Don’t Re-Invent The Wheel to Meet QAPI Requirements
DecisionHealth Audio Conference

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Condition of Participation § 418.58

- Transparency of information
- Encourage patient-centered care
- Reduce adverse events and improve patient safety
- To ensure that hospice resources are being used effectively and efficiently
- Ability to Compare Provider Performance – Benchmark
- Evidence of quality

Data Driven Quality and Performance!
• **Use DATA to Improve Your Performance**
  ◦ Develop, implement, and maintain an effective, continuous quality assessment and performance improvement program
  ◦ Use proven and reliable tools and processes
  ◦ Monitor and improve performance continually
  ◦ Respond to the needs, desires, and satisfaction levels of the patients and families
  ◦ Ensure effectiveness and efficiency

**Condition of Participation § 418.58**
• **Surveyors will focus on;**
  ◦ Scope of program...include **ALL** pertinent indicators
  ◦ How and why you chose specific quality measures
  ◦ How you ensure consistent data collection
  ◦ How you use data in patient care planning
  ◦ How you aggregate and analyze data
  ◦ How you use the data analysis to select PI projects
  ◦ How you implement PI projects
  ◦ How you use data to evaluate the effectiveness of those projects

**Condition of Participation § 418.58**  
**Quality Assessment – Performance Improvement**
Develop A QAPI Plan

Include in the PI Plan;

- Who will be responsible for QAPI program
- What services and processes are to be assessed
- What data to be documented and aggregated
- When high volume, problem prone care and services provided
- How often data will be collected and analyzed and how will the findings be used
- How you will implement action plan findings into ongoing care plan development
- What method(s) will be used to evaluate improvement
- How often you will report on performance
• Incorporate all PI activities into one program
  ◦ Key Hospice demographic data collection and benchmarking
  ◦ Patient and Family Satisfaction
  ◦ Employee Satisfaction
  ◦ Physician Satisfaction
  ◦ Adverse Event Monitoring
  ◦ Process Outcomes
  ◦ Patient Outcomes

It’s All About The Data...
• Incorporate all PI activities into one program
  ◦ Processes within hospice (examples)
    • Timeliness of physician signature on certification of terminal illness
    • Timeliness of spiritual and bereavement assessment
    • Incorporation of IDT care plan updates to practice
  ◦ Patient symptom management
    • Not only at selected time points
    • Ongoing – incorporation into patient care
QAPI – It’s All About The Data

- **Infection**
  - Surveillance
  - Identification
  - Prevention,
  - Control and investigation of infections
    and communicable disease

- **Customer Concerns**

- **Adverse Events**
  - Falls – witnessed and un-witnessed
  - Unexpected death
  - Suicide
Examples of Important Clinical Functions

- Pain and Symptom management
- Administration of narcotics – titration of narcotics
- Use of standing orders
- Delivery and set up of medical equipment
- Management of Oxygen therapy in the home
- Transferring patients from bed to commode
- Administration of IV, IM and subque medications

Identify Important Aspects and Functions of Care
• **Measurable Indicators**
  ◦ Relevant to YOUR agency and YOUR patient population
• High volume and problem prone measures
• Potential areas of risk
• Processes and outcome measures common in your agency
  ◦ Include all settings as appropriate

• Automate data collection whenever possible using established databases whenever possible
  ◦ Demographics
  ◦ Selected indicators

**Select Measurable Indicators**
Incorporate All Levels of Care

- Routine home care
- Respite care
- General Inpatient Care
- Skilled Facility as Residence
- Continuous Care
  - Largest concentration of patients
  - Highest risk and / or problem prone
**Patient Centered – Ongoing Symptom Management**

- Visit note – insert into clinical assessments
- Communication note – telephone or telehealth contact
- Create yes / no responses
- Standardize assessments and responses
- Collate data
  - Present ongoing findings at staff meetings
  - Use findings in IDG to update care plans

**Incorporate Into Clinical Practice**
Small privately owned hospice
- Census of 25 patients
- Performance Improvement plan initiated
  - Infection control, surveillance, and analysis
  - Employee occurrence monitoring
  - Patient adverse events
Quarterly clinical record audits / Process measures

- Documentation of Local Coverage Determinations (LCD) for each patient
- Signed physician certification of terminal illness
- Presence of orders for care and treatment
- Timeliness of completion of interdisciplinary care plan
- Timeliness of necessary assessments
- Interventions implemented according to care plan

Performance Improvement Program
## Performance Improvement Calendar

<table>
<thead>
<tr>
<th>Patient Record Audit</th>
<th>Monthly Data Gathering</th>
<th>Quarterly Reporting</th>
<th>Bi-Annual Data Gathering</th>
<th>Annual Reporting</th>
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</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
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<td>X</td>
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<tr>
<td>Patient Referral</td>
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<td>Source</td>
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<td>Staff</td>
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<tr>
<td>Adverse Events</td>
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<td>Customer Concerns</td>
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<td>Process Measures</td>
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<tr>
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<tr>
<td>Initiatives</td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>
Symptom Management

- Edmonton Symptom Assessment (ESAS)
- We chose 3 measures to begin
  - Pain score and SOB ≥ 4; intervention within 4 hours, reassess at 24, and 48 hours as indicated.
  - Constipation; no bowel movement ≥ 4 days; intervention within 4 hours; assess in 24, 48 and 72 hours as indicated.
## Symptom Assessment Flow Sheet (with constipation)

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>ID#</th>
</tr>
</thead>
</table>

*Completed by: 1-Patient alone, 2-Caregiver-Assisted, 3-Health Professional-Assisted, 4-Caregiver alone, 5-Health Professional alone*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Completed by*

Pain

Fatigue

Nausea

Depression

Anxiety

Drowsiness

Shortness of breath

Appetite

Feeling of wellbeing

**Total Distress**

Other:

# days since last BM
Visit Note – Pain Assessment

**PAIN:** □ No Problem □ Unchanged □ Deferred

*Is patient experiencing pain?* □ Yes □ No □ Unable to communicate

*Non-verbals demonstrated:* □ Diaphoresis □ Grimacing □ Moaning/ crying □ Anger □ Irritability □ Guarding □ Tense □ Restlessness □ Change in VS □ Other

**PAIN LOCATION:** (specify site(s)):

**COLLECTED USING:** □ 1-10 scale (subjective)

**Intensity:**

<table>
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<tr>
<th>NONE</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0= no pain</td>
<td>1 - 3</td>
<td>4 - 6</td>
<td>7 - 9</td>
<td>10</td>
<td>10 = worse pain ever</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>(MILD)</td>
<td>(MODERATE)</td>
<td>(SEVERE)</td>
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</tr>
</tbody>
</table>

□ FACES scale (per CGs)

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Worse pain level past 24hrs: __________

Patient / caregiver current acceptable level of pain: __________

If level of pain ≥ 4 over past 24 hrs, is Pt / CG satisfied w/ pain control regimen? □ Yes □ No

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Visit Note – Pain Assessment

- **Type:** □ Aching □ Nagging □ Dull □ Heavy □ Crushing □ Sharp □ Stabbing □ Throbbing □ Radiating □ Burning □ Tingling □ Cramping □ Pressure
- **Frequency:** □ Occasionally □ Continuous □ Intermittent □ Other: _______________________
- **What makes pain worse:** □ Movement □ Ambulation □ Other: _______________________
- **What makes pain better:** □ Heat / ice □ Massage □ Repositioning □ Rest / relaxation □ Medication □ Diversion □ Other: _______________________
- **BREAKTHROUGH medication needed over past 24 hrs:** _______________________
- **ROUTINE Pain medications taken over past 24 hrs:** _______________________

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Visit Note – Pain Interventions

Interventions:
☐ Attending notified current pain regime not adequate; adjustment requested
☐ Medications ordered / re-ordered:_______________________________________
☐ New medication_______________________________________________________

☐ Medication Administered______________________________________________

Instructed Patient/ CG:
☐ How to assess patient’s pain level based on subjective or objective criteria
☐ Proper administration, use, desired effect, & potential side effects of medications used for symptom control
☐ Need for routine dosing of pain medication to prevent increasing pain levels
☐ Need for increasing frequency of dosing of pain medication to prevent frequent breakthrough pain
☐ Use of pain log to document breakthrough medication used for symptom mgmt.
☐ Pharmacological & non-pharmacological methods of alleviating pain & other sx.
☐ Call hospice nurse for any unrelieved symptoms
☐ Importance of maintaining pain & other medications in safe place to prevent diversion & accidental use.

Comments:_________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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Visit Note – SOB

**Respiratory:**
- **Lung sounds:** Clear, Crackles/rales, Rhonchi, Absent, Diminished, Clear, Crackles/rales, Rhonchi, Absent, Diminished
- **Cough:** None, Non-Productive, Productive, Amt: Small, Med, Lg
- **Able / Unable to cough up secretions:**

**Respiratory Status:**
- Accessory muscles used
- Death rattle
- Cheyne-Stokes
- Orthopnea
- Stridor/retractions
- Dyspnea at rest
- SOB with exertion/activity
- O2 ______L/min
- Periods of apnea _______seconds
- Inhalation Therapy
- PRN
- continuous

**SOB (Circle Degree)**
- Current: _______
- Last 24 hrs. _______

If level of dyspnea ≥ 4 over past 24 hrs is Pt / CG satisfied w/ dyspnea control?
- Yes
- No

Comments: ____________________________________________________________
Interventions

☐ Oxygen ordered & Pt/ CG instructed safe use of O2 & equipment mgmt.
☐ Aerosol treatment equipment/ meds ordered & pt/CG instructed in use
☐ Increased medication dose____________________ per standing orders.
☐ Contacted MD regarding need for medication change
☐ New medication__________________________________________

☐ Medication administered____________________________________

Instructed patient/ CG:
☐ Respiratory disease process (disease progression/ measures to prevent exacerbation)
☐ Measures to control symptoms related to respiratory difficulties
☐ Notify hospice nurse of any unrelieved symptoms
☐ Changes in respiratory pattern of patient approaching death w/measures to control symptomology

Additional Interventions:_________________________________________
Visit Note – Constipation

GASTROINTESTINAL:
- No Problem
- Unchanged
- Deferred
- Continent
- Incontinent
- Belching / indigestion
- Diarrhea
- Constipation / impaction
- Nausea
- Vomiting

Current therapy for above symptoms:

Effective sx. control? Y N

OPIOID THERAPY: Y N (circle)

LAST BM (Date)

Current bowel / laxative therapy:

Ileostomy / Colostomy site:

Abdomen:
- Tenderness
- Pain
- Distention
- Hard / Soft
- Ascites

Bowel sounds:
- Present
- Absent
- Hypoactive
- Hyperactive

NG/ Enteral Tube

Tube feedings:

Rate:
Visit Note – Constipation

Interventions:
☐ Check for impaction  ☐ Disimpacted  ☐ Fleet’s enema  ☐ SSE
☐ Bowel program initiated (See standing orders)

Instructed Patient/ CG:
☐ GI disease process and progression & measures to control GI symptomology
☐ Potential for constipation R/T immobility and meds with measures to prevent
☐ Ileosotmy/ Colostomy care  ☐ NG/ enteral tube care and feeding technique
☐ Incontinent care
☐ Incontinent supplies left in home

Comments:______________________________________________________________
________________________________________________________
__________________________

Visit Note – Constipation
Follow Up Communication Note

Being completed for: □ New rating PAIN ≥ 4 □ New rating DYSPNEA 4

□ No BM reported in ≥ 4 days________

□ Telephone call □ SNV (If treatment documented on visit note STOP HERE)

PROBLEM: Pain or Dyspnea

Collected using: □ 0-10 scale □ FACES scale

Date:_________ Time:_________

Worse symptom level past 24 hrs:_______       Current level: _________

Acceptable level:_________  If level is ≥ 4, is Patient / CG satisfied with current level of symptom control?

□ YES □ NO

Comments:________________________________________

If YES STOP HERE.

(If no, go to TREATMENT below)  PROBLEM: Constipation

Number of days since last BM:_________

If no BM in ≥ 4 days, is there a reason treatment for constipation is not being initiated at this time?

□ Yes  □ No (If yes, explain):_____________________________________________________________________

TREATMENT: For new rating pain or dyspnea ≥ 4 or no BM in ≥ 4 days, was treatment initiated within 4 hours?

□ Yes  □ No  □ Attending notified and requested adjustment in medications

Instructed patient / CG in medication changes:________________________________________________________________________

□ Instructed patient / CG medication dosage adjustment:________________________________________________________________________

□ Instructed patient / CG in non-pharmacological methods to relieve symptoms:____________________________________________________

Comments:__________________________________________________________________________________________

Nurses

Signature:__________________________________________
• Concept of pain control
  • Not just current pain level
  • Patient’s level of acceptable pain
  • 24 hour pain control vs. at time of assessment

• Intervention requirement – **DO SOMETHING!**
  • Within 4 hours – Need for standing orders
  • Response from attending MD – Medical Director
  • Is it acceptable for a patient to have a score of 9 on pain scale for more than 4 hours?

• Assessment – Re-assessment
  • Telephone follow up
  • In home visit

• Documentation Clarity
  • Degree of ease / difficulty of audit process
• Each audit produces new data
• Findings initiate change in clinical practice
• Patient care has actually improved
• Clinicians are intervening in a timely manner
• Best practices are initiated for all hospice patients
  ◦ Pain assessment is ongoing
  ◦ Pain is managed to a level acceptable to the patient
What We Did...Pain

- Added assessment for present level of pain
- Changed wording; “worse pain in past 24 hours” instead of “worse pain gets”
- Implemented a faces scale to correspond with numerical 1 – 10 scale – mild-mod-severe
- Added patient/caregiver satisfied with current pain control regimen Y N
- Re-tooled standing orders

Action Plan
What We Did...SOB

- Re-educated clinicians regarding use of 1 – 10 scale to measure SOB
- Determined that if SOB occurs ONLY with ambulation and the patient is satisfied with respiratory status = 0
  - Rate degree of SOB with ambulation for future monitoring
What We Did...Constipation

- Reinforced bowel assessment Q visit
- Established “normal” for each patient
- Re-tooled bowel program interventions
• Implement Best Practices
  • Discuss patient findings at IDG
  • Identify specific interventions that have produced positive results
  • Update patient care plans with interventions as appropriate
  • Implement changes
  • Evaluate effectiveness of plan and interventions
  • Try again!
  • When it works...
    ◦ Develop a best practice and implement organization-wide

Performance Improvement Cycle
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Bedlam Farm Hospice Journal, Jon KatWashington County Hospice - photos

References