Nurse Leadership Prep Course for CDONA

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NADONA

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Lesson Ten - QAPI

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Contact Hour Accreditation

- This CNE activity has been provided by Ohio Nurses Association
- Learners must attend the entire session (live presentation or 11 webinars) and receive a passing post-test with a score of at least 80% in order to receive a certificate of contact hours.
- There is no conflict of interest for anyone with the ability to control content of this activity.
- This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)
- Approval Valid through June 1, 2024

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Disclosures

- Nancy has no relationships with commercial entities related to the healthcare industry.
- Nancy is the Assistant Director of Education for NADONA

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Objectives

- The participant will be able to
  - List 5 steps to implementing the QAPI program in a SNF
  - List 3 types of metrics to review
  - Relate process and outcomes needed to sustain the QAPI program
  - Describe the 4 components of PDSA
  - Describe the 4 elements in the PIP process

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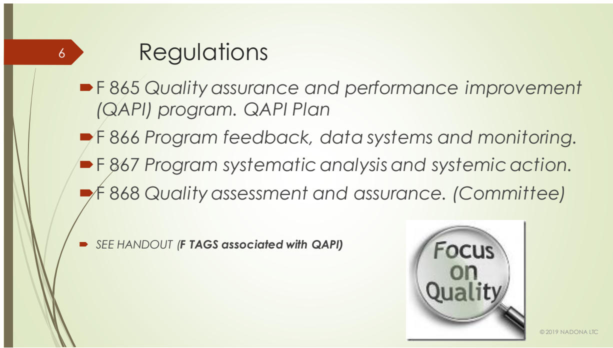

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F TAGS associated with QAPI

F865

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.75(a) Quality assurance and performance improvement (QAPI) program.

[§483.75 and all subparts will be implemented beginning November 28, 2019 (Phase 3), unless otherwise specified]

Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; [§483.75(a)(2) implemented November 28, 2017 (Phase 2)]

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.

A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

INTENT

These requirements are intended to ensure facilities develop a plan that describes the process for conducting QAPI/QAA activities, such as identifying and correcting quality deficiencies as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety.

GUIDANCE §483.75(a)(2)-(3), and (h)-(i)

QAPI Plan

A QAPI plan is the written plan containing the process that will guide the nursing home's efforts in assuring care and services are maintained at acceptable levels of performance and continually improved. The plan describes how the facility will conduct its required QAPI and QAA committee functions. The facility is required to develop a QAPI plan and present its plan to federal and state surveyors at each annual recertification survey and upon request during any other survey, and to CMS upon request.

The QAPI plan must describe in detail the scope of the QAA committee's responsibilities and activities, and the process addressing how the committee will conduct the activities necessary to identify and correct quality deficiencies. Each nursing home, including facilities which are a part of a multi-chain organization, should tailor its QAPI plan to reflect the specific units, programs, departments, and unique population it serves, as identified in its facility assessment.

The QAPI plan must describe how the facility will ensure care and services delivered meet accepted standards of quality, identify problems and opportunities for improvement, and ensure progress toward correction or improvement is achieved and sustained.

The QAPI plan must describe the process for identifying and correcting quality deficiencies. Key components of the

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F866-Program Feedback, Systems, and Monitoring

- Develop policies and procedures related to how the feedback and data will be collected and monitored.
- Use feedback provided by stakeholders, including direct care staff, residents and resident representatives.
- Identify high risk areas or problems.
- How the data will be maintained from all departments and used for performance indicators, including the Facility Assessment.
- How the performance improvement activities will be monitored and evaluated, including the method and frequency, to ensure sustainability.
- How the facility will use adverse events to develop activities to prevent in the future.

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F867-Program Systematic Analysis and Systemic Action

- How a systematic approach will be used to determine the underlying causes of problems that impact larger systems.
- How corrective action plans will be developed to effect change at the systems level to prevent problems related to quality of care, quality of life, or safety.
- Focus on high- risk, high -volume problem-prone areas.
- Include outcomes that focus on resident autonomy and choice.
- One PIP must include the facility's services through the Facility Assessment and another PIP must include a high-risk or problem-prone area that has been identified by the data collection.

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F868 Quality Assessment and Assurance-Committee

- The Committee must meet at least Quarterly
- The Committee must be comprised of the DON, IP, Medical Director or Designee, and 3 additional members, one of which is the Administrator, Owner, or Board member who hold a leadership role. The Consultant Pharmacist is also recommended to serve on the Committee as their input can address high-risk, quality of life, and other risk factors such as medication errors.
- It is important to note the membership as discussed in the CMS SOM is a MINIMUM requirement and it goes on to state the other department heads should have an opportunity to be involved as well as residents and family having vital information for the Committee.

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Clinical Decision Making is Fueled by QAPI

- Performance Improvement drives decision making
- Promotes Excellence in Quality of Care, Quality of Life and Person-Directed Care and Service
- Navigating this process gives you a starting point, an ending point and most importantly a system and process to follow in the day- to- day operations

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Your Role & Duties as the DON in the QAPI Process

- Role
  - Develop, maintain and periodically update written policies and procedures that govern the day- to- day functions of the Nursing Service Department
  - Develop, maintain and periodically update the Nursing Service Policy and Procedures Manual and nursing service objectives and philosophies
  - Develop methods for coordinating nursing services with other resident services to ensure continuity of the resident's total regiment of care
- Duties
  - Develop, maintain and periodically update written job descriptions for each level of nursing personnel
  - Maintain a reference library of written materials(PDR, SOM, Stop and Watch, AMDA guides) that will assist the Nursing Service Department in meeting the day to day needs of the resident
  - Develop, implement and maintain and ongoing QAPI Program for the Nursing Service Department

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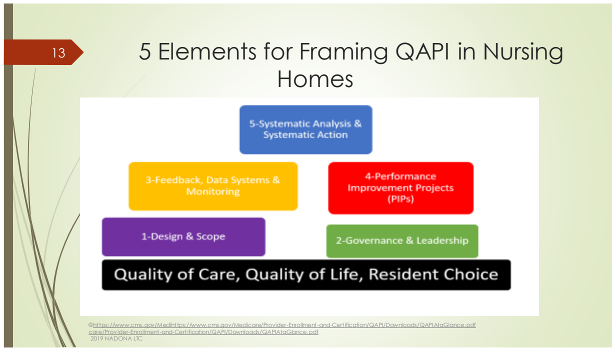

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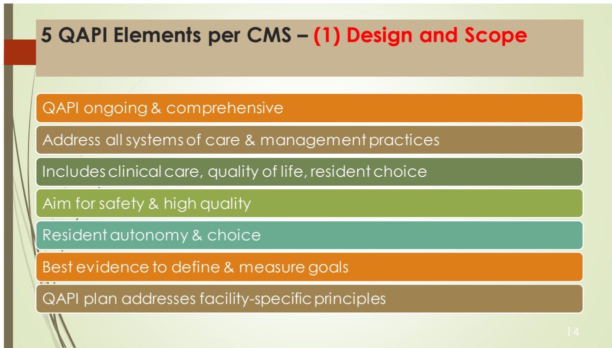

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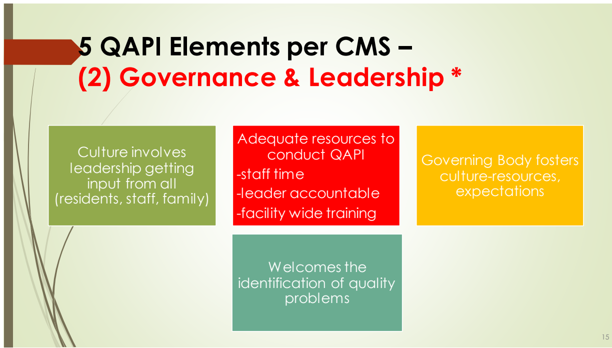

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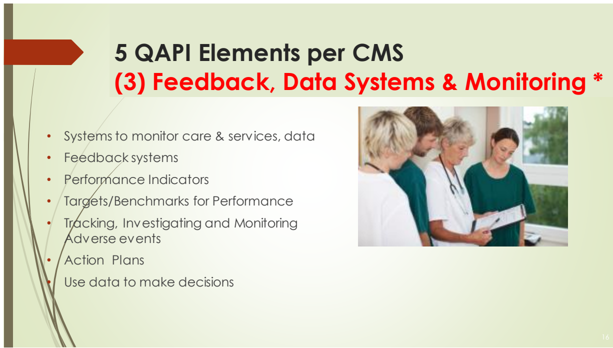

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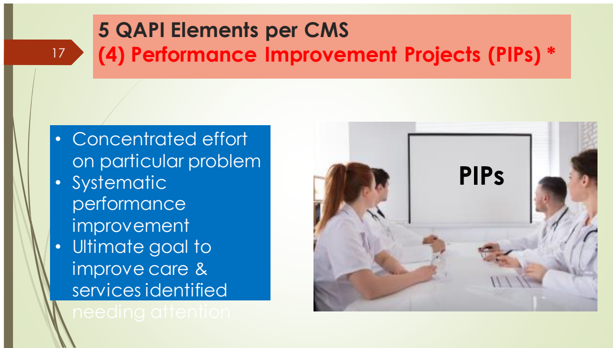

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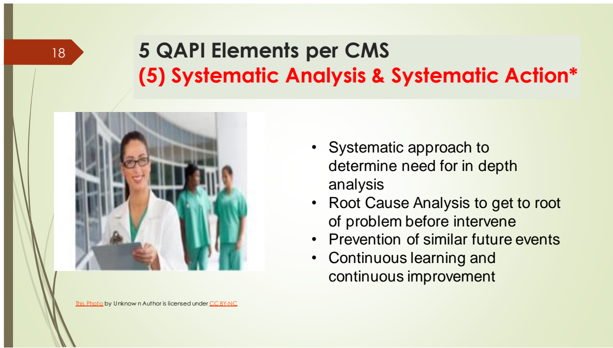

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QAPI

- QAPI is the merger of 2 approaches to quality.
  - QA – is a process of meeting quality standards and assuring that care reaches an acceptable level, hopefully beyond regulatory requirements. QA is a reactive, retrospective examination.
  - PI – is a proactive and continuous study of processes to identify areas of opportunity and new approaches to fix underlying causes of persistent or systemic problems, for better health care delivery and resident quality of life.

Both are data driven approaches to improving the quality of life, care and services in nursing homes, involving members at all levels of the organization.

Before QAPI was introduced we used to just report the data.

Source: CMS

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7 Components of QAPI

- Forming a team – having the right people on the team is critical to the success of the improvement effort
  - Who are your right people
  - Can you identify your clinical staff visionary, your educator and who are your workers?
  - How will you pay for their time?
- Setting Goals – the goal should be time specific and measurable. It defines the resident population and or system that will be affected
  - What are your goals
  - Think in terms of time and measure
  - Get specific - Falls with Major Injury, Reduction in Urinary Tract Infection and Reduction in 30 day Readmission to Hospital
- Establish Measures – Determine specific guidelines to be able to ascertain if the change leads to an improvement
  - Identify quantitative measures to determine if change leads to improvement
  - Focus on Reduction of Falls, Urinary Tract Infection and Readmission to Hospitals within first 30 days of discharge from hospital

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7 Components of QAPI cont.

- Selecting Changes – Ideas come from many sources such as staff, change concepts, creative thinking or borrowed from others successful experiences
  - Look at current clinical standard of practice and regulatory history
- Testing Changes – PDSA is a way to test the change by planning it, trying it, observing it and acting on what was learned.
- Implementing Changes – Once the pilot testing has gone through the PSDA process 1- multiple times and revised it is time to take it to a broader scale
  - Let the team direct the change based on initial focus group outcomes
  - Plan-Do Study-Act again
- Spreading Changes - Once the implementation has been deemed successful it can be taken to the entire organization or where it is needed
  - Culture Change
  - Update Policy and Procedure
  - Educate Current Staff and develop orientation education
  - Time and Place
  - Audit Outcomes

https://www.medline.com/media/mkt/pdf/ProvidigmQAPIToolkit.pdf

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Implementing the QAPI in a SNF

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- Ownership is established (Administrator must be in charge)
- Identify the team members (DON, Physician, 3 other staff members, 2019 New rules call for the Infection Preventionist) (This is #1 of the 5 elements-Design and Scope and #2-Governance and Leadership)
- Committee meets and discusses issues – Defines areas that need to be worked on and achievable/measurable goals-(#3-Feedback, Data systems, monitoring)
- Root cause analysis – Determine what caused this
- Determine Interventions – What might fix and prevent from happening again- Set up a PIP.
- Implement interventions – Start small, a few residents small unit etc.- (#4-Performance Improvement Projects)
- Audit results - Develop an audit tool and then audit while piloting the interventions
- Improve the process as indicated Use results from auditing to fine tune interventions
- Continuous audits to ensure the changes are sustained- (#5-Systematic Analysis and Systematic Action)

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Outline of the QAPI process

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QAPI committee – collects and reviews data from many sources (QMs, Satisfaction surveys, Infection data, rehospitalizations etc.).

→ QAPI Meets monthly – to identify areas of opportunity based on the eval of data

→ QAPI assigns Performance Improvement Project (PIP) team to an opportunity

→ PIP team does a root cause analysis (RCA) (5 WHYS)

→ PIP team meets often between meetings initiating the PDSA process and reports back to the QAPI

→ The QAPI then reviews and makes recommendations for further PDSA work or to enlarge the scope

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Performance Improvement Plan

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- A PIP is implemented when a problem is identified
- PIP systematically gathers information to clarify issues and intervene improvement
- Recommendations can be made to reinforce and expand identified positive approaches and outcomes
- New quality indicators should be developed to measure improvement

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PIP Process

- Based on the facility assessment or area of concern
- Identify the issue
- Root cause analysis
- Review the person-centered care plan / policy/procedure etc.
- Monitor and evaluate the outcome

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Another Way to Look at QAPI Steps to a PIP

- QAPI collects and evaluates the data
- QAPI meets monthly to identify opportunities for improvement
- A Root Cause Analysis is completed
- QAPI assigns a PIP
- PIP group meets outside of QAPI and reports back
- Monitor the sustainability of the outcome.

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PIP Scenario

- During a monthly QAPI meeting it was discovered that there was a pattern of unexplained weight loss over the past 2 months. The discussion revealed that there had been an increase in uneaten food and also in the use of supplements.
- A PIP was formed. It included a CNA, Charge nurse, SW, Dietician and a NP.
- Root Cause analysis was completed
  - No process existed for identifying and addressing risks for weight loss such as dental condition, diagnosis, or use of appetite suppressing medications;
  - No system existed to ensure resident preferences are honored;
  - Staff lacked an understanding of how to document food intake percentages; and
  - Residents reported the food was not appetizing.

https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiataglance.pdf

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Potential Interventions *

- Development of a protocol for identifying residents at risk for weight loss to be done on admission and with each care plan. This protocol included a review of medications (appetite suppressants), new diagnoses, and resident assessments, including dental issues;
- Development of standing orders for residents identified as "at risk" for weight loss. These would include bi-weekly weights, referral to attending physician and dietitian for assessment, and documentation of meal percentages;
- Development of a new program for CNAs to be "Food Plan Leads" for at risk residents. The program would include identification of food preferences and accurate documentation of meals - laminated badge cards with pictures of meal percentages were distributed to all CNAs; and
- Revision of the menu to focus on favorite foods, adding finger foods and increasing choices outside of mealtimes.
- Monitoring to show the PIP was sustained and results reported to QAPI.

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Prioritization Worksheet for Performance Improvement Projects

Directions: This tool will assist in choosing which potential areas for improvement are the highest priority based on the needs of the residents and the organization. Follow this systematic assessment process below to identify potential areas for PIPs. This process will consider such factors as high-risk, high-volume, or problem-prone areas that affect health outcomes and quality of care. This tool is intended to be completed and used by the QAPI team that determines which areas to select for PIPs. Begin by listing potential areas for improvement in the left-hand column. Then score each area in the following columns based on a rating system of 1 to 5 as defined below:

1 = very low	2 = low	3 = medium	4 = high	5 = very high

Rating is subjective and is meant to be a guide and to stimulate discussion. Finally, add the scores across the row and tally in the final column. Potential improvement areas with a higher score indicate a higher priority.

POTENTIAL AREAS FOR IMPROVEMENT Consider areas identified through: Dashboard(s) Feedback from staff, families, residents, other Incidents, near misses, unsafe conditions Survey	PREVALENCE The frequency at which this issue arises in our organization.	RISK The level to which this issue poses a risk to the well-being of our residents.	COST The cost incurred by our organization each time this issue occurs.	RELEVANCE The extent to which addressing this issue would affect resident quality of life and/or quality of care.	RESPONSIVENESS The likelihood an initiative on this issue would address a need expressed by residents, family and/or staff.	FEASIBILITY The ability of our organization to implement a PIP on this issue, given current resources.	CONTINUITY The level to which an initiative on this issue would support our organizational goals and priorities.	TOTAL SCORE TALLY

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Additional factors to take into account:

1. What existing standards or guidelines are available to provide direction for this initiative?
2. What measures can be used to monitor progress?
3. Is the topic publicly reported on Care Compare and/or is it a goal of the Advancing Excellence in America's Nursing Homes campaign?
4. . Which type of changes primarily will be involved (i.e., system changes, environmental changes, staffing changes)?
5. Which staff will be most affected by the initiative? What training needs will this initiative present?
6. Is there an identified champion(s) for this initiative?

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Process Improvement Example

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- Traditional
  - End of shift report discussion of everything that occurs in the past eight hours
  - Discussion of tasks not done
  - Share misc. information about events of the facility
- Transitional
  - Focus on Person centered needs of the resident
  - Assign staff to Assess and evaluate interventions provided to resident
  - Communicate to Care Partners needs of the residents and obtain actionable directives

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ADHOCS

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- Ad Hoc committee formed to consider a specific, urgent matter. Latin for, for this purpose.
- As issues come up in between QAPI meetings ADHOC committees are used to figure out the issue.
  - Example: Family member complained to DON that mother wasn't being positioned as requested.
  - DON formed a ADHOC committee comprised of Nurse manager, Med nurse and aides from 2 shifts to resolve this concern
  - ADHOC met and did a root cause analysis as to why this was occurring
  - Once the root cause was determined a plan was determined
  - The plan was put into place

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AD HOC Cont.

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- The family member was informed both of the plan and the auditing process. She was informed as to what and who to report to if the plan wasn't working.
- Auditing was done and the issue continued. The committee met again and reevaluated the plan. Changes were made and implemented.
- Auditing began again and results indicated plan was working
- Family member was contacted and was in agreement that the plan was working
- The plan remained and ADHOC plan and results were reported to the QAPI

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Metrics to Review

- There are many items that could come under review in QAPI
  - Clinical Outcomes
  - Customer Satisfaction
  - Readmission Rates
  - Length of stay
  - Resident costs
  - PPD Ratios
  - Turnover rates
  - Review of PIPs with Results
  - Physician performance metrics results

Cycle of Continuous Improvement: Written policies, standards & procedures; Staff training; Supervision; Internal & external audit; Corrective Action; Learning & improving services

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Metrics cont.

- What have you used in your QAPI???

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How to have your QAPI Survive and Thrive

- Monthly meetings 1-hour timeframe
  - **Standardized agenda** - An agenda provides structure that guides the meeting. Use of agendas improves meeting efficiency and improves likelihood of achieving outcomes
    - Includes:
      - Purpose of the Meeting
      - Topics
      - Time Estimates for each Topic
      - Lead Person for each Topic
    - Guidelines for use
      - The agenda should be developed prior to the meeting, if possible, and distributed to participants.
      - Review agenda with participants at the start of the meeting
      - Discuss and make any necessary changes.

https://www.medline.com/media/mkt/pdf/ProvidigmQAPIToolkit.pdf

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Monthly Meetings cont.

- Guidelines
  - Establish during first few minutes
  - Review and revise as necessary
- **Meeting Roles** - Assigning meeting roles clarifies and assigns responsibilities. Roles help hold members accountable and ensure meeting time is productive
  - Chair person
    - Sets the date and time of meeting
    - Prepares the agenda
    - Ensures the meeting room is set up
    - Notifies committee members of scheduled time and meeting location

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Monthly Meetings cont.

- Chairperson cont.
  - Notifies guests of scheduled time and meeting location
  - Prints and distributes the meeting minutes
  - Ensures data reports are available
  - Compiles a list of potential agenda topics and distributes to members
  - Looks for trends and prioritizes the information
  - Maintains meeting schedule
  - Schedules subsequent meetings in response to a significant finding

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Monthly Meetings cont.

- Facilitator
  - Facilitates the meeting
  - Opens meeting
  - Announces agenda and time allotments for each topic
  - Announces meeting direction and goals
  - Maintains control of flow of meeting
  - Encourages team member participation
  - Ensures needed actions are assigned
  - Defines and delegates tasks
  - Knows when it is time to summarize information
  - Announces next meeting time and place
  - Closes meeting
  - https://www.medline.com/media/mkt/pdf/ProvidigmQAPIToolkit.pdf

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Monthly Meetings cont.

- Timekeeper
  - Keeps accurate track of time during meeting
  - Alerts when the time allotted for an agenda topic is almost up so the group can decide whether to keep discussing or move on
  - Assists the group to manage time effectively
- Recorder (Note taker)
  - Writes updates on the Meeting Minutes as directed by the team discussion and input
  - Condenses discussion points when possible
  - Verifies that ideas and information is written accurately
  - Summarizes discussions in complete sentences
  - Gets input from group on wording of needs, preference, problems, goals and interventions

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Monthly Meetings cont.

- Member
  - Reviews data reports in their area of responsibility and notifies the meeting organizer of potential agenda topics
  - Arrives on time and is prepared
  - Remains attentive and focused throughout the meeting
  - Is prepared to share and participate in discussion
  - Contributes to development of action plans
  - Accurately completes assigned documentation
  - Proceeds to share/implement action plans

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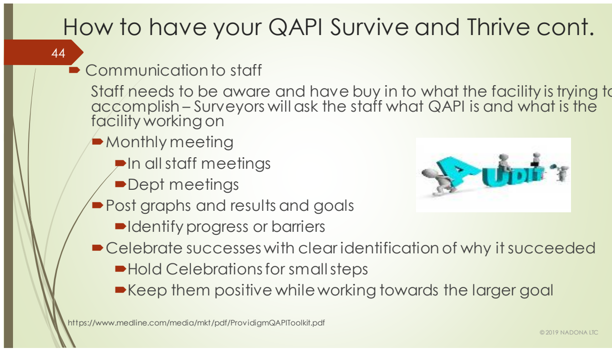

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Topic	Process Owner	Summary of Analysis should include Trends and Root Cause Analysis
Facility Specific Topic:	______	
CMS Quality Measures Flagging over 75% Short & Long Stay	______	Identify QM's flagging over 75% Analysis & Actions

Measure	%

Month:	Analysis:
Jan.	
Feb.	
Mar.	
Apr.	
May	
June	
July	

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QAPI Meeting Minutes – Action Plan

Issue/Concern	Person(s) Accountable	Root Cause Analysis	Goal/Plan	Action Steps	Follow Up

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PDSA process

- There are different methods that can be used to work through an issue
  - PDSA is one that is widely used
    - Plan a change
    - Do it (in a pilot)
    - Study to see if it is working
    - Act – continue if working or revise

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PDSA Example

- Family member complained to DON that mother wasn't being positioned as requested.
- DON formed a ADHOC committee comprised of Nurse manager, Med nurse and aides from 2 shifts to resolve this concern
- ADHOC met and did a root cause analysis as to why this was occurring
- Once the root cause was determined a plan was determined (P)
- The plan was put into place (D)
- The family member was informed both of the plan and the auditing process. She was informed as to what and who to report to if the plan wasn't working. (S)

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PDSA Example cont.

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- Auditing was done and the issue continued. The committee met again and reevaluated the plan. Changes were made and implemented. (A PD)
- Auditing began again and results indicated plan was working (SA)
- Family member was contacted and was in agreement that the plan was working
- The plan remained and ADHOC plan and results was reported to the QAPI

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Conducting a Root Cause Analysis

- #1 Example: CNA used wrong lift sling. Resident was in dire hurry to get up onto toilet before an incontinent episode and was insisting and very anxious.
- #2 Example: Resident did not get fed supper until all other residents had eaten.

Problem Statement
Why?
Why?
Why?
Why?
Why?

Root Causes:
1.
2.
3.

If you removed this Root Cause, would this event have been prevented?

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RCA #1 (Example Cont'd)

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- Why: Not able to find correct sling
- Why: Sling with no number was not in room
- Why: Slings in linen closet did not have any numbers
- Why: New slings had arrived and were not marked with correct numbers before putting into linen closet
- Why: Central Supply CNA was out on LOA. No one crossed trained to mark new slings
- (Why: This cross -training need was an oversight by the DON)
- Intervention or Action: Slings were marked and backup trained

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RCA #2 Example

- Why: No staff were available to assist resident
- Why: 3 aides on wing: all three were feeding 2 other residents each.
- Why: Nurses on Unit took supper breaks during resident meals.
- Why: It had always been scheduled that way.
- Why: They had more independent residents when that practice was started.
- Intervention or Action: Policy changed so no clinical staff off floor during resident mealtime.

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QAPI Tools

- During the Plan phase of PDSA, Quality Improvement tools are used to assist to determine 'why' a problem is occurring and to better understand performance improvement opportunities. Some common tools to assist in Root Cause Analysis (RCA) may include:
- Cause and Effect Diagram or Fishbone A cause and effect diagram is used to show what potential root causes of the problem might be by sorting ideas into categories.
- Root Cause Analysis (RCA) RCA can be used to evaluate events (adverse events, incidents, near miss or complaints) and to better understand performance opportunities.

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FISHBONE DIAGRAM

Category | Category | Category | Insert text here | Category | Category | Category

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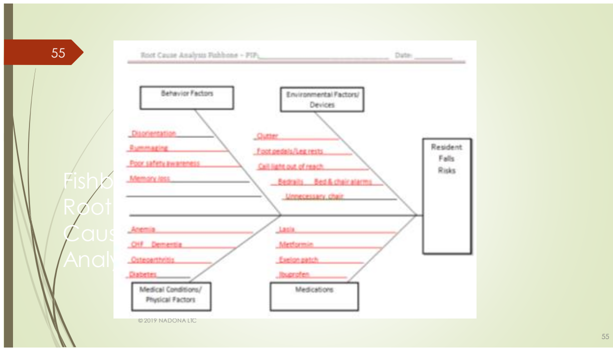

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Getting ready for QAPI

Based on data your outliers are :

A. Rehospitalization rate has increased

B. The Dementia Unit has an increase in falls compared to your other units

C. Your staff has reported 3 acquired pressure sores

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Solution based strategies

- But first ROOT cause analysis
- What is your process
  - 5 Whys

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You Need a Sustainability Plan

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- Identify your system approach to determine underlying causes of problems impacting larger systems
- Develop actions to effect change at the systems level to prevent quality of care, quality of life and safety problems
- Implement a monitoring system to ensure that improvements are sustained by measuring success and tracking ongoing performance
- Remember not to try and review EVERYTHING. Pick a few high risk or important areas, then work on another few.

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QAPI Agenda and Meeting Minutes
For month of January 2019

Facility Name:	Meeting Date
Meeting Facilitator:	Time:

Vision Statement: To be the premier provider of healthcare services in the communities we serve.
Mission Statement: To exceed customer expectations through genuine quality care, innovative services and positive operational outcomes.
Core Values: Respect, Empowerment, Accountability, Compassion, Trust.
Our QAPI Purpose: To take a proactive approach to continually improve the way we care for and engage our key stakeholders.

Members Name	Title	Attendance (✓)
	Administrator	☐
	Director of Nursing	☐
	Medical Director	☐
	Nurse Manager	☐
	Nurse Manager	☐
	Nurse Manager	☐
	QA/IC/Staff Development	☐
	MDS Coordinator	☐
	Social Worker	☐
	Director of Dietary Services, RSG	☐
	Pharmacy Consultant	☐
	EVS Manager	☐
	Director of Admissions/Marketing	☐
	Business Office Manager	☐
	Therapeutic Rec Director	☐

Review action plan from previous meeting

Issue/Concern	Person(s) Accountable	Root Cause Analysis	Goal/Plan	Action Steps	Follow Up

New Business

Quality of Care

Topic	Process Owner	Summary of Analysis should include Trends and Root Cause Analysis

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Topic	Process Owner	Summary of Analysis should include Trends and Root Cause Analysis
Readmission to Hospital Trend Tracker Time Frame for report = Average Rehospitalization = Actual Rehospitalization Rate = Expected Rehospitalization Rate = below 20 % Risk Adjusted Rehospitalization Rate =	DON	

	# of Admissions	# of Discharges	# of Deaths	# of Residents sent to hospital & admitted	Un-avoidable #	Un-avoidable %	Avoidable #	Avoidable %	30-day RTH % %	Total RTH % %
Jan.			0			%	0	0 %	%	
Feb.										
Mar.										
Apr.										
May										
Jun.										
Jul.										
Aug.										
Sept.										
Oct.										
Nov.										
Dec.										

Summary of Analysis: Trend Tracker (Quarterly Review)

Month:	Analysis:
Jan.	
April	
July	
Oct.	
Nov.	
Dec.	

Topic	Process Owner	Summary of Analysis should include Trends and Root Cause Analysis
Falls Total Falls	Nurse Manager	Falls

	Jan.	Feb	Mar.	Apr	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec

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Topic	Process Owner	Summary of Analysis should include Trends and Root Cause Analysis
Falls/with Injury	, Nurse Manager	Falls with Injuries:

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Fx	0											
Head	0											
Other Injury												
Total falls with injury												
Mo. Trends												

Summary of Analysis: Falls with Injury

Month:	Analysis:
Jan.	
Feb.	
Mar.	
Apr.	
May	
June	
July	
Aug.	
Sept.	
Oct.	
Nov.	
Dec.	

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Some Other Topic Examples

- 5 Star
- PU
- Dining
- Resident Council
- Activities Satisfaction

And maybe if not a high- risk area, you only review quarterly, not monthly.

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Resources

- **Federal Register** /Vol. 81, No. 192 /Tuesday, October 4, 2016 /Rules and Regulations
- QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home - CMS / U of MN Stratis Health

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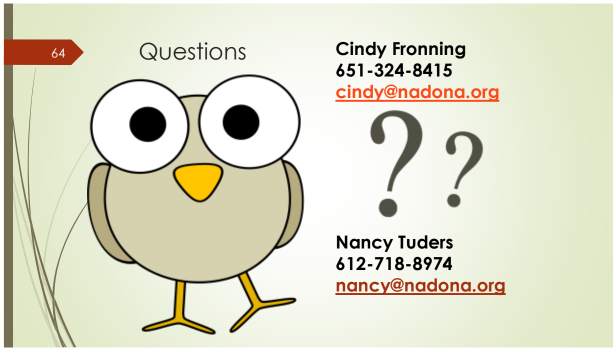

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