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Meaningful Quality Assurance/Risk Management Activities & Performance Improvement Studies

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What is a QAPI program?

- According to the American Health Care Association's® website:

What is QAPI?
QAPI is defined by CMS as "an initiative that goes beyond the current Quality Assessment and Assurance (QAA) provision, and aims to significantly expand the intensity and scope of current activities in order to not only correct quality deficiencies (quality assurance), but also to put practices in place to monitor care and services to continuously improve performance."

•**Quality Assurance (QA)** = the process of meeting quality standards and assuring that care reaches an acceptable level.

•**Performance Improvement (PI)** = continuously analyzing your performance and developing systematic efforts to improve it; also known as Quality Improvement.

"Quality Assurance/Performance Improvement (QAPI)." *Quality Assurance/Performance Improvement (QAPI)*. N.p., n.d. Web. 14 Aug. 2014. <http://www.ahcancal.org/quality_improvement/qapi/Pages/default.aspx>

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What's the Difference between QA & PI? According to CMS:

Both involve seeking and using information, but they differ in key ways:

- QA is a process of meeting quality standards and assuring that care reaches an acceptable level. QA is a reactive, retrospective effort to examine why a facility failed to meet certain standards. QA activities do improve quality, but efforts frequently end once the standard is met.
- PI (also called Quality Improvement - QI) is a pro-active and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems. PI aims to improve processes involved in health care delivery. PI can make good quality even better.
- QAPI is a data-driven, proactive approach to improving the quality of life, care, and services. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.

"QAPI Resources." - *Centers for Medicare & Medicaid Services*. N.p., n.d. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html>

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The 5 Elements of QAPI According to CMS

- The QAPI framework is established through five "elements." Each element describes an important component of QAPI, and all elements are interconnected.
- Element 1 - Design and Scope
- Element 2 - Governance and Leadership
- Element 3 - Feedback, Data Systems and Monitoring
- Element 4 - Performance Improvement Projects (PIP's)
- Element 5 - Systematic Analysis and Systemic Action

(*SEE CMS WEBSITE HANDOUT ON DETAILED 5 STEPS)

"QAPI Resources." - *Centers for Medicare & Medicaid Services*. N.p., n.d. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html>

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CMS Conditions for Coverage require ASCs to comply with the following condition:

416.43 Condition: Quality Assessment and Performance Improvement

The ASC must develop, implement and maintain an ongoing, data-driven quality assessment and performance improvement (QAPI) program.

This Condition includes the following standards:

- 416.43(a) Standard: Program Scope
- 416.43(b) Standard: Program Data
- 416.43(c) Standard: Program Activities
- 416.43(d) Standard: Performance Improvement Projects

The QAPI Committee should meet and report quarterly on all aspects of the program. Assure that you have documented all required delegations of authority and committee delegations as well as, credentialing approvals contract approvals. The QAPI Committee can meet in conjunction with the Governing Body quarterly, especially in smaller organizations. These meetings must be documented in meeting minutes.

Every ASC must annually assess their QAPI Program. The QAPI Annual Assessment Guide can be used to guide you through this process. It is not intended to be used as a "fill in the blanks". Your annual QAPI assessment should be written in a narrative format.

"QAPI Resources." - *Centers for Medicare & Medicaid Services*. N.p., n.d. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html>

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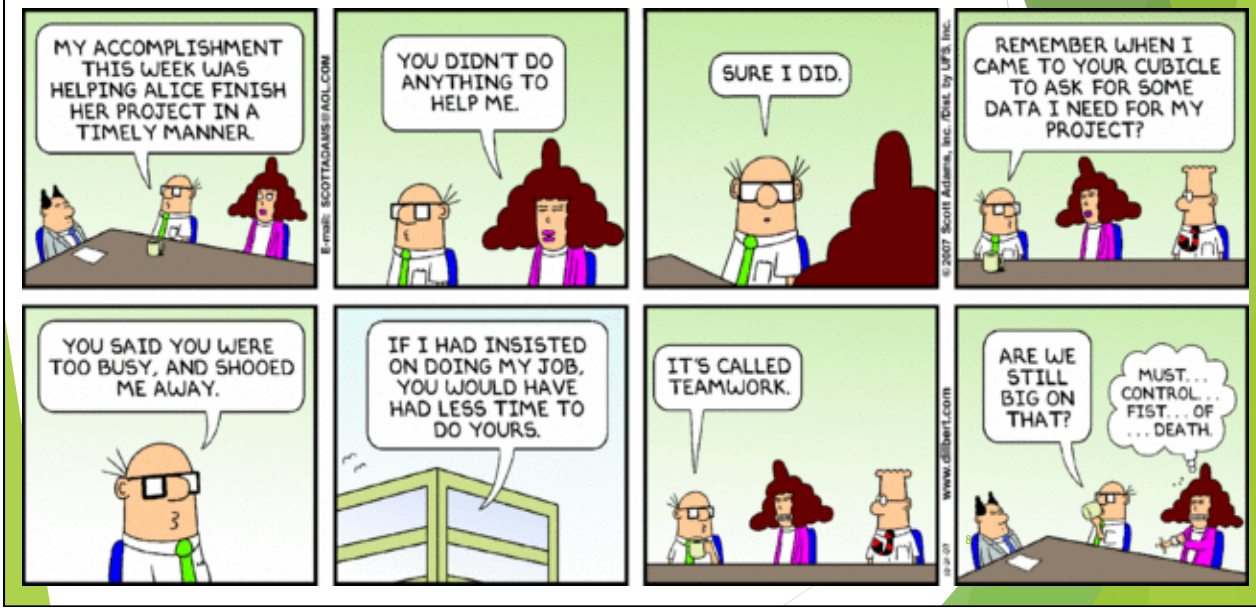
A SUCCESSFUL QAPI PROGRAM TAKES TEAMWORK!



Some ASC QAPI Activities

QAPI Tools on CMS Website:
http://www.cms.gov/Medicare/Provider-Enrollment-and Certification/QAPI/downloads/QAPISelfAssessment.pdf

GENERAL QAPI:	
CMS QUALITY DATA CODE REPORTING ASC 1-5	WEEKLY
P.I. STUDIES	BI-ANNUALY & PRN
ASC MEASURES 6, 7, 8, 9, 10 (11 IS VOLUNTARY)	ANNUALLY
FLU SHOT INJECTIONS FOR STAFF	ANNUALY
CHART AUDITS	QUARTERLY
QAPI REPORTS & ANALYSIS	QUARTERLY/PRN
PEER REVIEW	QUARTERLY

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ASC Measures/ Quality Data Codes

http://www.qualityreportingcenter.com/wp-content/uploads/2016/02/ASCQR-Reference-Checklist_FINAL.pdf

AMBULATORY SURGICAL CENTER QUALITY REPORTING MEASURES AND DATES

The chart below summarizes the Ambulatory Surgical Center Measure Reporting dates as outlined in the Specifications Manual V. 5.0a.

Claims-Based Measures			
Number	**Measures for CY 2018 Payment Year**	**Data Submission Dates**	
ASC-1	Patient Burn	Claims submitted for services furnished between January 1, 2016 and December 31, 2016	
ASC-2	Patient Fall	Claims submitted for services furnished between January 1, 2016 and December 31, 2016	
ASC-3	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	Claims submitted for services furnished between January 1, 2016 and December 31, 2016	
ASC-4	All-Cause Hospital Transfer/Admission	Claims submitted for services furnished between January 1, 2016 and December 31, 2016	
ASC-5	Prophylactic Intravenous (IV) Antibiotic Timing	Claims submitted for services furnished between January 1, 2016 and December 31, 2016	
ASC-12	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy	Claims submitted for services furnished between January 1, 2016 and December 31, 2016	
Web-Based Measures (Data Submitted Via an Online Tool)			
Number	**Measures for CY 2018 Payment Year**	**Data Collection Period**	**Submission Period**
ASC-6	Safe Surgery Checklist Use	January 1, 2016–December 31, 2016	January 1, 2017–August 15, 2017
ASC-7	ASC Facility Volume Data on Selected ASC Surgical Procedures*	January 1, 2016–December 31, 2016	January 1, 2017–August 15, 2017
ASC-8	Influenza Vaccination Coverage among Healthcare Personnel**	October 31, 2016–March 31, 2017	May 15, 2017
ASC-9	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	January 1, 2016–December 31, 2016	January 1, 2017–August 15, 2017
ASC-10	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	January 1, 2016–December 31, 2016	January 1 , 2017–August 15, 2017
ASC-11	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery†	January 1, 2016–December 31, 2016	January 1, 2017–August 15, 2017 **(Voluntary)**

*See www.qualitynet.org for procedure categories and corresponding HCPCS codes.
** Collected data for this measure will be submitted to the National Healthcare Safety Network (NHSN).
† ASCs may voluntarily submit data for CY 2016 but will not be subject to a payment reduction with respect to this measure during the voluntary reporting period.

Other QAPI Clinical Activities

CLINICAL/SAFETY/OSHA	
SUPPLY CHECK & ORDERING/ MATERIALS MANAGEMENT	WEEKLY & PRN
FRIDGE SUPPLIES & MED EXPIRATIONS	WEEKLY
TEMP, FRIDGE & EQUIP. LOGS	WEEKLY
STOCKING SUPPLIES & EQUIP.	WEEKLY
CRASH CART & MEDICATION INSPECTIONS/LOG	MONTHLY
PHARMACIST INSPECTION & NARCS ANNUAL INSPECTION	QUARTERLY & YEARLY
INFECTION CONTROL EVAL . OF STAFF	MONTHLY, QUARTERLY & PRN
APPROPRITE USE OF PPE BY STAFF EVAL	QUARTERLY & PRN
ENVIRONMENTAL COMPLIANCE/LIFE SAFETY ROUNDS CHECKLIST	MONTHLY & ANNUALY
PPD INITIAL TESTING 2-STEP FOR NEW STAFF	UPON HIRE
TB PLAN UPDATE, ANNUAL STAFF QUESTIONNAIRE & RISK ASSESSMENT OF STAFF FOR LOW RISK FACILITIES *OR SERUM/SKIN TB TESTING FOR OTHER FACILITIES THAT ARE NOT LOW RISK PER THE ASSESSMENT	YEARLY
TB FACILITY RISK ASSESSMENT	YEARLY
SHARPS SAFETY REVIEW/BLADE REVIEW	YEARLY & AS NEEDED W/ NEW INSTRUMENTS

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Other CLINICAL/SAFETY /OSHA/AAMI/ASHRAE:

TEMPERATURE & HUMIDITY MONITORING	DAILY & PRN FOR FALL OUTS
WATER QUALITY TESTING AT POINT OF USE FOR HTP COUNTS, MINERAL CONTENT, PH & HARDNESS (SEE AAMI TIR 34)	MINIMUM OF YEARLY W/NORMAL LEVELS. MONTHLY OR QUARTLERY MONITORING
UPDATE INFECTION CONTROL PLAN, REVIEW COUNTY PUBLIC HEALTH STATS, OUTBREAKS, LOCAL INFECTION RISKS, ETC. & ADDRESS IN I.C. & RISK MANAGEMENT PLAN.	ANNUALLY & PRN
MSDS UPDATE-CONVERSION TO SDS-UPDATING	YEARLY & AS INDICATED/RECEIVED
OCCURRENCE EVENT REVIEW & REPORTING TO MEC/GOV. BOARD	QUARTERLY
COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP) & EVALUATION OF IMPLEMENTATION/DRILL YEARLY REVISION OF SAFTEY/DISASTER PLANS	ANNUALLY ANNUALLY
COUNTY MEETINGS/UPDATES FOR CEMP	QUARTERLY & VIA EMAIL UPDATES
RISK ASSESSMENT : REVIEW RISKS, INCIDENTS, REVIEW WITH MEC/ BOD & IMPLEMENT PREVENTATIVE MEASURES DRAFT RISK MANAGMENT PLAN ACCORDINGLY	QUARTERLY & PRN ANNUALLY
RECALLS OF MEDICATIONS, SUPPLIES, EQUIPMENT, IMPLANTS, ETC.	MONTHLY/QUARTERLY UPDATES RECEIVED

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OTHER CLINICAL/SAFETY /OSHA/AAMI:

HOUSEKEEPING/ENVIRONMENTAL STAFF AUDITS SPD & GI TECH EVALUATION/PROCESSES COMPLIANCE AUDITS	QUARTERLY
HAZARDOUS MATERIALS SIGN POSTING & NOTIFICATION OF STAFF	YEARLY REVIEW & PRN/UPON HIRING
GENERAL SUPPLY STOCK & EXPIRATIONS	QUARTERLY
BIO-MED/EQUIP. CHECK BY VALLEY MEDICAL	ANNUALY & PRN
FIRE ALARM INSPECTION	ANNUALY
FIRE EXTINGUISHERS	ANNUALY
FIRE MARSHALL	ANNUALY
GENERATOR CHECK-LOG-PANEL-ANNUAL CHECK	WEEKLY & ANNUALY
LASER SAFTEY TRAININGS RADIATION EXPOSURE TAGS REVIEW & LOG LOG REVIEWED & SIGNED OFF BY MEDICAL DIRECTOR	QUARTERLY
AIR EXCHANGES/POSITIVE PRESSURE OR NEGATIVE PRESSURE ROOMS ADHERENCE TO STANDARDS ACCORDING TO PROCEDURES. DUCT SYSTEM CLEANING	ANNUALLY
EYE WASH STATIONS MAINTENENCE	MONTHLY

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STAFF EDUCATION

UPDATES/MEETINGS	MONTHLY/PRN
STAFF TRAININGS: ✓ **HIPPA** ✓ **INFECTION CONTROL** ✓ **RISK REDUCTION** ✓ **HAZARD COMMUNICATION** ✓ **SAFTEY & DISASTER PLAN REVIEW OF BINDER & DRILLS- YEARLY**	QUARTERLY
✓ **UPDATING ON QAPI RESULTS & IMPLEMENTATION/ EVALUATION OF CORRECTIVE ACTIONS**	QUARTERLY & AS INDICATED
✓ **BBP TRAININGS, SAFETY UPDATES**	ANNUALLY
✓ **NEW POLICIES & PROCEDURES**	ANNUALLY & PRN
✓ **PROPER PREPPING: AUDIT STAFF PRACTICES**	ANNUALLY & PRN
✓ **SURGICAL SAFETY CHECKLISTS/PROPER TIME OUT PRACTICES**	
STAFF COMPREHENSIVE COMPETENCY CHECKLISTS	ANNUALY
STAFF MEETINGS, INSERVICES, ONGOING TRAININGS	MONTHLY

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ADMINISTRATIVE DUTIES:	
SURGERY SCHEDULES	MONTHLY
REVIEW, UPDATE & APPROVAL OF POLICIES & PROCEDURES MANUAL	ANNUALLY
MEC MEETING & MINUTES	QUARTERLY
GOV BOARD & MINUTES	QUARTERLY
CODE RED & CODE BLUE DRILLS	QUARTERLY
BENCHMARKING	QUARTERLY
INTERNAL BENCHMARKING	QUARTERLY
PEER REVIEW & MEETING MINUTES	ANNUALLY
CONTRACT REVIEWS & CONTRACTING	ANNUALLY
BOARD OF PHARMACY CLINIC PERMIT	ANNUALLY
INSURANCE RENEWALS	ANNUALLY
CREDENTIALING OF STAFF BY HR INCLUDING UPDATED IMMUNIZATIONS, LICENSING, ACLS/BLS, MD & ANESTHESIA CREDENTIALING	ANNUALLY EVERY 2 YEARS
CLIA	ANNUALLY
DEA REGISTRATION	EVERY 3 YEARS
MEDIA & MARKETING	PRN
HOUSEKEEPING EVALUATION	BI-ANNUALLY
AAAHC/JOINT COMMISSION & CMS REGULATORY COMPLIANCE/UPDATES	ON-GOING
FICTITIOUS BUSINESS NAME RENEWAL	EVERY 3 YEARS
AAAHC & CMS SURVEY	EVERY 3 YEARS

CMS Performance Improvement Study Template:

- **http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf#page=1&zoom=auto,-98,798**

Model for Improvement: Three questions for improvement

1. What are we trying to accomplish (aim)?

State your aim (review your PIP charter – and include your bold aim that will improve resident health outcomes and quality of care)

2. How will we know that change is an improvement (measures)?

Describe the measurable outcome(s) you want to see

The First Time. *PDSA Cycle Template* (n.d.): n. pag. *CMS.GOV*. CMS.GOV. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf>.

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3. What change can we make that will result in an improvement?

Define the processes currently in place; use process mapping or flow charting
Identify opportunities for improvement that exist (look for causes of problems that have occurred – see Guidance for Performing Root Cause Analysis with Performance Improvement Projects; or identify potential problems before they occur – see Guidance for Performing Failure Mode Effects Analysis with Performance Improvement Projects) (see root cause analysis tool):

- Points where breakdowns occur
- "Work-a-rounds" that have been developed
- Variation that occurs
- Duplicate or unnecessary steps

Decide what you will change in the process; determine your intervention based on your analysis

- Identify better ways to do things that address the root causes of the problem
- Learn what has worked at other organizations (copy)
- Review the best available evidence for what works (literature, studies, experts, guidelines)
- Remember that solution doesn't have to be perfect the first time

The First Time. *PDSA Cycle Template* (n.d.): n. pag. *CMS.GOV*. CMS.GOV. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf>.

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Plan What change are you testing with the PDSA cycle(s)? What do you predict will happen and why? Who will be involved in this PDSA? (e.g., one staff member or resident, one shift?). Whenever feasible, it will be helpful to involve direct care staff. Plan a small test of change. How long will the change take to implement? What resources will they need? What data need to be collected?	**List your action steps along with person(s) responsible and time line.**
Do Carry out the test on a small scale. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage.	**Describe what actually happened when you ran the test.**

The First Time. *PDSA Cycle Template* (n.d.): n. pag. *CMS.GOV*. CMS.GOV. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf>.

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Study Study and analyze the data. Determine if the change resulted in the expected outcome. Were there implementation lessons? Summarize what was learned. Look for: unintended consequences, surprises, successes, failures.	**Describe the measured results and how they compared to the predictions.**
Act Based on what was learned from the test: Adapt – modify the changes and repeat PDSA cycle. Adopt – consider expanding the changes in your organization to additional residents, staff, and units. Abandon – change your approach and repeat PDSA cycle.	**Describe what modifications to the plan will be made for the next cycle from what you learned.**

The First Time. *PDSA Cycle Template* (n.d.): n. pag. *CMS.GOV*. CMS.GOV. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf>.

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SAMPLE QI/PI STUDY FORMAT

1. Purpose of the Study:
(State the Purpose of your study and indicate the importance of carrying out this study)

2. Performance Goal:
(Identify a measurable goal for the QI Study you are conducting. Identify what you want to achieve. Make sure it is measurable)

3. Data Collection Plan:
(State how you will collect your data & which type of data you will collect)

4. Evidence of Data Collection:
(List the data you have already collected)

5. Data Analysis:
(Document your data findings)

"Progressive Surgical Solutions . " *Progressive Surgical Solutions*. N.p., n.d. Web. 14 Aug. 2014. <https://www.progressivesurgicalsolutions.com/quality-management-quality-improvement-study/>.

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6. Comparison:
(Compare your current performance to performance goal identified in this study)

7. Corrective Actions:
(Detail which interventions/corrective actions took place for the this study & how they were implemented)

8. Re-measurement:
(Document the second round of data collected and how it was collected. Compare the new current performance verus goal for the QI study being conducted)

9. Additional Corrective Actions:
(After evaluation/re-measurement, indicate if any additional corrective actions are necessary. If so, what has or will be done. Re-evaluate & follow up until goal is met if possible)
Report the study & findings to: QAPI COMMITTEE, MAC & GOV. BOARD

"Progressive Surgical Solutions . " *Progressive Surgical Solutions*. N.p., n.d. Web. 14 Aug. 2014. <https://www.progressivesurgicalsolutions.com/quality-management-quality-improvement-study/>.

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Some Study Ideas

You Can Create a Study to Address ANY ISSUE or Area Needing Improvement. Here are some ideas:

- Cost Analysis of: supplies/cost per case, equipment, medications, linens, paid staff hours/case, general cost per case
- Infection Control Practices by Staff: hand hygiene, cleaning/disinfecting practices (following manufacturer directions), terminal cleanings/room cleanings, wearing PPE, tracking infection trends, root-cause analysis on infections or significant complications, etc.
- Instrument Processing Practices: following manufacturer directions with cleaning agents, equipment, instruments, assembling packs, running sterilization times, spore testing, sterilization indicator strips, logging & tracking all information.
- Address Risk Assessment Issues: slippery or uneven floors, sharps/blade evaluations, managing sharps on sterile field, using PPE, appropriate patient screening & selection for ASC setting, trends in staff injuries, pt transfers, etc.
- Benchmarking Results & Internal Benchmarking: comparing your facility with national/State benchmarks, comparing your internal benchmarks quarter over quarter, year over year
- Aging A/R Analysis & Improvement

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More Study Ideas

- Staff Education Issues
- Occurrence Event Issues
- Post-op Complications
- Patient Surveys/Satisfaction Issues
- Housekeeping Eval. Issues: getting your housekeeping up to par
- Surgical Outcome Issues
- Case Cancellation Issues/Prevention/Pt Screening Issues/Transfers
- Supply Management & Use: maintaining supplies, addressing expiration or waste issues, insuring single use is occurring, supply costs
- Disaster Plan/Safety/Emergency Strategies Implementation Issues
- Water Quality Issues
- Staff turnover or staff issues

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Make it MEANINGFUL! Finding Meaning & Purpose in QAPI Activities

In the midst of the plethora of activities we have to be involved in to run an effective QAPI program, we can get "buried" or "lost" in all the paperwork, meetings, reporting, regulatory mandates, etc.. However, if we are passionate about carrying out meaningful activities, the results of those activities will have a substantial positive impact on our patients, staff, facility & community.

Make it relevant & your staff will join in your mission. When seeking out areas to focus on, we must prioritize & involve our staff in doing so. Just shooting out new policies or protocols without taking it to a deeper level with our staff often results in non-compliance & resentment.

Avoid just sticking with the simple, no brainer studies where you are completing them just to merely meet the mandate. Again, prioritize & the more the "fix" is needed, the more impact it will have. Your staff need to actively be aware of the significance of the QAPI process.

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Risk Management Tips & Strategies:

KEEP IT SIMPLE! Speak your MEC's & BOD's language….

The traditional way of explaining the risk management process is (per ISO 31000):

- Establish the context
- Identify risks
- Analyze risks
- Evaluate risks
- Treat risks
- Communicate and consult (throughout the above)
- Monitor and review (continuously)

Can this be translated into plain English?

How about this:

- Anticipate what might happen
- Analyze the possibilities
- Ask: Is there a problem? Can we do better?
- What are the options? Can we improve them?
- Which is best?
- Decide
- Act
- Review/monitor/learn

I especially like the work ***anticipate.*** It's better than talking about "uncertainty," another word that risk practitioners understand (I hope) but that executives find difficult.

(Article Link: http://insurancethoughtleadership.com/risk-management-in-plain-english/)
Source: "Risk Management, in Plain English - Insurance Thought Leadership." *Insurance Thought Leadership*. N.p., 15 June 2016. Web. 12 July 2016.

Sample Risk Management Plan Template

Source Link: http://www.beckersasc.com/asc-accreditation-and-patient-safety/sample-

Potential Risks/Problems	What is the probability of the event/condition occuring				Potential Impact on Patients/Staff or delayed stay				Current Systems/ Preparedness				Score
HIGHLIGHTED AREAS INDICATE SCORES OF 6 OR GREATER	High	Med	Low	None	High	Med	Low	None	None	Poor	Fair	Good	
	3	2	1	0	3	2	1	0	4	3	2	1	
ABX Resistant organisms													
MRSA													
C Diff													
VRE													
ESBL/other Gram Negative bacteria													
Failure of Prevention Activities													
Lack of Hand Hygiene													
Lack of Respiratory Hygiene/ Cough Etiquette													
Lack of Patient Influenza Immunization													
Lack of Patient Pneumovax Immunization													

Universal/Standard Precautions/PPE													
<100% Compliance ALL Precautions SPD													
<100% Compliance ALL Precautions-OR													
<100% Compliance Precautions-GI													
<100% Compliance ALL Precautions-PACU & Pre-Op													
Policy and Procedure													
Lack of current policies or procedures - (specify)													
Failure to follow established policy or procedure (specify)													
Preparedness													
Exposure to Bio-terrorism Agents													
Exposure to SARS/Pandemic Influenza/Other Respiratory Infections													

Healthcare Acquired Infections													
Surgical Site Infections (SSI) Cardiac													
SSI - Orthopedic w/implants													
Norovirus													
Outbreak													
Sentinel Event													
Environment													
Infection From Inadequate Sterilization													
Problems with Cleaning/ Disinfection													
Contamination/ Infection From Medications/Pharmacy Environment													
Infection Related to Construction/ Renovation													
Power Outage/Disruption of Service													

Employee Health													
Lack of Staff Influenza Immunization													
Lack of Compliance with Health Reviews													
Exposure to Bloodborne Pathogens													
Exposure to Tuberculosis													
Risk of Unknown Level of Communicable Disease Among Employees													
Sharps Injury Occurrence													
Employee Injuries													
Exposure to Pertussis													

Other													
Risk of Community Outbreak													
Pt preparedness for surgery day: lack of transportation or home care, lack of understanding of procedure (break down by MD or specialty if indicated)													
Inadequate Pt Screening (ie: labs, EKG, Cardiac Clearance													
Pt not meeting ASC criteria													
PACU Complications: Delayed Recovery													
PACU: Severe N/V													
PACU: Difficulty Controlling Pain													
Post-op Bleeding													
Intra-op or Post-Op Hypotension/ Unstable Vitals or Status													
Post-Op DVT													
Medication Errors													
Patient Complaints/Satisfaction Issues													

Other													
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Medication Errors													
Patient Complaints/Satisfaction Issues													

Oh, Jaimie. "Sample Infection Control Risk Assessment." *Sample Infection Control Risk Assessment*. Becker's ASC Review, 30 Nov. 2010. Web. 12 July 2016. <http://www.beckersasc.com/asc-accreditation-and-patient-safety/sample-

Template *Source:* National Surgical Hospitals. Adapted and reprinted with permission by Becker's ASC (Further adapted by L. Silva for Multi-specialty ASC Settings)

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Water Quality Testing at Point of Use…

Often overlooked, yet ***crucial*** as a starting point for the cleaning, disinfection & sterilization of our instruments.

Water for the reprocessing of medical devices: AAMI TIR34:2007

Review Guidelines per AAMI at this LINK:

https://fmc4me.qa-intranet.fmcna.com/idc/idcplg?IdcService=GET_FILE&Rendition=Primary&RevisionSelectionMethod=Latest&dDocName=PDF_100032428

Sample Water Quality Study Template

by L. Silva

Performance Improvement Study:
Water Quality at Point of Use in Instrument/Medical Device Processing and Processing Practices by Staff

Problem/Issue of Concern:
During a water testing process, the hetero platelet count in the SPD and GI lab samples tested out of range with elevated HTP count which indicates a higher level of microbes than expected.

Reason to resolve/address issue:
To decrease the risk of excessive contaminants in our water used for initial instrument cleaning and reduce related posed risk of infection for our patients. Our infection control/QAPI nurse in collaboration with administration, consultants and our department staff will work diligently to resolve this issue and ensure that our processes and procedures continue to properly produce sterile instruments and uncontaminated scopes.

Performance Goal:
Instruments shall be processed per protocol step by step 100% of the time
Staff shall wear proper PPE 100% of the time
All logs shall be completed accurately 100% of the time
Hand hygiene shall be carried out 100% of the time
All processing quality indicators and testing of equipment will be 100% complete and WNL
HTP counts will come down to acceptable range per water quality lab (<5700 cfu's/ml)
Cultures of water will show no significant growth (zero) of any threatening organisms

Data Collection Requirements:
Observation will take place of the completion/frequency of the following and documented:
Quality assurance testing completed at the beginning of each day to include:
- *Spore/Biological testing
- *Sterilization Indicators
- *Sterilization Tape
- *Bowie Dick testing

Use of PPE in dirty areas
Use of PPE in clean areas
Proper transportation of instruments into decontamination
Rinsing of instruments
Soaking of instruments in enzymatic solution
Hand washing of instruments
Final rinsing of instruments
Machine washing/irrigation of instruments
Proper wrapping and packing of instruments for autoclave
Appropriate cycle times used in autoclaves
Proper loading of trays/instruments into autoclaves
Proper storage and labeling of instruments after processing
Required PM's completed by MFR on all required equip: Autoclaves, Steris, Washer, Custom Ultrasonics, Water Filters and Tanks
Biomed yearly testing complete on all required equipment
HTP counts within acceptable ranges
Cultures of water if indicated after HTP counts

Data:

Date of observation:
Staff observed:

Area Evaluated	Frequency of standard met	% Compliance	Explanations of unmet standard or special notations for improvement
*Spore/Biological testing *Sterilization Indicators *Sterilization Tape *Bowie Dick testing			
GI Custom Ultrasonics Chemical Testing Passed			
GI Custom Ultrasonics Machine Cycles Complete and Passed			
Use of all required PPE in dirty areas: Gown Mask Face Shield Bouffant			
Use of PPE in clean areas			
Proper transportation of instruments into decontamination (trays/instruments covered)			
Rinsing of instruments			
Soaking of instruments in enzymatic solution			
Hand washing of instruments			
Final rinsing of instruments			
Machine washing of instruments Machine hose irrigation of used instruments w/lumens			
Proper wrapping and packing of instruments for autoclave			
Appropriate cycle times used in autoclaves and logging of packs, sterilization tracking, etc..			
Proper loading of trays/instruments into autoclaves			
Proper storage and labeling of instruments after processing			
Proper disposal of all PPE after cleaning Dawning of new PPE upon leaving dirty area and entering clean area.			
PM's logged and complete for Autoclaves, Steris, Washer, Custom Ultrasonics, Water Filters and Tanks			
Biomed yearly testing complete on all required equipment			

Initial HTP Counts

Date:	GI Room Sample:	cfu's/ml
Date:	SPD Sample:	cfu's/ml

Findings:

Reporting:
Reported results to Administrator immediately upon receiving results.

Implementation of Corrective Action:

Evaluation of Implementation of Corrective Action Data Collection Requirements

Evaluation Data Collected:

HTP Count	Date:	GI:	SPD:
Culture Results (If indicated)	Date:	GI:	SPD:
HTP Count follow up	Date:	GI:	SPD:

Date: Quality Indicators:	% Passed/Complete
*Spore/Biological testing *Sterilization Indicators *Sterilization Tape *Bowie Dick testing	
GI Equipment	
SPD Autoclaves: 1 2 Steris Sterrad	

Evaluation of Data/Corrective Measures:

Reporting:
During this process, findings, corrective actions and results have been reported day by day to the administrator, Medical Executive Committee, Board of Directors, representatives, along with director of infection control.

Additional Corrective Actions taken and to be taken given Findings:

Additional Follow Up Actions Completed (if indicated):

Final Evaluation of Action Steps and Future Surveillance:

Strategies:

- Be passionate about QAPI & Risk Management activities & everything you do (your staff will see right through you if you really don't care about what you do)
- **INSPIRE** YOUR STAFF. Be the example of adhering to high standards. Set the bar high for yourself & your staff will likely follow (no one likes to follow a hypocrite with low personal standards)
- Ask your staff what issues they are aware of & get their input
- When they see the issue with their own eyes & have a deeper understanding of WHY it needs to be addressed, they are likely to "buy into" the process & help resolve it
- Discuss implications of leaving the issue uncorrected
- Brainstorm with staff on solutions
- Set realistic goals
- Communicate progress & congratulate your staff for "making it happen"
- Honor your superstars: when you are blessed with some outstanding employees who truly care, acknowledge their contributions to the whole facility & often, others will want to emulate them
- **CREATE a CULTURE of EXCELLENCE, COMPASSION & PASSION. This starts at the top & affects all staff & ALL PATIENTS**

When everyone cares, everyone wins…

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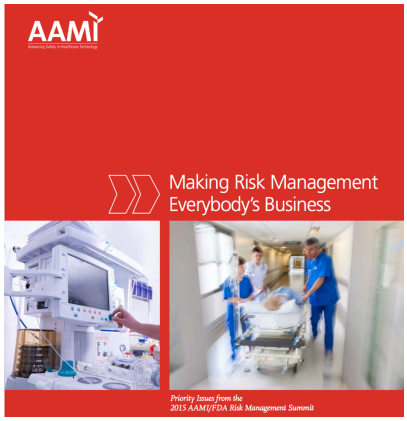
Additional Risk Management Resource Links:



Risk Management Summit Report:
http://s3.amazonaws.com/rdcms-aami/files/production/public/FileDownloads/Summits/2015_Risk_Mgmnt_Summit_Report.pdf?/Risk_Management_Summit_Report

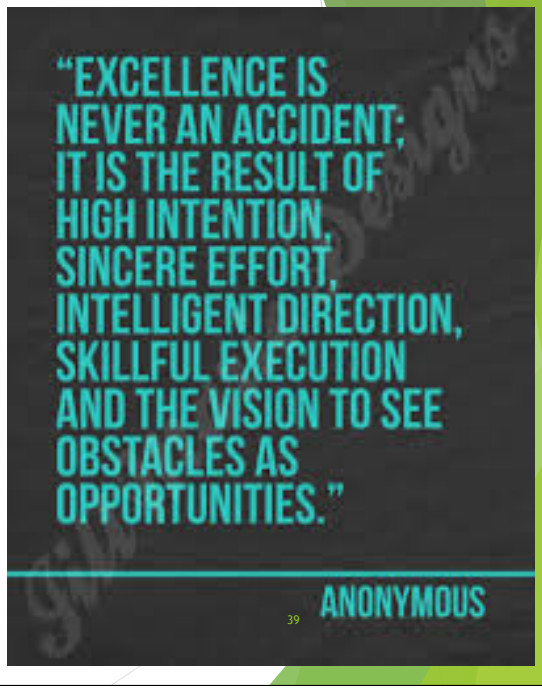
Additional QAPI Resource Links:

ASC MEASURES:
http://www.ascaconnect.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=b3148327-3606-fea9-b17a-e47bffad6931&forceDialog=0

GI ASC 9 & ASC 10 MEASURES
EXCEL TRACKING TEMPLATE TOOL BY L. SILVA, RN, BSN

Quarter/ YR Color coded	Q1 2015	Q2 2015	Q3 2015	Q4 2015				
ASC Measures ASC-9 & ASC-10 Reporting								
Sample Size 96	ASC 9-1 (ASC 9 Denominator)	ASC 9-2	ASC 9-3 (ASC9 Numerator)	Sample Size 96	ASC 10-1 (ASC10 Denominator)	ASC 10-2	ASC 10-3	ASC 10-4 (ASC10 Numerator)
PT ID	Pt is age 50 or older on encounter without biopsy or polypectomy	Recommending < 10 yrs followup for medical reason	Recommending at least a 10 yr follow up	PT ID	Age 18+ w/ prior polyp on encounter (*exclude from measure 10 if NO)	Documented <3 yrs due to medical reasons	Documented <3yrs due to system reasons (unable to find records)	Documentec >3yrs since last colonoscopy

ENTER EACH QUARTER & HIGHLIGHT ACCORDINGLY. ENTER FORMULA TO ADD EACH COLUMN UP AT BOTTOM SO AS YOU ENTER YOUR DATA, IT IS SUMMING IT ALL UP FOR YOU BY NUMERATOR & DENOMINATOR FOR EACH MEASURE. YOUR SAMPLE SIZE IS DETERMINED BY YOUR VOLUME.
SEE ASC MEASURES GUIDELINE LINK.



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"QAPI Resources." - *Centers for Medicare & Medicaid Services*. N.p., n.d. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html>

The First Time. *PDSA Cycle Template* (n.d.): n. pag. *CMS.GOV*. CMS.GOV. Web. 14 Aug. 2014. <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/PDSACycledebedits.pdf>.

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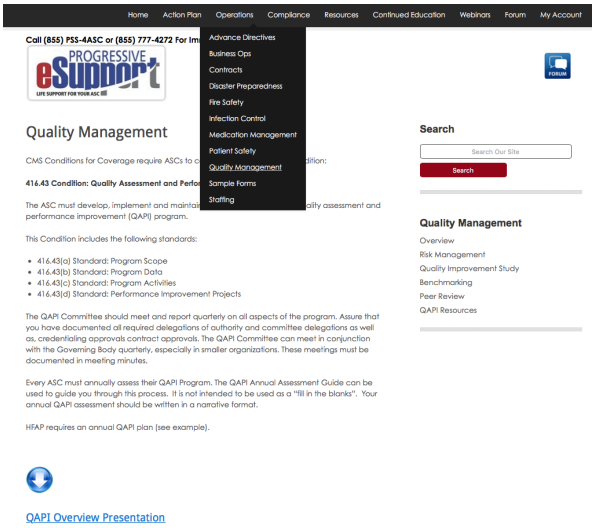
- Operations/Quality Management



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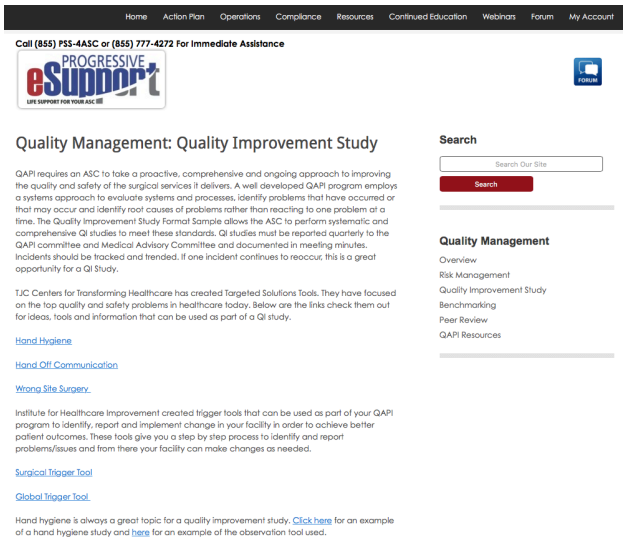
- Operations/Quality Management/ Quality Improvement Study



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