Worksheet to Create a Performance Improvement Project Charter

What is a project charter? A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an Improvement Project (PIP). The charter is typically developed by the QAPI team and then given to the team that will carry out the PIP, so that the PIP team has a clear understanding of what they are being asked to do. The charter is a valuable document because it helps a team stay focused. However, the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish.

Use this worksheet to define key charter components.

PROJECT OVERVIEW

Name of project:

Example: Reduction in use of position change alarms

Improving the accuracy of assessed acuity at admission to reduce readmissions

Problem to be solved:

Example: Alarms going off frequently detract from a homelike environment and may give staff a false sense of security.

Nursing home staff members are discovering some residents have a higher level of acuity than expected after they are admitted from the hospital; this creates an unexpected burden on staff members, patients, caregivers, and resources when caring for the resident.

Background leading up to the need for this project:

Example: Residents and families have complained about the sound of alarms going off frequently. Staff feel pressure to do "something" when a resident falls.

[Tip: Reference specific background documents, as needed.]

The admissions coordinator, nurses, and physicians have observed that when patients are evaluated after admission, co-morbid diseases, routine medication needs, wound care, recent infections, and antibiotic use are not completely known at the time of transfer.

The goal(s) for this project:

Example: Decrease the percentage of residents with position change alarms used on XX unit by 25% by XX/XX/XX.

[Tip: See Goal Setting Worksheet]

Increase the completeness and accuracy of communication related to patients' clinical condition and care needs at transfer to ≥ 80 percent using a standardized tool (Skilled Nursing Facility [SNF] Transfer Checklist) by 12/31/22.

Scope—the boundary that tells where the project begins and ends.

The project scope **includes:**

Example: Use of position change alarms on XX unit.

The scope includes all patients transferred from one unit at Best Hospital Medical Center for skilled nursing care between 9/1, and 12/31.

PROJECT APPROACH

Recommended Project Time Table:

PROJECT PHASE	START DATE	END DATE
Initiation: Project charter developed and approved	10/2	10/4
Planning: Specific tasks and processes to achieve goals defined	10/7	10/18
Implementation: Project carried out	10/21	10/31
Monitoring: Project progress observed and results documented	10/21	10/31
Closing: Project brought to a close and summary report written	11/3	11/14

Project Team and Responsibilities:

TITLE	ROLE	PERSON ASSIGNED
Project Sponsor	Provide overall direction and oversee financing for the project	Joe Jones, NHA
Project Director	Coordinate, organize and direct all activities of the project team	Fred Kline, MD, Medical Director
Project Manager	Manage day-to-day project operations, including collecting and displaying data from the project	Sally Bailey, Admission Coordinator
Team members*	Carry out specific tasks based on action planning	Director of nursing (DON), discharge planner/case manager, nurse practitioner, staff nurse
Hospital team		Discharge team, Chief Medical Officer (CMO), case managers, nursing director of unit, care coordination staff members, unit hospitalist

*Choice of team members will likely be deferred to the project manager based on interest, involvement in the process, and availability.

Material Resources Required for the Project (e.g., equipment, software, supplies):

- Health Services Advisory Group (HSAG) SNF Transfer Checklist
- HSAG Nursing Home Readmissions Report
- Quarterly Certification and Survey Provider Enhanced Reports (CASPER) Confidential Feedback Report
- SNF 30-Day All-Cause Readmission Measure (SNF-RM) Baseline and Performance Period Rates
- Curaspan Referral Documentation Application
- Computer access and spreadsheet to track progress
- Hospital and Nursing Home Communication Log

Barriers

What could get in the way of success?	What could you do about this?
Example: A resident could fall and staff could automatically blame the lack of an alar.	*Example:* Educate staff on the lack of relationship between alarms and falls; collect data on removal of one alarm at a time.
Example: Staff complaints of need for additional staff to watch everyone if alarms are removed.	*Example:* Focus on anticipation of resident needs, and assess if additional hands-on-deck are needed during busy times on unit.
Physicians insist on transferring residents to hospital.	Use INTERACT tools to identify early symptoms and to provide staff member education, provide physician timely clinical updates, provide physician facility capability list.
Family insists on transferring residents to hospital.	Provide family and resident facility capability list before or upon admission, educate family on transfer protocols, keep Physician Orders for Life-Sustaining Treatment (POLST) up to date.
Hospital discharge staff members fail to use checklist.	Maintain regular meetings with hospital leadership during PIP to ensure compliance with the plan.

PROJECT APPROVAL

The signatures of the people below relay an understanding and approval of the purpose and approach to this project. By signing this document you agree to establish this document as the formal Project Charter and sanction work to begin on the project as described within.

TITLE	NAME	SIGNATURE	DATE
Administrator	Joe Jones		10/4
Project Sponsor	Joe Jones		10/4
Project Director*	Fred Kline		10/4
Project Manager*	Sally Bailey		10/4

*May not always have both roles.

Disclaimer: Use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance.

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