How and Why Quality Improvement Programs Are Developing at a Growing Rate

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The process of reviewing clinical care in nursing homes has been in place for years, and has had many labels, including quality assurance, quality improvement, continuous quality improvement, and performance improvement. For assisted living (AL), however, no such review process has been considered necessary. But as AL residents exercise their option to "age in place," many AL facilities are faced with the need to provide increasingly higher levels of nursing and medical care for their residents. As a result, the level of care in AL today is similar to the care that was provided in nursing homes 10 years ago. This trend encourages us to take a new look at the level of care AL residents require and how to deliver that care in a manner that enhances their quality of life. The issue, then, is how do we insure that the resident is receiving "quality" care?

By utilizing the models developed in long-term care (LTC) settings, we can implement effective data-collection tools and monitor aspects of quality that are specific to AL residents. Although each AL community has its own unique personality, there are common issues and challenges that face all of them, including the declining independence of their residents, falls, weight loss, medication administration, and infections.

In our experience, the nurses and caregivers who work in AL have a sincere interest in their residents and in making each day of their lives as pleasant as possible.

Central to that goal is the accurate assessment, monitoring, and documenting of the events that the residents experience. By documenting those events and evaluating circumstances and situations surrounding those events, they can identify opportunities to make improvements

that will benefit the residents. Our involvement with LTC facilities has revealed that in order to have a successful quality improvement program, we need to help nurses develop documentation and data-collection tools that will meet their specific needs. TLC HealthCare™ Quality Improvement Organization includes nurses in the consulting group to address these service needs.

Once an AL facility makes the commitment to develop a quality improvement process, the key individuals need to develop a plan on the outcomes they would like to achieve and the questions they would like addressed by the process. In the AL facility that moves from a social model to a medical model, the key areas would include incidents (falls and injuries), infectious disease, and medication administration issues.

The next step that needs to be taken in the quality improvement process is the collection and interpretation of data. There are two components to data collection: collecting just the right pieces of data and then making sure that the collection is accurate and consistent. In the organizations we work with, a leadership team from the facility meets with our staff to select data points that will be monitored. Appropriate data collection forms are selected or created. The facility staff provides data monthly to our quality improvement organization (QIO) team, which then consolidates the data in an easily interpreted format that the medical director or quality improvement specialist can analyze at the facility's monthly quality meeting. As staff members begin to take an active role in the process, they become more aware of the possibilities for improving care and the overall quality of life for their residents. Eventually, new areas of interest may emerge as staff members identify creative techniques to monitor trends, collect data, and

Table 1.
Steps involved in making a quality improvement program successful

- Identify the end-goal: What result are you trying to achieve?
- Identify what data is to be collected
- Identify how the data will be collected
- Identify who will be responsible for data collection
- Establish definitions for the data points
- Collect the data in a user-friendly format
- Summarize the data on a monthly basis
- Create ways to compare the same data on a month-to-month basis
- Schedule monthly quality meetings where the data is discussed and analyzed
- Identify areas where improvement is desired and create a plan for improvement
- Share the information with staff
- Encourage staff participation
- Continue to monitor the data to evaluate the effectiveness of the plan and make adjustments as needed

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analyze and implement change. Table 1 shows the steps that should be taken for a successful quality improvement program.

Implementation in a Sample Facility

After discussion with the facility staff, our QIO team initiated the first step of our patented quality improvement method: exploration of the questions that the facility wanted to address. Remember that in healthcare, many regulatory agencies have an impact on the type of data that needs to be documented, so there are really two kinds of data that you will need to collect: the first set is the data that is required by outside sources; the second addresses the questions that the facility specifically wants to answer. Ultimately, the goal is to blend both into a coherent program. For example, regulations require that you monitor the number of falls in the facility; a special facility interest may be to monitor the number of falls per day of the week or time of day.

The initial list of questions revealed many areas that the facility wanted to analyze for its improvement process. Table 2 lists some of these factors.

Three factors influence the initiation of the quality-improvement process: time, money, and personnel constraints; the accessibility and retrievability of the data; and the interest and sophistication of the team. Concerning the latter, it is not in the best interest of the group to collect a bucketful of data if this is the first time the team

these tools can change, especially in the beginning of a new program. We consult with over 20 facilities at present, and yet we rarely use the same falls data form at each facility. We find that it takes about 3 months to go through this initial phase of collecting data efficiently in each facility; many issues arise including establishing definitions, changing the data collection tool to reflect each facility's personality, establishing more detailed documentation in the patient charts, increasing awareness of the issue on the units about which data to collect, and fostering an understanding of the fall issue by the person organizing and/or collecting the data. The facility in this case changed the data tool 4 times during the first 2 weeks. Due to these changes, we shifted the initiation

ten and implemented for each individual. The staff was trained on the strategies to be used, the therapy department was involved in screening residents who fell more than once in a month to determine if there was a need for strengthening exercises, and the activities department visited to determine if additional activities of interest might decrease restlessness if this was a factor.

For example, one resident had 3 falls on 3 consecutive nights, all around midnight as he was attempting to self-toilet. As a result of the fall review, a plan to assist this resident to the restroom at 11 PM each night was initiated. In addition, the resident was checked for a possible urinary tract infection, and non-skid slippers were issued. As a result, the resident sustained no further falls that month. Another resident who had multiple falls was started on physical therapy and actually regained enough strength to ambulate safely again with her walker. She continued her exercise program with the restorative aide after therapy was discontinued, and not only did her falls decrease, but her socialization was enhanced as well. The number of falls in our sample facility still varies month to month.

Our sample facility continues to track falls, along with other data that relates to the quality of resident care. The administrative team shares this data openly with the care-giving staff so that it can participate actively in finding solutions and implementing systems. In this way, the entire staff shares in the success of their efforts and quality improvement is not just a mandatory monthly meeting. ALC

is participating in this type of project. It is much better to collect only a few data points as a learning tool. In this case, it was decided that the facility would collect only data related to the first five factors listed in Table 1.

The next step is to start collecting data on a limited location within the facility. Collecting even the first 5 factors can be an extraordinary task for an entire facility. We often recommend that the data be collected on one unit or section of the facility first. Often, the group wants to begin data collection on the most troublesome section of the facility. In our experience, this is not the best way to move forward; we usually recommend starting on the least troublesome or most stable unit so that the difficulties arising in data collection can surface and be refined before overburdening the more challenged units. This facility chose its best unit to initiate the fall data collection program.

Paper tools often are generated to make data collection easier, but

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of the data collection process to the beginning of the next month, so that better comparisons could be made in the future.

We find that it also takes about 3 months of consistent data collection before patterns of care can be identified. With this facility, after just 2 months into the process, the facility began to identify patterns that led them to implement a Fall Risk Protocol. An interdisciplinary team reviewed each fall so that an effective care plan could be writ-

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