Get Ready for Phase 2: How to Use the Facility Assessment to Drive Person-Centered Care
Today’s Objectives

- Analyze progress on major Arizona Nursing Home Quality Care Collaborative (NHQCC) goals.
- Describe the Phase 2 Requirements of Participation.
- Illustrate how the facility assessment can be used as the foundational document to drive decision making at all levels of the nursing home and how QAPI facilitates person-centered care.
- Identify templates, tools, and resources that can be used to build Phase 2 plans.
### Primary Arizona NHQCC Goals

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce unnecessary antipsychotic medication use</td>
<td>Maintain QAPI* self-assessments</td>
<td>Score 6 percent or less on the Composite Score</td>
</tr>
</tbody>
</table>

*QAPI=Quality Assurance & Performance Improvement
Arizona NHQCC Participation

• **Goal:** 75 percent of homes by March 2017
• **Achieved:** February 2016
• **128** Arizona nursing homes have joined!

89 percent of Arizona’s nursing homes have joined the collaborative
Aim for 6

Let HSAG help you earn a Quality Measure Composite Score of 6 percent or less!
Quality Measure Composite Score Update

• **CMS Five-Year Goal**: 50 percent of AZNHQCC
• **First Goal**: 15 percent by March 2016
• **Second Goal**: 25 percent by March 2017
• **Third Goal**: 45 percent by March 2018

**Current**: 62 percent!
Arizona Composite Score Ranking

Arizona

State Ranking: Percent of RTN with a QM Composite Score <= 6.00 (2015Q2 Through 2017Q1)

% of RTN with a QM Composite Score <= 6.00

Rank

Jul 2017 Target (2015Q2 Through 2017Q1): 25%
Antipsychotic Medication Use in Arizona

**Arizona NHQCC Goal**
15 percent reduction*

Current Reduction
22.81 percent

22.81%

**National Partnership 2016 Goal**
30 percent reduction**

Current Reduction
38.20 percent

38.20%

*Baseline period: Q1 2013–Q4 2013
**Baseline: Q4 2011
Arizona NHQCC QAPI Self-Assessment Trends

- 100% completion rate for both collaboratives

<table>
<thead>
<tr>
<th>QAPI Status</th>
<th>Collab I</th>
<th>Collab II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Started</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Just Starting</td>
<td>36%</td>
<td>13%</td>
</tr>
<tr>
<td>On Our Way</td>
<td>26%</td>
<td>32%</td>
</tr>
<tr>
<td>Almost There</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>Doing Great</td>
<td>12%</td>
<td>25%</td>
</tr>
</tbody>
</table>
CDI Initiative

- 28 participating nursing homes in Arizona
- National Healthcare Safety Network (NHSN) enrollment
- 10-month data collection for baseline
- Quality improvement
  - Starting in early 2018
An Overview of
Phase Two Requirements
Effective November 28, 2017

Sylvia Balistreri, RN, BSN
Director of Quality and Regulatory Services
Arizona Health Care Association
Phase Two Requirements

• Resident Rights
  – Providing contact information for state & local advocacy organizations, MCR & MCAID eligibility, Aging & Disability Resources, MCAID Fraud Control Unit (F574)

• Freedom from abuse, neglect, exploitation
  – Reporting Crimes (F608)

• Admission, Transfer and Discharge
  – Transfer/discharge documentation (F622)

• Comprehensive Person-Centered Care Plan
  – Baseline Care Plan (F655)
Phase Two Requirements (cont.)

• Nursing Services
  – In relation to the Facility Assessment:
    • Sufficient Nursing Staff (F725)
    • Competent Nursing Staff (F726)

• Behavioral Health Services
  – Sufficient/competent staff (F741)
  – Treatment for mental/psychosocial concerns (F742)
  – No pattern of behavioral difficulties (F743)
  – Treatment/services for dementia (F744)
Phase Two Requirements (cont.)

• Pharmacy Services
  – Medical Chart Review (F755)
  – Psytropic medications (F758)

• Dental Services
  – Loss or damage of dentures and policy for referral (F790)

• Food & Nutrition Services
  – Qualified dietician (F801)

• Administration
  – Facility Assessment (F838)
Phase Two Requirements (cont.)

- Quality Assurance & Performance Improvement
  - Present QAPI Plan to State Agency (F865)
- Infection Control
  - Antibiotic Stewardship (F881)
- Physical Environment
  - Policies regarding smoking (F926)
The Facility Assessment

Joel Bunis, MBA
Director of Emergency Preparedness and Regulatory Services
Arizona Health Care Association
Purpose of the Facility Assessment

• To determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.
• To make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility.
• That each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.
  – Using a competency-based approach
Overview of the Facility Assessment

- Organized into three parts
- **Resident profile** including numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care
- **Services and care offered** based on resident needs; including types of care your resident population requires;
  - **Not** to include individual level care plans in the facility assessment
- **Facility resources needed** to provide competent care for residents
  - includes staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment
Guidelines for Conducting the Assessment: Team Composition

- Administrator
- Representative of the governing body
- Medical Director
- Director of Nursing
- Environmental operations manager
- Other department heads (e.g., the dietary manager, director of rehabilitation services, or other individuals including direct care staff) should be involved as needed
- Encouraged to seek input from residents or their representatives
Guidelines for Conducting the Assessment

• May include input from corporate organization, but facility assessment must be done at facility level

• Must review and update annually or whenever there is a change in service
  – E.g.: adding a secured dementia unit, adding dialysis residents

• Assessment serves as a record for understanding decisions made regarding staffing and other resources
Facility Assessment and Survey

• Interpretive Guidance
  – If systemic care concerns are identified that are related to the facility’s planning, review the facility assessment to determine if these concerns were considered as part of the facility assessment process

• Example: Concerns over providing bariatric care
  – Surveyor will look at assessment to see if this patient population has been planned for
Resident Profile Numbers

• Indicate the number of residents you are licensed to provide care for: (enter number of beds) ______.
  – Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).

• Indicate your average daily census: (enter a range) ______.
  – Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).
  – Consider if it would be helpful to describe the number of persons admitted and discharged, as these processes can impact staffing needs.
Resident Profile: Diseases/Conditions, Physical and Cognitive Disabilities

• Indicate if you may accept residents with, or your residents may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management.

• The intent is not to list every possible diagnosis or condition. Rather, it is to document common diagnoses or conditions in order to identify the types of human and material resources necessary to meet the needs of resident’s living with these conditions or combinations of these conditions.
<table>
<thead>
<tr>
<th>Category</th>
<th>Common diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric/Mood Disorders</td>
<td>Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions</td>
</tr>
<tr>
<td>Heart/Circulatory System</td>
<td>Congestive Heart Failure, Coronary Artery Disease, Angina, Dysrhythmias, Hypertension, Orthostatic Hypotension, Peripheral Vascular Disease, Risk for Bleeding or Blood Clots, Deep Venous Thrombosis (DVT), Pulmonary Thrombo-Embolism (PTE)</td>
</tr>
<tr>
<td>Neurological System</td>
<td>Parkinson’s Disease, Hemiparesis, Hemiplegia, Paraplegia, Quadriplegia, Multiple Sclerosis, Alzheimer’s Disease, Non-Alzheimer’s Dementia, Seizure Disorders, CVA, TIA, Stroke, Traumatic Brain Injuries, Neuropathy, Down’s Syndrome, Autism, Huntington’s Disease, Tourette’s Syndrome, Aphasia, Cerebral Palsy</td>
</tr>
<tr>
<td>Vision</td>
<td>Visual Loss, Cataracts, Glaucoma, Macular Degeneration</td>
</tr>
<tr>
<td>Hearing</td>
<td>Hearing Loss</td>
</tr>
<tr>
<td>Musculoskeletal System</td>
<td>Fractures, Osteoarthritis, Other Forms of Arthritis</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>Prostate Cancer, Breast Cancer, Lung Cancer, Colon Cancer</td>
</tr>
<tr>
<td>Metabolic Disorders</td>
<td>Diabetes, Thyroid Disorders, Hyponatremia, Hyperkalemia, Hyperlipidemia, Obesity, Morbid Obesity</td>
</tr>
<tr>
<td>Respiratory System</td>
<td>Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Respiratory Failure</td>
</tr>
<tr>
<td>Genitourinary System</td>
<td>Renal Insufficiency, Nephropathy, Neurogenic Bowel or Bladder, Renal Failure, End Stage Renal Disease, Benign Prostatic Hyperplasia, Obstructive Uropathy, Urinary Incontinence</td>
</tr>
<tr>
<td>Diseases of Blood</td>
<td>Anemia</td>
</tr>
<tr>
<td>Digestive System</td>
<td>Gastroenteritis, Cirrhosis, Peptic Ulcers, Gastroesophageal Reflux, Ulcerative Colitis, Crohn’s Disease, Inflammatory Bowel Disease, Bowel Incontinence</td>
</tr>
<tr>
<td>Integumentary System</td>
<td>Skin Ulcers, Injuries</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Skin and Soft Tissue Infections, Respiratory Infections, Tuberculosis, Urinary Tract Infections, Infections with Multi-Drug Resistant Organisms, Septicemia, Viral Hepatitis, Clostridium difficile, Influenza, Scabies, Legionellosis</td>
</tr>
</tbody>
</table>
• Describe the process to make admission or continuing care decisions for persons that have diagnoses or conditions that you are less familiar with and have not previously supported.

• For example, how do you determine, if you have the opportunity to admit a person with a new diagnosis to your facility, or to continue caring for a person that has developed a new diagnosis, condition or symptom, if you have the resources, or how you might secure the resources, to provide care and support for the person?
Resident Profile: Acuity

- Describe your residents’ acuity levels that help you to understand potential implications regarding the intensity of care and services needed.
- Intent of this is to give an overall picture of acuity – over the past year, or during a typical month, for example.
- Potential data sources include RUGs, MDS data, and resident/patient acuity tools.
- Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).
## Resident Profile: Acuity-Major RUG-IV Categories

<table>
<thead>
<tr>
<th>Major RUG-IV Categories</th>
<th>Number/Average or Range of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Plus Extensive Services</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Extensive Services</td>
<td></td>
</tr>
<tr>
<td>Special Care High</td>
<td></td>
</tr>
<tr>
<td>Special Care Low</td>
<td></td>
</tr>
<tr>
<td>Clinically Complex</td>
<td></td>
</tr>
<tr>
<td>Behavioral Symptoms and Cognitive Performance</td>
<td></td>
</tr>
<tr>
<td>Reduced Physical Function</td>
<td></td>
</tr>
</tbody>
</table>
## Resident Profile: Acuity-Special Treatments and Conditions

<table>
<thead>
<tr>
<th></th>
<th>Special Treatments</th>
<th>Number/Average or Range of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer Treatments</strong></td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiation</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Treatments</strong></td>
<td>Oxygen therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suctioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tracheostomy Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ventilator or Respirator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BIPAP/CPAP</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Behavioral Health Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active or Current Substance Use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>IV Medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transfusions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ostomy Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respite Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isolation or Quarantine for Active Infectious Disease</td>
<td></td>
</tr>
</tbody>
</table>
## Resident Profile: Acuity-Assistance with ADLs

<table>
<thead>
<tr>
<th>Assistance with Activities of Daily Living</th>
<th>Independent</th>
<th>Assist of 1-2 Staff</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other care, describe:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility</td>
<td>Independent</td>
<td>Assistive Device Used to Ambulate</td>
<td>In Chair Most of Time</td>
</tr>
</tbody>
</table>
Resident Profile: Ethical, Cultural, or Religious Factors

- Describe ethnic, cultural, or religious factors or personal resident preferences that may potentially affect the care provided to residents by your facility. Examples may include activities, food and nutrition services, languages, clothing preferences, access to religious services, or religious-based advanced directives.

- Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs (e.g., residents’ preferences with regard to daily schedules, waking, bathing, activities, naps, food, going to bed, etc.).
Services and Care Offered Based on Resident Needs

- List the types of care that your resident population requires and that you provide for your resident population.

- List by general categories, adding specifics as needed
  - Not expected to quantify each care or practice in terms of the number of residents that need that care, or enter an aggregate of all resident care plans here.

- Intent is to identify and reflect on resources needed (in Section 3) to provide these types of care.
### Services and Care Offered: Needs

<table>
<thead>
<tr>
<th>General Care</th>
<th>Specific Care or Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities of daily living</strong></td>
<td>Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself</td>
</tr>
<tr>
<td><strong>Mobility and fall/fall with injury prevention</strong></td>
<td>Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself</td>
</tr>
<tr>
<td><strong>Bowel/bladder</strong></td>
<td>Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity</td>
</tr>
<tr>
<td><strong>Skin integrity</strong></td>
<td>Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds)</td>
</tr>
<tr>
<td><strong>Mental health and behavior</strong></td>
<td>Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td>Awareness of any limitations of administering medications Administration of medications that residents need By route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc Assessessment/management of polypharmacy</td>
</tr>
</tbody>
</table>
# Services and Care Offered: Needs

<table>
<thead>
<tr>
<th>General Care</th>
<th>Specific Care or Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain management</strong></td>
<td>Assessment of pain, pharmacologic and nonpharmacological pain management</td>
</tr>
<tr>
<td><strong>Infection prevention and control</strong></td>
<td>Identification and containment of infections, prevention of infections</td>
</tr>
<tr>
<td><strong>Management of medical conditions</strong></td>
<td>Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as UTI and gastroenteritis, pneumonia, hypothyroidism</td>
</tr>
<tr>
<td><strong>Therapy</strong></td>
<td>PT, OT, Speech/Language, Respiratory, Music, Art, management of braces, splints</td>
</tr>
<tr>
<td><strong>Other special care needs</strong></td>
<td>Dialysis, hospice, ostomy care, tracheostomy care, ventilator care, bariatric care, palliative care, end of life care</td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td>Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis</td>
</tr>
</tbody>
</table>

*HSAG Health Services Advisory Group*
### Services and Care Offered: Needs

| Provide person-centered/directed care: Psycho/social/spiritual support: | Build relationship with resident/get to know him/her; engage resident in conversation. Find out what resident’s preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information. Record and discuss treatment and care preferences. Support emotional and mental well-being; support helpful coping mechanisms. Support resident having familiar belongings. Provide culturally competent care: learn about resident preferences and practices with regard to culture and religion; stay open to requests and preferences and work to support those as appropriate. Provide or support access to religious preferences, use or encourage prayer as appropriate/desired by the resident. Provide opportunities for social activities/life enrichment (individual, small group, community). Support community integration if resident desires. Prevent abuse and neglect. Identify hazards and risks for residents. Offer and assist resident and family caregivers (or other proxy as appropriate) to be involved in person-centered care planning and advance care planning. Provide family/representative support. |
Facility Resources: Staff Type

• Identify the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for residents.
  – Potential data sources include staffing records, organization chart, and Payroll-Based Journal reports.
Facility Resources: Staff Type (cont.)

- Administration (e.g., Administrator, Administrative Assistant, Staff Development, QAPI, Infection Control and Prevention, Environmental Services, Social Services, Discharge Planning, Business Office, Finance, Human Resources, Compliance and Ethics)
- Nursing Services (e.g., DON, RN, LPN or LVN, CNA or NAR, medication aide or technician, MDS nurse)
- Food and Nutrition Services (e.g., Director, support staff, registered dietician)
- Therapy Services (e.g., OT, OTA, PT, PTA, RT, RT tech, speech language pathology, audiologist, optometrist, activities professionals, other activities staff, social worker, mental health social worker)
- Medical/Physician Services (e.g., Medical Director, Attending Physician, Physician Assistant, Nurse Practitioner, Dentist, Podiatrist, Ophthalmologist)
- Pharmacist
Facility Resources: Staff Type (cont.)

• Behavioral and mental health providers
• Support staff (e.g., engineering, plant operations, information technology, custodians, housekeeping, maintenance staff, groundskeepers, laundry services)
• Chaplain/Religious services
• Volunteers, students
• Other (vocational services worker, clinical laboratory services worker, diagnostic X-ray services worker, blood services worker, psychiatric services, and mental health providers)
Facility Resources: Staffing Plan

- Based on your resident population and their needs for care and support
  - **Must** meet the needs of the resident
- Describe your general approach to staffing to ensure that you have sufficient staff members to meet the needs of the residents at any given time
  - Normal operations and during an emergency
- Different methodologies that all work
- Review staffing references based on Resident Profile
**Staffing Plan**

<table>
<thead>
<tr>
<th>Position</th>
<th>Total Number Needed or Average or Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed nurses providing direct care</td>
<td></td>
</tr>
<tr>
<td>Nurse aides</td>
<td></td>
</tr>
<tr>
<td>Other nursing personnel (e.g., those with administrative duties)</td>
<td></td>
</tr>
<tr>
<td>In addition to nursing staff, other staff needed for behavioral healthcare and services (list other staff positions/roles):</td>
<td></td>
</tr>
<tr>
<td>Dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services</td>
<td></td>
</tr>
<tr>
<td>Food and nutrition services staff</td>
<td></td>
</tr>
<tr>
<td>Respiratory care services staff</td>
<td></td>
</tr>
</tbody>
</table>
## Staffing Plan

<table>
<thead>
<tr>
<th>Staff</th>
<th>Plan</th>
</tr>
</thead>
</table>
| **Licensed Nurses (LN): RN, LPN, LVN providing direct care** | DON: 1 DON RN full-time Days; if has other responsibilities, add x more RN as Asst. DON to equal one FTE  
RN or LPN Charge Nurse: 1 for each shift  
1-x residents DON may be Charge Nurse  
1:x LN ratio Days and Evenings (consider breaking this down by RN and LPN per shift)  
1:x LN ratio Nights (consider breaking this down by RN and LPN per shift) |
| **Direct care staff** | 1:x ratio Days (total licensed or certified)  
1:x ratio Evenings  
1:x ratio Nights  

Or  
x hours per resident days (HPRD) indicating: a) total number of licensed nurse staff hours per resident per day, b) RN hours per resident per day, c) LPN/LVN hours per resident per day, d) Certified Nursing Assistant hours per resident per day, e) Physical therapy staff hours per resident per day |
| **Other (e.g., department heads, nurse educator, quality assurance, ancillary staff in maintenance, housekeeping, dietary, laundry)** | Note: comparative data for HPRD are available on Nursing Home Compare |
Facility Assessment: Staff Assignments and Training

• Describe how you determine and review **individual staff assignments** for coordination and continuity of care for residents within and across these staff assignments.

• Describe the staff **training/education and competencies** that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies.
Facility Assessment

• Describe how you evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice
  – Include your process to determine if new or updated policies are needed, and how they are developed or updated

• Describe your plan to recruit and retain enough medical practitioners (e.g., physicians, nurse practitioners) who are adequately trained and knowledgeable in the care of your residents/patients
  – Include how you will collaborate with them to ensure that the facility has appropriate medical practices for the needs and scope of your population.
Facility Assessment (cont.)

• Describe how the management and staff members familiarize themselves with what they should expect from medical practitioners and other healthcare professionals related to standards of care and competencies that are necessary to provide the level and types of support and care needed for your resident population.

• Do you share expectations for providers that see residents in your nursing home on the use of standards, protocols, or other information developed by your medical director?

• Do you have discussions on what providers and staff members expect of each other in terms of the care delivery process and clinical reasoning essential to providing high quality care?
Facility Assessment: Physical Environment and Building Needs

<table>
<thead>
<tr>
<th>Physical Resource Category</th>
<th>Resources</th>
<th>If applicable, process to ensure adequate supply, appropriate maintenance, replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings and/or other structures</td>
<td>Building description, garage, storage shed</td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td>Transportation van</td>
<td></td>
</tr>
<tr>
<td>Physical equipment</td>
<td>Bath benches, shower chairs, bathroom safety bars, bathing tubs, sinks for residents and for staff, scales, bed scales, ventilators, wheelchairs and associated positioning devices, bariatric beds, bariatric wheelchairs, lifts, lift slings, bed frames, mattresses, room and common space furniture, exercise equipment, therapy tables/equipment, walkers, canes, nightlights, steam table, oxygen tanks and tubing, dialysis chair and station, ventilators</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Waste management, hazardous waste management, telephone, HVAC, dental, barber/beauty, pharmacy, laboratory, radiology, occupational, physical, respiratory, and speech therapy, gift shop, religious, exercise, recreational music, art therapy, café/snack bar/bistro</td>
<td></td>
</tr>
</tbody>
</table>
## Facility Assessment: Physical Environment and Building Needs

<table>
<thead>
<tr>
<th>Physical Resource Category</th>
<th>Resources</th>
<th>If applicable, process to ensure adequate supply, appropriate maintenance, replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other physical plant needs</td>
<td>Sliding doors, ADA compliant entry/exit ways, nourishment accessibility, nurse call system, emergency power</td>
<td></td>
</tr>
<tr>
<td>Medical supplies (if applicable)</td>
<td>Blood pressure monitors, compression garments, gloves, gowns, hand sanitizer, gait belts, infection control products, heel and elbow suspension products, suction equipment, thermometers, urinary catheter supplies, oxygen, oxygen saturation machine, Bi-PAP, bladder scanner</td>
<td></td>
</tr>
<tr>
<td>Non-medical supplies (if applicable)</td>
<td>Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers</td>
<td></td>
</tr>
</tbody>
</table>
Facility Assessment: Other

- List contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies.
  - Consider including a description of your process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements.

- List health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.
  - How will the facility securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility
  - How downtime procedures are developed and implemented
  - How the facility ensures that residents and their representative can access their records upon request and obtain copies within required timeframes.
Facility Assessment: Other

• Describe how you evaluate if your infection prevention and control program includes effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement, that follow accepted national standards.

• Provide your facility-based and community-based risk assessment, utilizing an all-hazards approach
  – It is acceptable to refer to the risk assessment of your emergency preparedness plan and focus on high-volume, high-risk areas.
## Synthesize and Use

<table>
<thead>
<tr>
<th>Areas Facility Assessment Informed</th>
<th>Action To Be Taken/Already Taken This Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention/Control</td>
<td></td>
</tr>
<tr>
<td>Training, Competencies</td>
<td></td>
</tr>
<tr>
<td>QAPI Initiatives/Performance</td>
<td></td>
</tr>
<tr>
<td>Improvement Projects</td>
<td></td>
</tr>
<tr>
<td>Business Strategy</td>
<td></td>
</tr>
</tbody>
</table>
Integrating QAPI and the Facility Assessment: Workflow Case Study
The Scenario

• A nursing home was cited for falls with major injury.
• DON conducted reactive three-month, post-citation analysis
  – Falls training
  – Fall QM by nursing home wing
Results of Initial Analysis

• After three months, falls with major injury increased
  – Month 1: 2.4% (3/126)
  – Month 3: 4.8% (6/126)
  – State average: 2.9%

• Overall fall rate also increased
  – Month 1: 35.7% (45/126)
  – Month 3: 59.5% (75/126)
  – State average: 35.4%
Results of Initial Analysis (cont.)

• Education/Training Observations
  – All staff members passed basic knowledge competency
  – Random observation on weekdays showed that, in general, staff members were following proper protocol.
CNA overheard why analysis was occurring
- “Is this why you’re doing this?”
- Team complains they are understaffed on weekends
- More groups and visitors over the weekend

DON decides to organize and present PIP to QAPI committee
Falls With Major Injury: Areas to Consider

- Coding
- Root cause analysis
- Assessments and scoring
- Preventive devices
- Environmental precautions
- Medication management

- Comfort
- Therapy involvement
- Restorative maintenance
- Quality rounding for safety
- Safety committee
Falls With Major Injury: HSAG Tip Sheet

Quality Measure Tip Sheet: Falls With Major Injury—Long Stay

Quality Measure Overview

- This measure is a look-back scan measure. If the resident had one or more falls with a major injury on one or more of the look-back scan assessments, it will trigger the measure.
- This measure triggers if the event/condition occurred any time during a one-year period.
- Fall history is obtained with a look-back of up to six months prior to admission.

Exclusions:
- The occurrence of fall was not assessed.
- The assessment indicates a fall occurred and the number of falls with major injury was not assessed.

MDS Coding Requirements

In the Minimum Data Set (MDS):
- Include fall history on admission/entry or re-entry.
- Include number of falls since admission/entry, re-entry, or prior assessment (Omnibus Reconciliation Act [OBRA] or scheduled Medicare Prospective Payment System assessment), whichever is more recent.
- Indicate major injuries for:
  - Bone fractures
  - Joint dislocations
  - Closed head injuries with altered consciousness
  - Subdural hematomas

Ask These Questions ...

- Was the MDS coded as per the Resident Assessment Instrument requirements?
- Was a fall risk assessment completed on admission, quarterly, and with changes to identify appropriate risk?
- Was a process in place based on fall score to initiate preventive devices?
- Were preventive devices communicated to direct-care staff members?
- Are interventions monitored for placement and function?
- Are gait belts accessible for transfers?
- Do the nurses demonstrate competence for assessing fall risk?
- Are the direct-care staff members proficient in transfers and mobility functions?
- Are fall precautions taken if the resident is on anticoagulants, antidepressants, anticonvulsants, antihypertensives, antiparkinson agents, benzodiazepines, diuretics, nonsteroidal anti-inflammatory agents, psychotropics, vasodilators, narcotics, glucocorticoids, tranquilizers, or hypnotics/SEDATs/SEDATs?
- Are vision issues addressed?
- Is appropriate footwear utilized?
- Is the resident appropriately positioned?
- Are pain and comfort issues addressed? Are rest periods provided?
- Are activity programs individualized for the resident to meet his/her needs/preferences?
- Is continence managed?

For guidance on your quality measures, reach out to Health Services Advisory Group (HSAG).

https://goo.gl/MCK1fw
# PERFORMANCE IMPROVEMENT PROJECT (PIP) GUIDE

<table>
<thead>
<tr>
<th>START DATE</th>
<th>REVIEW DATE(S)</th>
<th>COMPLETE DATE</th>
<th>PIP SQUAD MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROJECT LEADER:

<table>
<thead>
<tr>
<th>KEY AREA FOR IMPROVEMENT:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>2.</td>
<td>3.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL: Specific Measureable Attainable Realistic Time-Bound</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.</td>
<td>5.</td>
<td>6.</td>
</tr>
<tr>
<td></td>
<td>7.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHAT IS THE ROOT CAUSE(S) FOR THE PROBLEM? Ask “Why is this happening?” five times. If you removed this root cause, would the event have been prevented?

<table>
<thead>
<tr>
<th>BARRIERS:</th>
<th></th>
</tr>
</thead>
</table>

https://goo.gl/mEjFNw
• A significant number of falls over weekends
  – 20/45 (44%)
• Facility assessment staffing needs not updated in one year
• Staffing needs did not account for weekend fluctuations
• Team checked visitor logs
  – Groups, such as church services, volunteers, more likely to visit over weekend
PIP Intervention

• Maintain regular, weekday staffing over the weekend to handle the workload.

• SMART Goal: Reduce the percentage of falls below the state average of 35.4% by maintain staffing levels over the weekends.
Three-Month PIP Results

- Falls decreased to 27.8% (35/126)
- PIP recommendations to QAPI Committee
  - Make staffing change permanent
  - Update the facility assessment to reflect weekend staffing burden and ratios
  - Maintain current staff training
  - Add fall QMs to monthly QAPI dashboard
  - Management to review QRP falls QM to ensure facility isn’t losing money through value-based payment
Phase 2 Resources
Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) Plan Review

QAA Review – This review should occur at the end of the survey, after completion of investigation into all other requirements. However, identification of systemic concerns to be reviewed during the QAA review should begin with Offsite Preparation and occur throughout the survey.

Offsite: Make note of concerns identified during offsite preparation, which will be further investigated during the survey (repeat deficiencies, ombudsman concerns, and complaints/facility-reported incidents). These represent possible systemic issues, which if validated during the survey, should be cited under the relevant outcome tag, and incorporated into the QAA review for investigation.

Team Meetings: During end of day team meetings, the survey team discusses potential systemic issues or shared concerns for further investigation, or those that have been validated for incorporation into the QAA review.

☐ Were any offsite concerns (repeat deficiencies, ombudsman concerns, and complaints/facility-reported incidents) validated during the survey?
☐ Were new systemic concerns validated (concerns which will likely be cited at pattern or widespread, or substandard quality of care) during the survey?
☐ Has more than one surveyor identified and validated the same concern?

Note: Disclosure of documents generated by the QAA committee may be requested by surveyors only if they are used to determine compliance with QAA regulations.

QAA Committee: Determine through review of the information requested by the TC during Entrance, an interview with the QAA contact person and review of QAA records:

☐ Does the facility have a QAA committee that meets at least quarterly?
☐ Does the QAA committee include the required members?
  • Director of Nursing Services;
  • Medical Director;
  • Nursing home administrator, owner, board member, or other individual in a leadership role; and
  • Two other staff members.

For every systemic issue identified and validated during the survey, determine if the QAA committee also has identified the issue and made a “Good Faith Attempt” to correct it. To determine this, do the following: a) interview the QAA contact person, and b) review evidence in order that will answer the following questions:

☐ Is the QAA committee aware of this issue?
☐ Is the issue a high risk, high volume, or problem-prone issue that the committee should know about?
☐ Has action been taken to correct this issue since it was identified?
☐ Is the QAA committee monitoring to ensure the corrective action has been implemented and the correction is being sustained?

https://goo.gl/5CskGv
QAPI Plans

Guide for Developing a QAPI Plan

DIRECTIONS:
The QAPI plan will guide your organization's performance improvement efforts. Prior to developing your plan, complete the Guide to Develop Purpose, Guiding Principles, and Scope for QAPI. Your QAPI plan is intended to assist you in achieving what you have identified as the purpose, guiding principles, and scope for QAPI; therefore this information is needed before you begin working on your plan. This is a living document that you will continue to refine and revisit. Use these step-by-step instructions to create your QAPI plan. This plan should reflect input from caregivers representing all roles and disciplines within your organization.

I. QAPI Goals
   Based on the Guide to Develop Purpose, Guiding Principles, and Scope for QAPI, indicate the QAPI goals that your plan will strive to meet. Goals should be specific, measurable, actionable, relevant, and have a time line for completion. (See Goal Setting Worksheet).

II. Scope
   a. Describe how QAPI is integrated into all care and service areas of your organization.
   b. Describe how the QAPI plan will address:
      i. Clinical care
      ii. Quality of life
      iii. Resident choice (i.e., individualized goals for care)
   c. Describe how QAPI will address safety and high quality with all clinical interventions while emphasizing autonomy and choice in daily life for residents (or residents' agents).
   d. Describe how QAPI will utilize the best available evidence (e.g., data, national benchmarks, published best practices, clinical guidelines) to define and measure goals.

III. Guidelines for Governance and Leadership
   a. Describe how QAPI is integrated into the responsibilities and accountabilities of top-level management and the Board of Directors (if applicable).
   b. Describe how QAPI will be adequately resourced:
      i. Designate one or more persons to be accountable for QAPI leadership and for coordination.
      ii. Indicate the plan for developing leadership and facilitate training on QAPI.
      iii. Describe the plan to provide caregivers, time, equipment, and technical training as needed for QAPI.
      iv. Indicate how you will determine if resources are adequate for QAPI.
      v. Describe how your caregivers will become and remain proficient with process improvement tools and techniques. How will you assess their level of proficiency?

Arizona Nursing Home Quality Care Collaborative (NNHQCC)

Creating a Quality Assurance and Performance Improvement (QAPI) Plan for Your Facility

This document offers a template to assist your facility in creating a QAPI Plan that will guide your organization’s performance improvement efforts.

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

www.hsag.com/aznursinghome
Facility Assessment

https://goo.gl/2qYPkk
CDC: Core Elements of Stewardship

• Leadership commitment
• Accountability
• Drug expertise
• Action
• Tracking
• Reporting
• Education

AHRQ NH Antimicrobial Stewardship Guide

• Examples of protocols, policies, and practices

https://www.ahrq.gov/nhguide/index.html
Nursing Home Training Sessions Introduction

We hope that you find these training tools and resources helpful in your work to implement antibiotic stewardship and prevent *C. difficile* infections in your residents. All are welcome to explore this site and use the information as applicable to you and your organization. Thank you for your dedication to preventing infections in residents (and staff, too) and promoting appropriate antibiotic use.

Training sessions and resources for nursing homes to support:
- Implementation of principles and practices of antibiotic stewardship
- Prevention and management of *Clostridium difficile* infections

*C. difficile* harms residents!

http://www.qioprogram.org/nursing-home-training-sessions
Action Items

- Review facility assessment template and complete by November 28.
- Review QAPI plan basics with committee members and complete plan by November 28.
- Review and apply CDC Core Elements into antibiotic stewardship plan, due November 28.
Thank You!
CMS Disclaimer

This material was prepared by Health Services Advisory Group, Inc., the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Publication No. AZ-11SOW-10202017-01