Hospital Patient Safety Initiatives: Quality Assessment and Performance Improvement

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• Related to three Conditions of Participation (CoPs)
  – 482.21 Quality Assessment and Performance Improvement (HFAP Hospital Chapter 12)
  
  – 482.42 Infection Control (HFAP Hospital Chapter 7)
  
  – 482.43 Discharge Planning (HFAP Hospital Chapter 15)
Worksheet Purpose

• Reduce hospital acquired conditions (HAC) including hospital acquired infections (HAI) and preventable readmissions.

• Designed to assist surveyors and hospital staff to identify when and where compliance is an issue.
CMS Worksheet Development

- Was in draft form until midyear 2013

- Currently in use by state surveyors and accrediting agencies.
CMS Worksheets:

• Facilitate recording of observations by surveyors

• Are a self-assessment tool
Findings

• Hospitals with higher readmission rates may be at greater risk for noncompliance with all three CoPs.

• The tools assist facilities in focusing on key issues that impact positive patient outcomes and thereby compliance.
Verification Methods

• Interview

• Observation

• Topic Specific Document Review

• Medical Record Review

• Other Document Review
Hospital Patient Safety Initiatives

• Quality Assessment and Performance Improvement

• Infection Control

• Discharge Planning
HOSPITAL PATIENT SAFETY INITIATIVE

FIVE SECTIONS:

1.0 HOSPITAL CHARACTERISTICS

3.0 DATA COLLECTION AND ANALYSIS—QUALITY INDICATOR TRACERS

4.0 APPLYING QUALITY INDICATOR INFORMATION—ACTIVITIES AND PROJECTS

5.0 PATIENT SAFETY—ADVERSE EVENTS AND MEDICAL ERRORS

6.0 BROAD QAPI REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES
3. DATA COLLECTION AND ANALYSIS—QUALITY INDICATOR TRACERS

• NINE QUESTIONS IN FIRST PART OF THIS SECTION

• ALL NINE TRACER QUESTIONS SCORED IN THE FOLLOWING STANDARDS:
  – 12.00.03 Program scope
  – 12.00.09 Program accountability
  – 12.00.10 Program Data
  – 12.00.12 Data Collection
3. DATA COLLECTION AND ANALYSIS—QUALITY INDICATOR TRACERS, cont.

- Select three quality indicators

- Focus on indicators related to quality activities or projects

- Select indicators that have been in place long enough to be able to answer to questions of data collection and analysis over time.
3. DATA COLLECTION AND ANALYSIS—QUALITY INDICATOR TRACERS, cont.

• Can you provide evidence that each quality indicator is related to improved health outcomes?

• Is the scope of data collection appropriate to the indicator? *(Is data being collected from all applicable areas?)*

• Is the method and frequency of data collection specified? *(observations, chart review)*
3. DATA COLLECTION AND ANALYSIS—QUALITY
INDICTOR TRACERS, cont.

• Is the data actually collected as specified? (timely, complete)

• If unit staff collect data, is it done consistent with specifications?

• Has the data been aggregated consistent with hospital specified methodology?
3. DATA COLLECTION AND ANALYSIS—QUALITY INDICATOR TRACERS, cont.

- Has the collected data been analyzed?

- If the indicator measures rate, has the rate been calculated for points in time over time and then compared to benchmarks?

- When feasible, is data broken into subsets for comparison? (restraint or fall data by unit)
3. DATA COLLECTION AND ANALYSIS—QUALITY INDICTOR TRACERS, cont.

- ADDITIONAL FOUR QUESTIONS IN SECTION THREE

- REMAINING FOUR TRACER QUESTIONS SCORED IN THE FOLLOWING STANDARDS:
  - 12.00.10 Program Data
  - 12.00.13 Program Activities
  - 12.00.15 Sustained Improvements
3. DATA COLLECTION AND ANALYSIS—QUALITY
   INDICTOR TRACERS, cont.

- If data indicates required improvement, have interventions been instituted? (quality team, unit project, process change)

- Have the interventions been evaluated for effectiveness?
3. DATA COLLECTION AND ANALYSIS—QUALITY INDICATOR TRACERS, cont.

- If interventions were unsuccessful in improving outcomes, were additional interventions instituted?

- If interventions were successful, was the indicator monitored for sustained improvement?
Total of 5 questions in section 4.

- Can you provide evidence that improvement activities focus on areas that are high risk, high volume or problem prone?

Surveyor will look at top DRGs and risk management reports to determine if quality initiatives are related to identified issues.

Scored at 12.00.13
4.0 APPLYING QUALITY INDICATOR INFORMATION—ACTIVITIES AND PROJECTS

3 Questions in this subsection, scored at 12.00.16

• Can the hospital provide evidence that it conducts distinct performance improvement projects?

Provide a list of projects.
4.0 APPLYING QUALITY INDICATOR INFORMATION—ACTIVITIES AND PROJECTS

• Is the number of projects proportional to the scope and complexity of the facility?

And

• Does the scope of projects reflect the complexity of the facility?

The surveyor will review the performance improvement projects to determine that they are representative of the scope and complexity of the hospital.
4.0 APPLYING QUALITY INDICATOR INFORMATION—ACTIVITIES AND PROJECTS

1 Question in this subsection scored at 12.00.18

• Can the hospital provide evidence showing why each project was selected?

*QIO cooperative projects and IT projects do not require rationale.*
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

5.1 Does hospital leadership set expectations for patient safety? -- 3 questions scored at 12.00.21

- Is there evidence of widespread staff training/communication to convey expectations for patient safety to all staff?

*Review of staff education/HR file*
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of medical errors? (also 12.00.22) *Policy review, staff education, staff interview.*

• On each unit surveyed, can staff explain what the hospital’s expectations are for their role in promoting patient safety? *Interview*
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• The governing body must provide strong, clear, and visible attention to setting expectations for safety and for allocating adequate resources for measuring, assessing, improving, and sustaining the hospital’s performance and for reducing risks to patients.

• The medical staff and Administrative officials must be held accountable for the implementation of an effective program consistent with Governing Body direction that demonstrates a sustained improvement in patient outcomes and a reduction in medical errors.
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

5.2 Does the hospital have a systematic process to identify medical errors including near misses or close calls and adverse events on an ongoing basis? 10 questions in subsets

- On each unit/program surveyed, can staff describe what is meant by medical errors?

Staff Interview and policy review
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• On each unit/program surveyed, can staff explain how and/or to whom they should report medical errors? **Staff Interviews and policy review**

• Does the hospital employ methods, in addition to staff incident reporting, to identify possible medical errors? **Interviews and document review**
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Can the hospital provide evidence of medical errors and adverse events identified through staff reports or other methods? *Document Review*
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

The surveyor will review documents and interview the quality manager. Verify:
The hospital has a method for tracking, analyzing, implementing corrective strategies / preventive actions, providing feedback, and training.

• Scored at 12.00.09 & 12.00.14
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Is there QAPI program collaboration with infection control officers to identify and track avoidable healthcare-acquired infections? *Document Review*

• Is there evidence that problems identified by infection control officers are addressed through QAPI program activities? *Document Review*

Scored at 12.00.09 and 07.01.04
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Does the QAPI program identify and track medication administration errors, adverse drug reactions and drug related incompatibilities?

Review of quality reports.
Scored at 12.00.09, 12.00.23 & 25.01.10
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Is there a QAPI program process for staff to report blood transfusion reactions to identify medical errors?

*Review quality reports*

Scored at 12.00.09 & 16.01.06
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Did the survey team have prior knowledge of or identify while on site serious preventable adverse events that the hospital failed to identify?

*Document review/chart review*

Score at 12.00.09 & 12.00.23
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Has the hospital conducted causal analyses of all serious preventable adverse events it has identified?

*Review serious preventable events for completion of a root cause analysis*

Scored at 12.00.09 & 12.00.23
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

5.9 Has the hospital conducted any causal analysis in the 12-24 months prior to the survey date? If no, skip to Section 6.0 Otherwise, do tracers on up to three events, one of which should have sufficient time since the occurrence to evaluate the impact and implement changes if necessary.
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

6 questions scored at 12.00.23, 12.00.09 & 12.00.14

• Has the hospital identified potential underlying causes?
• Has the hospital identified all parts of the hospital utilizing similar processes/at similar risk?
• Has the hospital developed and implemented preventive actions based on the analysis in at least one area of the hospital?
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Has the hospital evaluated the impact of the preventive actions, including tracking reoccurrences of similar events/near misses?

• If evaluation showed the interventions did not meet goals, did the hospital implement a revised intervention and evaluate it?
5.0 PATIENT SAFETY--ADVERSE EVENTS AND MEDICAL ERRORS

• Has the hospital implemented preventive actions found to be effective in all parts of the hospital utilizing similar processes/at similar risk, unless there are documented reasons for not doing so?
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

11 Questions in 5 subsections

• Is there evidence that the hospital has a formal QAPI program including written policies and procedures, budget resources, and clearly identified responsible staff-approved by the governing body after input from the CEO and medical staff leadership.
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

The surveyor will review the governing body mission, bylaws, annual report and minutes to determine the requirement was met.

Lack of appropriate direction from the board, or appropriate involvement and intervention by medical staff or the administrative officials will be scored here. Scored at 12.00.21
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

- Has the hospital maintained and made available for surveyor review evidence of its QAPI program?

The surveyor will review the QAPI program for involvement at all levels—Governance, Medical Staff, Administration and hospital staff.

Scored at 12.00.01 COP
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

Is the program hospital-wide?

• Using information on services offered from the Hospital/CAH Data Base Worksheet, can the QAPI manager provide evidence of QAPI monitoring related to each service?
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

The Hospital/CAH Medicare Database Worksheet, Exhibit 286 is an important tool used by the Centers for Medicare & Medicaid Services (CMS) to gather detailed information about hospitals and critical access hospitals (CAHs) participating in Medicare. It is completed by the State Agency or, in some limited cases, by the CMS Regional Office and included in the initial certification package for each hospital and CAH. It must be updated each time the State Agency is on site completing a full standard survey – i.e., an initial, recertification, or validation survey.

Search “Hospital/CMS Data Base Worksheet”
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

The surveyor must validate that all hospital departments, including ambulatory sites, and contract services participate in the QAPI program.

Scored at 12.00.01 COP
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

• Using information from the hospital identifying services provided under arrangement, can the QAPI manager provide evidence of QAPI monitoring for each service related to clinical care provided under contract or arrangement? (administrative services are not required to be included)
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

The QAPI plan addresses a broad scope and includes any clinical or clinical support services provided under contractual arrangement.

Scored at both 12.00.01 COP and 01.00.28
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

• Is there evidence that the governing body, Hospital CEO, Medical Staff leadership, and other senior administrative officials including the CNO play a role in QAPI program planning and implementation?
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

The surveyor will review:

the governing body mission, bylaws, annual report and minutes to determine the requirement was met. Lack of appropriate direction from the board, or appropriate involvement and intervention by medical staff or the administrative officials will be scored here.

QAPI related education provided to the administrative team, governing board, medical staff, and hospital line staff.

Scored at 12.00.04 & 12.00.21
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

Is there evidence that the hospital’s governing body:

• approves the QAPI program indicators selected and frequency of data collection?

_The surveyor will review governance minutes and attachments to verify the indicators and reporting frequency for all departments including contract services have been approved annually._

Scored at 12.00.12
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

• Ensures the QAPI program annually determines the number of distinct QAPI projects to be conducted in the coming year?

• Actively reviews the results of QAPI data collection, analyses, activities, projects and makes decisions based on such review?
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

The surveyor will review the governing body mission, bylaws, annual report and minutes to determine the requirement was met.

The surveyor will want to see discussion by governance of issues identified.

Scored at 12.00.21
6.0  BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

• Holds the CEO accountable for the effectiveness of the QAPI program?

*The surveyor will review the CEO job description regarding this accountability. This standard would also be scored if it was apparent that the CEO was disengaged from the process or inadequate resources were provided to support the program.*

Scored at 01.00.17 & 12.00.21
6.0 BROAD REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES

Resource Allocation

- Is there evidence of the amount of resources (funding and personnel) dedicated to the hospital’s QAPI program and the functions for which those resources are used?
- If there are condition level QAPI program deficiencies, is there evidence that lack of QAPI resources are a significant contributing cause of these deficiencies?
The surveyor will verify that adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital’s performance and reducing risk to patients. If identified issues do not come to resolution and demonstrate improvement, or if significant events have occurred where it is apparent resources were an issue, the facility would be scored here.

Scored at 12.00.21 for both.
QUESTIONS?

Please submit questions to:

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