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*

- **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

Develop A QAPI Plan

It's All About The Data…

- **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

- **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

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

- Routine home care
- Respite care
- General Inpatient Care
- Skilled Facility as Residence
- Continuous Care
    - Largest concentration of patients
    - Highest risk and / or problem prone

Incorporate **All Levels** of Care

- **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

Tidewater Hospice

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

Patient Record Audit	Monthly Data Gathering	Quarterly Reporting	Bi-Annual Data Gathering	Annual Reporting
Infection Control	X	X		
Satisfaction Patient Referral Source Staff			X	X
Adverse Events	X	X		
Customer Concerns	X	X		
Process Measures	X	X		
Patient Outcomes	X	X		
Patient Safety Initiatives	X	X		

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.

Patient Outcomes

Flow Sheet

Symptom Assessment Flow Sheet (with constipation)

Patient Name		**ID#**	

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

Date														
Time														
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

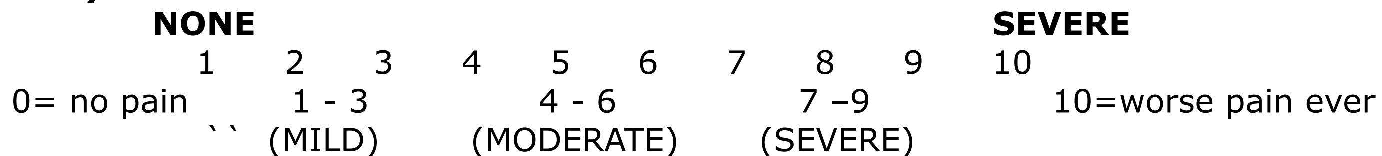
Is patient experiencing pain? ▢Yes ▢No ▢Unable to communicate

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

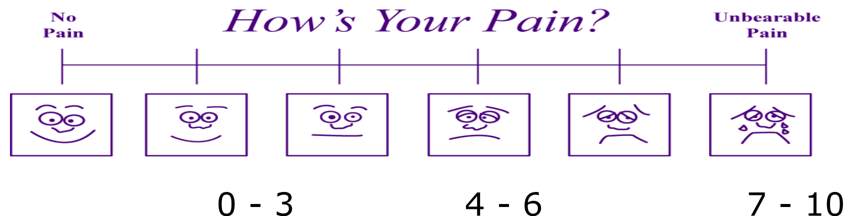
PAIN LOCATION: (specify site(s):____

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

Intensity:



▢ **FACES** scale (per CGs)



Worse pain level past 24hrs: __________ **Current pain level:** ________________

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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RESPIRATORY: ▢ No Problem ▢ Unchanged ▢ Deferred

Lung sounds **:** ▢ Clear ▢ Crackles/rales ▢ Rhonchi ▢ Absent ▢ Diminished **Cough**: ▢ None ▢ Dry/Acute/Chronic ▢ 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**) 1 2 3 4 5 6 7 8 9 10**
Current:_________
Last 24 hrs._______

If level of dyspnea ≥ 4 over past 24 hrs is Pt / CG satisfied w/ dyspnea control?

▢ **Yes** ▢ **No**

Comments:____

Visit Note - SOB

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 - SOB

GASTROINTESTINAL: ☐ No Problem ☐ Unchanged ☐ Deferred

☐ Continent ☐ Incontinent ☐ Belching / indigestion ☐ Diarrhea ☐ Constipation/ impaction ☐ Nausea ☐ Vomiting Current therapy for above symptoms:______________________________

____

☐ Effective sx. control? Y N

OPIOD THERAPY: Y N (circle) **LAST BM (Date)**_______________

Current bowel / laxative therapy:

____

☐ Ileostomy / Colostomy site:(describe surrounding skin)____________________________________

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

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 sympto m 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 torelieve symptoms:____

Comments:____

Nurses Signature: ____

Follow Up Communication Note

Integrate Findings Into Practice

- 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

Integrate Findings Into Practice

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

Action Plan

- **What We Did…Constipation**
- **Reinforced bowel assessment Q visit**
- **Established "normal" for each patient**
- **Re-tooled bowel program interventions**

Action Plan

- **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 i**mplement organization-wide

Performance Improvement Cy

References

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