QA/PI
QUALITY ASSESSMENT
&
PERFORMANCE IMPROVEMENT
WHERE TO START?

Presented by:
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President

WHY DO WE DO QA/PI???

- CMS
- AAAHC
- TJC
- AAAASF
- IMQ

THE REAL GOAL

PROVIDE QUALITY PATIENT CARE

- STREAMLINE SERVICES
- IMPROVE PATIENT CARE/OUTCOMES

THE NEW FOCUS

PEOPLE → PROCESS

"DOING THINGS RIGHT THE FIRST TIME"

MOST COMMON APPROACH

IMPORTANCE OF QUALITY ISSUE IDENTIFICATION

- INCIDENCE, SEVERITY (death, wrongs, return to OR)
- PREVALENCE (falls, outdated meds/supplies)
- COST (sharps injuries, laundry service)
- SAFETY (medication errors, instrument cleaning)
- COMPLAINTS (long wait times, painful IVs)

MOST COMMON APPROACH

CLARIFICATION OF THE ELEMENTS

- INITIAL DISCOVERY – DESIGN
- FACILITY WIDE INVOLVEMENT – MEASURE
- ANALYSIS – ASSESS
- ACTION PLAN – IMPROVE

MOST COMMON APPROACH

VERIFIABLE EVIDENCE (PROOF)

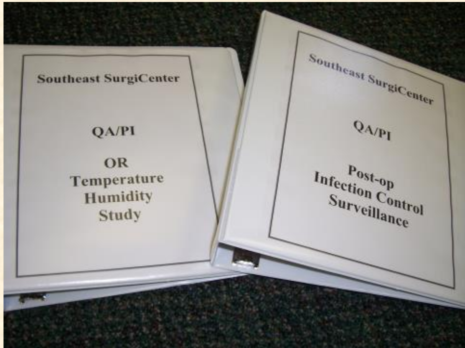
- COMMUNICATION
- SUSTAINABLE RESULTS (ROUND TWO)

QA/PI

GENERAL RULES

- ONGOING
- DATA DRIVEN
- ANNUALLY
- WRITTEN DOCUMENTATION
- CONNECTION TO INFECTION CONTROL ISSUES

ORGANIZATION



ORGANIZATION

- SCOPE
- DATA
- ANALYSIS
- ACTION
- REPORTING

1. WHAT & WHY?

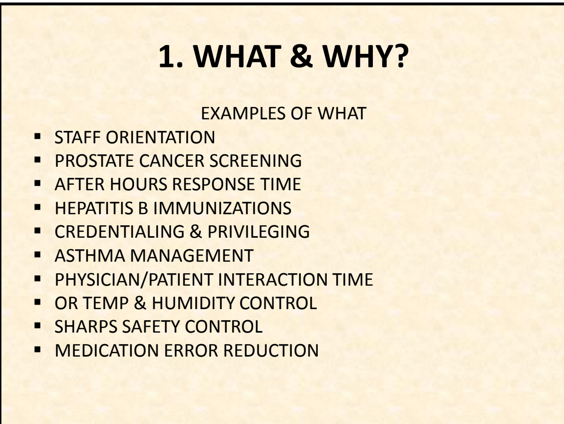
FOCUS OF STUDIES

- SAFETY ISSUES
- PRIORITIZATION / RELEVANCE
- INFECTION CONTROL
- ADVERSE PATIENT EVENTS
- GB OVERSITE

1. WHAT & WHY?

EXAMPLES OF WHAT

- HANDWASHING
- PATHOLOGY REPORT RECONCILIATION
- INFUSION SITE COMPLICATIONS
- PRE-ANESTHESIA ASSESSMENTS
- FLASH STERILIZATION
- HEALTHCARE ASSOCIATED INFECTIONS
- HOSPITAL TRANSFERS
- ANTIBIOTICS – ADMINISTRATION TIME
- ENVIRONMENTAL CLEANING OF THE OR
- PPE COMPLIANCE



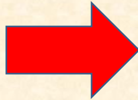
1. WHAT & WHY?

EXAMPLES OF WHAT

- STAFF ORIENTATION
- PROSTATE CANCER SCREENING
- AFTER HOURS RESPONSE TIME
- HEPATITIS B IMMUNIZATIONS
- CREDENTIALING & PRIVILEGING
- ASTHMA MANAGEMENT
- PHYSICIAN/PATIENT INTERACTION TIME
- OR TEMP & HUMIDITY CONTROL
- SHARPS SAFETY CONTROL
- MEDICATION ERROR REDUCTION

1. WHAT AND WHY?

Example
of
Scope
Statements



The Regional Surgery Center

2013

Employee Flu Vaccine

Program Scope

RSC is committed to being an example of high standards within the health care community. Knowing that the CDC has made a recommendation for flu vaccination among healthcare workers, the organization has elected to not only provide its employees with a fully paid opportunity to receive the vaccine, but also to openly promote the importance of vaccination. Our hope it that 2013 participation will exceed 2012.

Per the CDC, the timing of flu is very unpredictable and can vary from season to season. Flu activity most commonly peaks in the U.S. in January or February. However, seasonal flu activity can begin as early as October and continue to occur as late as May. Most of the flu vaccine offered for the 2013-2014 season will be trivalent (three component). Some seasonal flu vaccines will be formulated to protect against four flu viruses (quadrivalent flu vaccines) and will be available as well according to manufacturers. All nasal spray vaccines are expected to be quadrivalent, however, this makes up only a small portion of total vaccine. RSC will offer the most effective vaccine it is able to secure.

Primary Surgery Center

2014

Patient Cancellation Study

Program Scope

PSC dedicates 1.5 FTE's to schedule patients for surgery, verify insurance, assemble charts, and engage in general scheduling patient communications as well as reminder calls. Recently the incidence of cancellations appears to have increased and the organization is concerned regarding motivation for cancellation. Tracking and analyzing specific reasons for cancellations is being conducted to uncover additional areas of concern as well an effort to examine work process in hopes for improvement. As a premier ASC in the Las Vegas area it is important to the organization to uncover any incidents where we fall short of patient expectations.

Additionally it is recognized that expenses may be inflated due to losses for salaries directed towards manpower involved. These patient openings often occur so close to the surgery date that the time slots cannot be filled with another patient thus loosing revenue and potential down time for surgical staff causing again extra staff salary expense.

2. HOW?

- TOOLS
- PHONE CALLS
- SURGEON/PHYSICIAN FOLLOW-UP

Data Collection Plan

&

Goals

Patient Cancellation Study

1. 100% of cancellations will be recorded.

2. Goal to determine reason for 100% of cancellations.

3. Goal to reschedule 80% of cancellations with successful completion of surgery.

4. Goal to decrease cancellation rate (percentage to be determined after analysis).

2. HOW?

1. Design the tools you will use
2. Document details:

- By whom
- Where
- When
- For how long
- Percentage or entire universe

3. ANALYSIS

What does all this data mean?

Numerator
Denominator

Show your work!

4. ACTION PLAN

- PROCESS CHANGE / WORK FLOW
- STAFFING CHANGE
- PRODUCT CHANGE
- VENDOR CHANGE
- CAPITAL EQUIPMENT
- EDUCATION / TRAINING

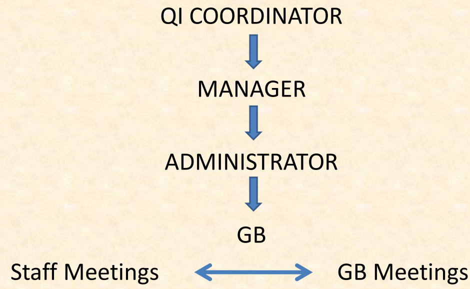
Lab/Path Report Action Plan: ***Prevention Initiatives***

Problem:	Lab/Path reports not signed by provider and in some cases not filed in medical records
Outcome Goal:	100% of tests performed signed by provider and filed in medical record
Beginning Measure:	43% of facilities are in 100% compliance
Post Intervention Measure:	

Problem	Baseline #	Prevention Strategies	Implementation* Status/Date Person Responsible	Post Intervention Results	Comments
Unsure if all tests logged reflect accurate number of tests actually done.	7 of 15 facilities had lab/path tests performed	Keep NCR Copy of requisition so we can cross ref with logs	Each location DON, start 11/1/13 (IP)	Nov results were 100% accurate	
Not all test results have been filed in the ASC medical record.	One facility was missing one result when logs were used to cross reference charts	Each location has been in-serviced as of 11/1/13			
Not all tests have been reviewed and signed by a provider.	Of the 37 reports reviewed only 28 or 76% were signed by a provider per our policy	Medical Director to instruct all surgeons	Medical Director send letters to all surgeons 11/1/13		12/1/13 Medical Staff meeting 100% of attendees acknowledge receipt of letter

*Pending (P) In Progress (IP) Completed (C)
± Year, Quarter, Month

5. OVERSIGHT / REPORT



QA/PI Committee Meeting

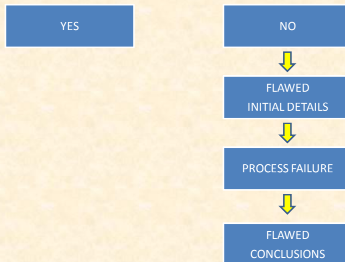
DATE: Dec. 12, 2013

Attendance	
Attendees	Dr. Smith, Pharmacist Mary, DON Jane, Infection Preventionist Ellen, Jackie CRNA, Nancy Nurse
Guests	Roger -
Excused	Jim Administrator
Absent	Julie Scrub Tech

Study	Start Date	Current Stage	Responsible Team Member	Comments
Hand Hygiene	10/15/13	Collection of 1st round data completed	Ellen	Ellen will report analysis at next meeting
Lab Reports	12/1/13	Collection of data has started	Jane	Jane trained all staff filling out detail for consistency
Sharps injuries	2/1/13	Study completed 12/1/13	Finished	Dr. Smith remarked since completion of study no new incidents!!

SUSTAINABLE RESULTS?

Round Two



QUALITY IMPROVEMENT

1. A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and **explains why it is significant to the organization**.

QUALITY IMPROVEMENT

1. Recent observations have caused concerns that staff may not be consistently and properly washing hands. Healthcare acquired infections have been linked by the CDC to poor handwashing techniques.

QUALITY IMPROVEMENT

2. Identification of the performance goal against which the organization will compare its current performance in the area of study.

QUALITY IMPROVEMENT

2. Current performance goal desired is 90% compliant.

QUALITY IMPROVEMENT

3. Description of the data that will be collected in order to determine the organization's current performance.

QUALITY IMPROVEMENT

3. Observation will occur in all areas of the facility on a targeted basis. Indicator Data Requirements will include:

- Wash with soap and water when visibly soiled
- Before & after patient contact, procedures
- Before & after gloving
- Before & after eating or using restroom

QUALITY IMPROVEMENT

4. Evidence of data collection.

QUALITY IMPROVEMENT

4. Monitoring tool used in each area of the facility one time weekly on a unscheduled basis.

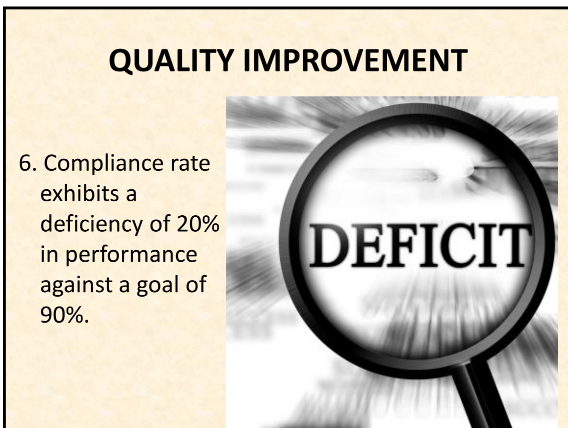
QUALITY IMPROVEMENT

5. Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).

QUALITY IMPROVEMENT

Sun	Mon	Tue	Wed	Thu	Fri
			1	2	3
24	25			30	
31					

5. Over an 8 week period, it was observed in general, a 70% compliance rate, with the least compliant area being the pre-op area upon removal of gloves.



QUALITY IMPROVEMENT

7. Implementation of corrective action(s) to resolve identified problem(s).

QUALITY IMPROVEMENT

7.

- Staff meeting scheduled with training on handwashing.
- ABHS availability increased throughout the facility.

QUALITY IMPROVEMENT

8. Re-measurement (a second round of data collection and analysis to objectively determine whether the corrective actions have achieved the sustained demonstrable improvement).

QUALITY IMPROVEMENT

8. 8 week re-measurement study performed.

QUALITY IMPROVEMENT

9. If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implement additional corrective action(s) and continued re-measurement until the problem is resolved or is no longer relevant.

QUALITY IMPROVEMENT

9. Compliance now at 90%, which does meet the overall objective. However, it was noted that 99% of the non-compliance rate was attributed to employee NO 29. Additional corrective action involved individual counseling of this employee. Study to continue for an additional 8 weeks.

QUALITY IMPROVEMENT

10. Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities.

QUALITY IMPROVEMENT

10.

- Report to Facility Administrator
- Communication of findings to staff at the monthly staff meeting (include in-service).
- Report to Medical Director
- Report to GB

Surgery Center XYZ
Quality Improvement Study — **Jan 2010**

Timely Filing of Pathology Reports

Assessed Problem	Purpose	Why important to fix
Pathology reports were not being filed in the patients medical records in a timely manner.	To ascertain that pathology reports are reviewed by the physicians and incorporated into the medical records in a timely manner.	Improving the process will ensure compliance to and adherence to the center's policy and procedures on timely filing and completion of medical records. This will potentially affect patient outcomes if notification untimely.
Goals	**Measure**	**Data needed**
To increase awareness and compliance with Surgery Center XYZ *Medical Records* Policy on timely filing of path reports.	Audit tool developed to measure when the procedure was performed and when pathology reports were received from Lab and filed.	Audited all medical records for filing of path reports from Jan 1 to May 31, 2010. Total records audited were 728
Identification of data	**Actual vs. desired conditions**	**Data Collected Results**
Pathology log sheet	• All charts will have pathology reports filed as per P&P within 7 days.	For the GI physicians there were 14 path reports missing (2%) and 22 (3%) reports received after 14 days of procedural date. 5% noncompliance rate noted and reported.
Interventions	**Desired Outcome**	**New Processes**
Board agreed to hire a dedicated Medical Records employee for the oversight of the clinical records to include follow up on absent reports.	• Increase awareness for timely filing of reports. • Facilitate a smooth communication between the colo-rectal physicians office and the Endoscopy center	• Maintain awareness through education • Continue daily documentation of receipt of pathology reports • If reports are not received in 7 days, the Medical Records employee will reach out to the appropriate office for compliance
Re-Measurement	**Effectiveness of Corrective Actions**	**Repeat in data collection**
Random weekly audits	100% compliance	Maintaining 100% compliance. This will be an ongoing concurrent tracking for compliance.
Communication	**Quality Improvement Changes**	**Reporting**
Quality improvement activities reported to the Governing body and staff.	Physicians are aware of Bylaws, Rules and regulations as it pertains to completion of medical records	The process shared with the staff at staff meeting, the Board and Corporate.

Surgery Center XYZ SPECIMEN LOG

Patient Label	# of Specimens	RN Initials	Courier Name	Date/Time Picked up	Date report Received	Date filed in chart	Follow Up/ Initials

COOK EYE SURGERY CENTER
POSTOPERATIVE INFECTION REPORT

Date/Time Discovered: ___/___/___at ___:___AM/PM

Infection Control Coordinator Notified Date: ___/___/___ Time ___:___AM/PM

Patient ______________ DOS: ______________ Dr. # ______________

Procedure: ______________________________
Discovered by: ☐ Surgeon ☐ Patient ☐ I/C Survey ☐ Post-Op Follow-up

☐ Surgeon Call ☐ Patient ☐ I/C Survey ☐ Post-Op Follow-up

PATIENT INFORMATION:

Risk Factors ______________________________
Age Social Factors (Work, Living Environment)

Physical Condition/Diseases ______________________________

Return to Surgery? ☐ Yes ☐ No (If yes when, were, what procedure performed) ______________________________

Wound Classification: ☐ Clean ☐ Clean-Contaminated ☐ Contaminated ☐ Infected

ASA Classification: ☐ ASA I ☐ ASA II ☐ ASA III

Antibiotic administered DOS: ☐ Yes ☐ No (If yes type and dosage) Within 60 minutes or Incision: ☐ Yes ☐ No
Comment: ______________________________

Antibiotic prescribed by physician for take home: ☐ Yes ☐ No (If yes type and dosage) ______________________________

☐ Drain – Type: ______________ ☐ Removed before discharge ☐ In- place at discharge ☐ Dressing - ☐ Removed before discharge ☐ In place at discharge By: ______________

Date of Post-op Call: ___/___/___ Any problems reported? ☐Yes ☐ No

Date(s) of patient post-op visits to physician's office: ___/___/___; ___/___/___; ___/___/___; ___/___/___; ___/___/___

COOK EYE SURGERY CENTER
POSTOPERATIVE INFECTION REPORT

Treatment of Infection: ☐ Hospitalization required ___ Treatment w/ meds only
___ Surgery Required;

Follow-up procedure: ______________________________

Patient treatment by Physician on outpatient basis: ☐ YES ☐ NO

SURVEILLANCE ACTIVITY

Wound Cultured: ☐ Yes ☐ No By Physician: ☐ Yes ☐ No ☐ Hospital ☐ Other

Cultures obtained at Center? ☐ Yes ☐ No If yes, note culture source and results: ______________

Organism Identified: ______________________________

Sterilization Records Applicable and Attached:

*Flash ☐ Load ☐ Steris ☐ High level disinfectant ☐ other ______________
*Note: If more than one, give details: ______________________________

Parameters for time & temperature Met? ☐ Yes ☐ No

Parameters for Attest and Bowie/Dick Met? ☐ Yes ☐ No

Circulator(s): ______________ Scrub(s): ______________ First Assistant: ______________
(use personnel numbers not names) Number of exchanges of staff.

Procedure Length: ______________ Prep Used: ______________

COMMENTS/ACTIONS/RECOMMENDATIONS

Note: Attach all follow-up hospital medical records/physician office notes.

REVIEW

Infection Control Coordinator: ______________________________ Date: ______________

Administrator: ______________________________ Date: ______________

Infection Control Coordinator Review: ______________

GB Review: ______________

COOK EYE SURGERY CENTER
POST-OP INFECTION LOG

YEAR______________

Patient ID No	Age	Male Female	DOS	Date Incident Reported	Dr. #	Anesth # Type of	Anesth	Procedure	What # case of the day?	Scrub	Circulator	Prep	time adm. Antibiotic yes/no	Implant **yes/no**	Organism Identified	Comments	Date Reviewed

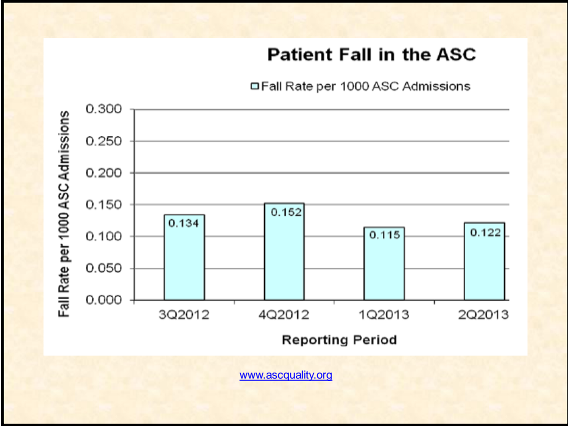
QA/PI

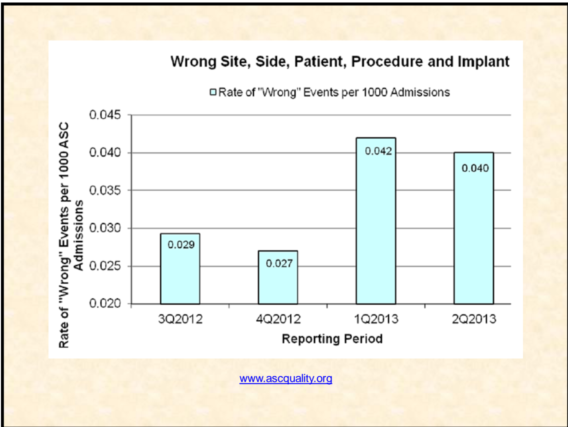
The ASC Quality Collaboration

Endorsed by the National Quality Forum (NQF)

1. Patient Burn
2. Patient Fall in the ASC
3. Wrong Site, Side, Patient, Procedure, and Implant
4. Hospital Transfer / Admission
5. Prophylactic IV Antibiotic Timing
6. Appropriate Surgical Site Hair Removal (not mandated)

www.ascquality.org


Patient Fall in the ASC
Fall Rate per 1000 ASC Admissions
Fall Rate per 1000 ASC Admissions
0.300
0.250
0.200
0.150
0.100
0.050
0.000
0.134
0.152
0.115
0.122
3Q2012
4Q2012
1Q2013
2Q2013
Reporting Period
www.ascquality.org


Wrong Site, Side, Patient, Procedure and Implant
Rate of "Wrong" Events per 1000 Admissions
Rate of "Wrong" Events per 1000 ASC Admissions
0.045
0.040
0.035
0.030
0.025
0.020
0.029
0.027
0.042
0.040
3Q2012
4Q2012
1Q2013
2Q2013
Reporting Period
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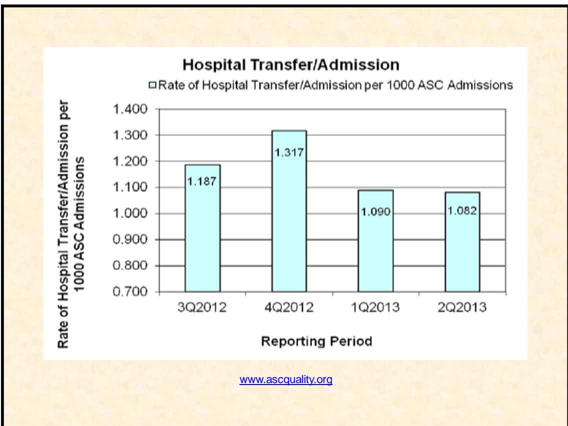
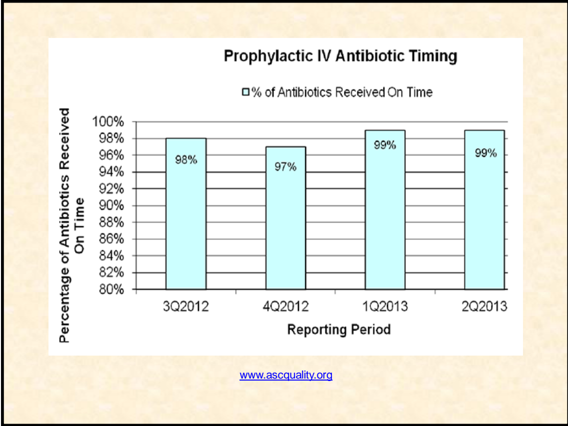

Hospital Transfer/Admission
Rate of Hospital Transfer/Admission per 1000 ASC Admissions
Rate of Hospital Transfer/Admission per 1000 ASC Admissions
1.400
1.300
1.200
1.100
1.000
0.900
0.800
0.700
1.187
1.317
1.090
1.082
3Q2012
4Q2012
1Q2013
2Q2013
Reporting Period
www.ascquality.org


Prophylactic IV Antibiotic Timing
% of Antibiotics Received On Time
Percentage of Antibiotics Received On Time
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
98%
97%
99%
99%
3Q2012
4Q2012
1Q2013
2Q2013
Reporting Period
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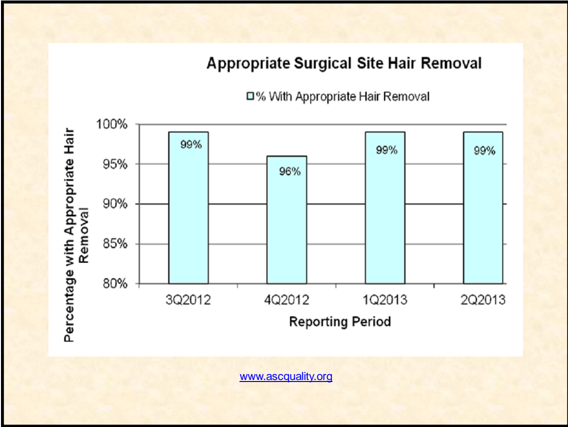
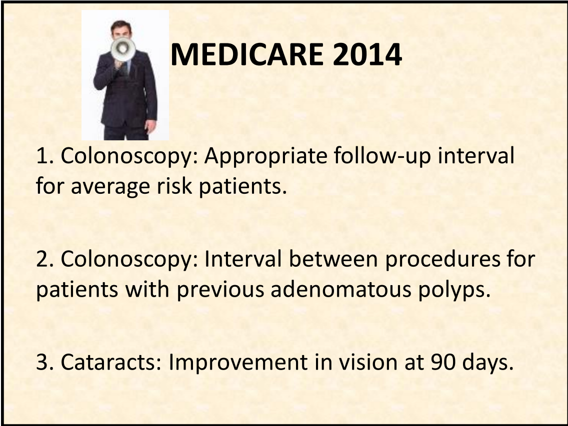

Appropriate Surgical Site Hair Removal
% With Appropriate Hair Removal
Percentage with Appropriate Hair Removal
100%
95%
90%
85%
80%
99%
96%
99%
99%
3Q2012
4Q2012
1Q2013
2Q2013
Reporting Period
www.ascquality.org


MEDICARE 2014
1. Colonoscopy: Appropriate follow-up interval for average risk patients.
2. Colonoscopy: Interval between procedures for patients with previous adenomatous polyps.
3. Cataracts: Improvement in vision at 90 days.

MEDICARE 2014

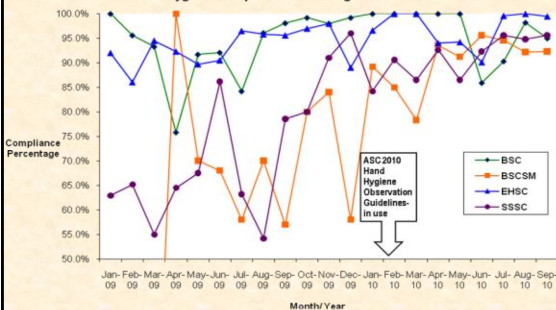
- Approved November 2013
- Data collection CY 2014
  *Data will be a “sampling”, details yet to come
- Effects payments CY 2016

QA/PI

Society for Healthcare Epidemiology of America
4/1/11 Dallas Conference
21 month comparison of 4 ASC HH compliance

http://shea.confex.com/shea/2011/webprogram/Paper4704.html

QA/PI



EXCERPTS FROM CMS SURVEYOR TRAINING

"Ask the ASC to show you documentation for performance improvement projects **currently underway**, as well as those completed in the **prior year**."

EXCERPTS FROM CMS SURVEYOR TRAINING

"If a large, complex, or high volume ASC has **only one project** underway, is the scope of that project such that it is likely to have a significant impact upon the ASC's quality of care or patient safety?"

EXCERPTS FROM CMS SURVEYOR TRAINING

"When there is a **team surveying** the ASC, the survey of the QA/PI Condition should be **coordinated by one surveyor**."

EXCERPTS FROM CMS SURVEYOR TRAINING

"The ASC is required to focus on high risk, high volume, and problem-prone areas…

The incidence, the annual incidence of emergency transfers to a hospital would be the rate that results when **dividing** the number of such transfers by the total number of surgical cases during the same year."

EXCERPTS FROM CMS SURVEYOR TRAINING

"The prevalence, ie. How widespread something is…

Appropriate measure might be periodic observation of the **hand hygiene** practices of all staff providing direct patient care, in order to assess the prevalence of good versus deficient practices."

EXCERPTS FROM CMS SURVEYOR TRAINING

"The **severity** of problems. For example, any **single instance of a transfer** of a patient to a hospital represents a serious adverse, unplanned outcome of the surgical procedure, and it would be appropriate for an ASC to track and evaluate all such cases, due to their severity, even if they are low volume incidents."

EXCERPTS FROM CMS SURVEYOR TRAINING

"Ask the ASC's leadership to describe the QA/PI program, including **staff responsibilities** for QA/PI and the quality/safety indicators being tracked."

EXCERPTS FROM CMS SURVEYOR TRAINING

"Ask what the rationale is for the particular indicators that the ASC has chosen to track. Are they based on **nationally recognized recommendations**? If not, what evidence does the ASC have that the indicators it has chosen are associated with improvement in patient health outcomes and safety?"

EXCERPTS FROM CMS SURVEYOR TRAINING

"The ASC must not only have identified a number of indicators or measures of quality and patient safety, but it must actively collect data related to those measures at the intervals called for by its QA/PI program. **Staff responsible** for collection of the data should be **trained** in appropriate techniques to collect and maintain the data."

EXCERPTS FROM CMS SURVEYOR TRAINING

"The ASC may choose to use **contractors** for technical aspects of the QA/PI program, including analysis of data, but the ASC is also expected to **actively involve the ASC staff** in the program and the ASC's leadership retains the responsibility for the ongoing management of the program, even when a contractor is used."

EXCERPTS FROM CMS SURVEYOR TRAINING

"The ASC must also have a method to ensure that the improvements it makes are sustained over time. For example, if an ASC QA/PI program identifies problems with **hand hygiene** in the ASC staff providing care to patients, the ASC must be able to demonstrate that whatever solution it adopted to address the problem continues to work over time. Generally this means that the ASC must collect data on the indicators that measure staff hand hygiene on an ongoing basis."

EFFECTIVE QA/PI PROJECTS

- IMPORTANT ISSUES
- TEAMWORK
- ACCURATE COLLECTION OF FACTS
- ANALYZING CAPABILITIES
- LOGICAL INTERVENTION
- ONGOING ACTIVITIES

QUESTIONS & ANSWERS

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