p>					
<p>From our identified opportunities for improvement, we have a systematic and objective way to prioritize the opportunities in order to determine what we will work on. This process takes into consideration input from multiple disciplines, residents and families. This process identifies problems hat pose a high risk to residents or caregivers, is frequent in nature or otherwise impact the safety and quality of life of the residents.</p> <p>Notes:</p>					
<p>When a performance improvement opportunity is identified as a priority, we have a process in place to charter a project. This charter describes the scope and objectives of the project so the team working on it has a clear understanding of what they are being asked to accomplish.</p> <p>Notes:</p>					
<p>For our Performance Improvement Projects, we have a process in place for documenting what we have done, including highlights, progress and lessons learned. For example, we have project documentation templates that are consistently used and filed electronically in a standardized fashion for future reference.</p> <p>Notes:</p>					
<p>For every Performance Improvement Project, we use measurement to determine if changes to systems and process have been effective. We utilize both process measures and outcome measures to asses impact on resident care and quality of life. For example, if making a change we measure whether the change has actually occurred and also whether it has had the desired impact on the residents.</p> <p>Notes:</p>					
<p>Our organization uses a structured process for identifying underlying causes of problems, such as Root Cause Analysis.</p> <p>Notes:</p>					
<p>When using Root Cause Analysis to investigate an event or problem, our organization identifies system and process breakdowns and avoids focus on individual performance. For example, if an error occurs, we focus on the process and look for what allowed the error to occur in order to prevent the same situation form happening with another caregiver and another resident.</p> <p>Notes:</p>					
<p>When systems and process breakdowns have been identified, we consistently link corrective actions with the system and process breakdown, rather than having our default action focus on training education, or asking caregivers to be more careful or remember a step. We look for ways to assure that change can be sustained. For example, if a policy or procedure was not followed due to distraction or lack of caregivers, the corrective action focuses on eliminating distraction or making changes to staffing levels.</p> <p>Notes:</p>					
<p>When corrective actions have been identified, our organization puts both process and outcome measures in place in order to determine if the change is happening as expected an that the change has resulted in the desired impact to resident care. For example, when making a change to care practices around fall prevention that is a measure looking at whether the change is being carried out and a measure looking a the impact on fall rate.</p> <p>Notes:</p>					
<p>When an intervention has been put in place and determined to be successful, our organization measures whether the change has been sustained. For example, if a change is made to the process of medication administration, there is a plan to measure both whether the change is in place, and have the desired impact (this is commonly done at 6 or 12 months).</p> <p>Notes:</p>					

\*The Centers for Medicare & Medicaid define "Unavoidable" as; the resident developed a pressure ulcer even though the facility had evaluated the resident's clinical condition and pressure ulcer risk factors; defined and implemented interventions that are consistent with resident needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate.

\*\*The Centers for Medicare & Medicaid define "Avoidable" as; the resident developed a pressure ulcer and that the facility did not do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with resident needs, resident goals, and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate.

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