OMB#: 0938‐XXXX

(Exp. TBD)



**Nursing Home Quality Improvement**

**Questionnaire**

Your answers are being collected by Abt Associates, Inc., a contractor for CMS, who will maintain utmost confidentiality of individual responses. Only anonymous aggregate information will be sent to CMS. The questionnaire is typically completed within 20 minutes. Should you have any questions, Allison Muma at Abt Associates can be contacted at [Allison\_Muma@abtassoc.com.](mailto:Allison_Muma@abtassoc.com) CMS and Abt Associates sincerely appreciate your participation.

**Instructions:**

 Please read each question carefully and respond by marking an “X” in the box of the response that most closely represents your opinion.

 Please mark only one “X” for each question, unless it tells you to “Mark all that apply.”

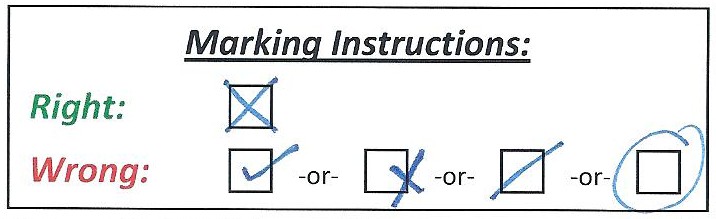
 While you can use a pen, please use a PENCIL in case you want to change your answer.

 Please do NOT use felt tip pens.

 Make solid heavy “X” marks in the box.

 Please erase cleanly or white out any marks you wish to change.

 Please do not make any stray marks on the form.



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938‐XXXX. Public reporting burden for this collection of information is estimated to average 20 minutes, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed,

and completing and reviewing the collection of information.

**1. Does your facility have a written quality assurance/improvement plan or policy?**

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| g. Expectations for formal quality improvement training (e.g., who receives training and how often)? |  |  |
| h. New employee orientation practices related to quality? |  |  |
| i. A focus on quality of life? |  |  |
| j. What staff should do if they discover a safety or quality concern? |  |  |
| k. How priorities for quality improvements are established? |  |  |
| l. Which services are reviewed for quality? |  |  |
| m. Sources of data to compare your facility’s performance to others? |  |  |
| n. Actions to be taken if an adverse event occurs in your facility? |  |  |

 Yes

 No ***IF NO, SKIP TO QUESTION 4***

|  |  |  |
| --- | --- | --- |
| **2. Does your *current* plan/policy**  **specify the roles and responsibilities for the…** | Yes | No |
| a. Administrator/Executive Director? |  |  |
| b. Director of Nursing (DON)? |  |  |
| c. Medical Director? |  |  |
| d. Quality Committee? |  |  |
| e. Residents? |  |  |
| f. Governing Body?  A Governing Body is legally responsible for  establishing and implementing policies regarding management and operation of the facility (e.g., board of directors, corporation, or owners). |  |  |
| g. Direct care staff? |  |  |

**4. What staff members, if any, receive formal training in quality improvement methodologies or techniques (e.g., how to do a root cause analysis, interpret data variation, or use a fishbone diagram)?**

|  |  |  |
| --- | --- | --- |
| **3. Does your *current* plan/policy specify...** | Yes | No |
| a. Which staff members serve on the quality committee? |  |  |
| b. How often the quality committee meets? |  |  |
| c. Who is responsible for reviewing quality results? |  |  |
| d. Who is responsible for ensuring quality in the event of a change in facility leadership? |  |  |
| e. When a quality/performance improvement project is required? |  |  |
| f. The improvement methodology or model to be used for quality improvement activities (e.g., PDCA/PDSA, Six Sigma, Lean, SMART, etc.)? |  |  |

***SELECT ALL THAT APPLY***

 Executive Leadership (Nursing Home

Administrator or Director of Nursing)

 Quality Committee members

 Certified Nursing Assistants (CNAs)

 Patient care nurses

 Non‐clinical staff

 All staff

 No formal quality improvement training provided at this time

 Quality Improvement Coordinator

 Don’t know

**5. Do you have a dedicated** **position, such as a Quality Improvement Coordinator, that has been established specifically to manage, coordinate, or oversee quality assurance/improvement activities in your facility (e.g., train staff in quality methods, how to use quality tools, or to lead quality improvement projects)?**

 Yes

 No ***IF NO, SKIP TO QUESTION 8***

***Please answer the following questions for the staff member that fills the position described above.***

**6. Is this position shared with a second person?**

 Yes

 No ***IF NO, SKIP TO QUESTION 7***

***Please answer the following questions for this additional staff member.***

|  |  |
| --- | --- |
| **a. Please indicate the percentage of this person’s time that is *dedicated* specifically to quality improvement coordination.** | % |
| **b. What other role(s), *if any*, does this person have in your facility?**  ***SELECT ALL THAT APPLY*** |  No other roles /  100% of time is dedicated to quality improvement coordination  ‐‐‐‐‐‐‐‐‐‐OR‐‐‐‐‐‐‐‐‐‐   Staff Development  Coordinator   ADON   DON   NHA   Infection Control   Dietary   Other (Specify): |
| **c. Does this person have any formal certification or degree related to quality improvement or organizational development?** |  Yes   No   Don’t Know |

**7. If the questions on this page do not adequately capture the nature of quality improvement coordination at your facility, please describe:**

|  |  |
| --- | --- |
| **a. Please indicate the percentage of this person’s time that is *dedicated* specifically to quality improvement coordination.** | % |
| **b. What other role(s), *if any*, does this person have in your facility?**  ***SELECT ALL THAT APPLY*** |  No other roles /  100% of time is dedicated to quality improvement coordination  ‐‐‐‐‐‐‐‐‐‐OR‐‐‐‐‐‐‐‐‐‐   Staff Development  Coordinator   ADON   DON   NHA   Infection Control   Dietary   Other (Specify): |
| **c. Does this person have any formal certification or degree related to quality improvement or organizational development?** |  Yes   No   Don’t Know |

**8. Select the frequency that most closely matches how often performance data are routinely reviewed by the Nursing** **Home** **Administrator (during QA meetings or otherwise) for each of the topics listed below.**

***FREQUENCY*** ***OF*** ***REVIEW***

***SELECT ONE ANSWER FOR EACH TOPIC***

As needed but

not routinely

Daily

Weekly

Monthly

Quarterly

Annually

Not Reviewed

Not Applicable

SATISFACTION DATA

a. Resident satisfaction         b. Family satisfaction         c. Staff satisfaction        

d. Consistent assignment of CNAs or other

caregivers (monitoring whether consistent assignments actually occur as scheduled)

       

e. Call light response times        

f. Quality of food services        

g. Other (Specify):

       

CLINICAL DATA

h. Quality Measures from MDS (QMs)       

i. Adverse events (e.g., medication error, falls with injury)

j. Near misses (could have caused harm, e.g., medication filled incorrectly but not given)

k. Data related to rehabilitative therapy outcomes (e.g., return to community/previous residence)

l. Healthcare‐Associated Infections (including multi‐drug resistant organisms)

       

       

       

       

m. Antipsychotic use        

n. Hospital admissions/readmissions        

o. Other (Specify):

       

***Item 8 (Continued) FREQUENCY*** ***OF*** ***REVIEW***

***SELECT ONE ANSWER FOR EACH TOPIC***

As needed but

not routinely

Daily

Weekly

Monthly

Quarterly

Annually

Not Reviewed

Not Applicable

STAFFING and OPERATIONAL DATA

p. Staff turnover        

q. Staff absenteeism        

r. Financial        

s. Quality Improvement Project

A Quality Improvement Project is a set of related activities designed to achieve measurable improvement in processes and outcomes.

       

t. QA Committee meeting minutes        

u. Direct care nursing hours per resident day

       

v. Use of agency/temp staff        

w. Resident census        

x. Other (Specify):

       

STATE SURVEY & PUBLIC DATA

y. State survey deficiencies       

z. Complaints       

aa. Occurrences or incidents reportable to survey agency

      

bb. Advancing Excellence Campaign       

cc. Five Star Rating       

dd. Other (Specify):

       

**9. Do you currently have *specific,*** ***measurable improvement*** ***targets* established for any of the following topics?**

Goal, but No

Specific Target

***SELECT ONE ANSWER FOR EACH TOPIC***

m. Hospital admissions/

Yes

No

readmissions

  

Yes

No

a. Resident satisfaction    b. Family satisfaction    c. Staff satisfaction   

Goal, but No

Specific Target

d. Consistent assignment of

CNAs or other caregivers

n. Staff turnover    o. Staff absenteeism    p. Financial   

q. Quality Improvement   

Project(s)

r. Direct care nursing hours

(monitoring whether

consistent assignments actually occur as scheduled)

  

  

per resident day

s. Use of agency/temp staff   

t. Resident census   

e. Call light response times   

f. Quality of food services   

u. State survey deficiencies   

v. Complaints   

g. Quality Measures from

MDS (QMs)

h. Adverse events (e.g., medication error, falls with injury)

i. Near misses (could have

  

  

w. Occurrences or incidents reportable to survey agency

x. Advancing Excellence

Campaign

  

  

caused harm, but identified before event, e.g., medication filled incorrectly but not given)

j. Healthcare‐Associated infections (including multi‐ drug resistant organisms)

  

  

y. Five Star Rating   

k. Antipsychotic use   

l. Data related to rehabilitative therapy outcomes (e.g., return to community/previous residence)

  

**10*.* Select the extent to which you *Agree* or *Disagree* with each of the following statements about your facility’s practices related to ADVERSE** **EVENTS and follow up ACTION** **PLANS.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Agree | Strongly Agree | Don’t Know |
| i. Our facility monitors the *progress* of improvement action plans to determine if desired results are being obtained. |  |  |  |  |  |
| j. Our facility monitors improvement project results *after* *completion* to determine if desired results are sustained over time. |  |  |  |  |  |
| k. We almost always make changes to systems or processes when adverse events occur. |  |  |  |  |  |
| l. We almost always make changes to policies and protocols when adverse events occur. |  |  |  |  |  |
| m. Disciplinary action is not taken when adverse events are reported by staff, unless the outcome was the result of deliberate intent to harm. |  |  |  |  |  |
| n. Staff members are encouraged to report an adverse event. |  |  |  |  |  |
| o. Staff feel safe when reporting an adverse event (do not feel they will be disciplined or fear losing their jobs). |  |  |  |  |  |
| p. Our Governing Body reviews all adverse event findings. |  |  |  |  |  |
| q. We have set clear expectations of staff  to ensure resident safety. |  |  |  |  |  |
| r. It is easy to make changes to improve resident safety in this nursing home. |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NOTE:  An Adverse Event is an  untoward, undesirable, and usually unanticipated event that actually or potentially causes serious harm, affecting a resident’s quality of life or quality of care. | Strongly Disagree | Disagree | Agree | Strongly Agree | Don’t Know |
| UNDERSTANDING ADVERSE EVENTS | | | | | |
| a. Our facility has defined what we consider to be an adverse event. |  |  |  |  |  |
| b. Our facility has a specified methodology *to evaluate* adverse events. |  |  |  |  |  |
| c. Our facility does a root cause analysis when an adverse event occurs. |  |  |  |  |  |
| d. Our facility tracks data related to adverse events. |  |  |  |  |  |
| e. Our facility provides training to key staff on how to investigate an adverse event. |  |  |  |  |  |
| f. Our facility has a policy that protects staff who report adverse events from retaliation. |  |  |  |  |  |
| RESPONDING TO AN ADVERSE EVENT | | | | | |
| g. Our facility develops an improvement action plan or project after an adverse event occurs. |  |  |  |  |  |
| h. Our facility’s improvement action plans routinely include measureable goals or targets for desired improvements. |  |  |  |  |  |

**11. Who would perform a root cause analysis (RCA) and action plan following an adverse event in your facility?**

***SELECT THE ONE ANSWER THAT MOST*** ***CLOSELY MATCHES THE PRACTICE THAT OCCURS IN***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NOTE:  A Quality Improvement Project is a set of related activities designed to achieve measurable improvement in processes and outcomes. | Strongly Disagree | Disagree | Agree | Strongly Agree | Don’t Know |
| a. Quality improvement projects are initiated only when something goes wrong. |  |  |  |  |  |
| b. Our Governing Body mandates what improvement projects will be undertaken in our facility. |  |  |  |  |  |
| c. Our facility maintains a calendar that provides a schedule to evaluate the performance of important care and service areas on  a regular basis. |  |  |  |  |  |
| d. The Quality Committee decides when an improvement project needs to occur. |  |  |  |  |  |
| e. When several residents complain about the same issue, the need for initiating a performance improvement project is evaluated. |  |  |  |  |  |
| f. Staff members in our facility identify areas in need of improvement. |  |  |  |  |  |
| g. Residents in our facility identify areas in need of improvement. |  |  |  |  |  |

***YOUR FACILITY.***

 We would not perform a RCA

 An individual (e.g., QA/QI Coordinator, NHA, DON) performs the RCA

 A team performs the RCA

 A team performs the RCA and the team includes those involved in the event

**12. Select the source(s) of data that your facility uses to evaluate your facility’s performance.**

***SELECT ALL THAT APPLY***

 Advancing Excellence Campaign

 Corporate data

 MDS QM reports

 National averages

 Nursing Home Compare

 Results achieved in other industries

 Satisfaction survey vendor reports

 Software vendor reports (e.g., quality tracking programs or products)

 State averages

 Compare to our own previous data or trend

 Other (Specify):

 None

**13. Select the extent to which you Agree or Disagree with the following statements about your facility’s INITIATION of quality improvement projects or action plans.**

**14. Select the extent to which you Agree or Disagree with the following statements about ACTIONS** **TAKEN** **and** **RESULTS from your facility’s quality improvement projects.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Agree | Strongly Agree | Don’t Know/NA |
| h. Our organization continues to advance the quality of our services by maintaining  improvements over long periods of time. |  |  |  |  |  |
| i. An evaluation of any needed change to the environment, equipment or physical  plant is generally part of our improvement plan process. |  |  |  |  |  |
| j. Our Medical Director actively participates in quality improvement teams. |  |  |  |  |  |
| k. Physicians working in our nursing home  (other than our Medical Director) actively participate in our  quality improvement  teams. |  |  |  |  |  |
| l. Nurse Practitioners and/or Physician Assistants working in our nursing home actively participate in our quality improvement teams. |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| NOTE:  A Quality Improvement Project is a set of related activities designed  to achieve measurable improvement in processes and outcomes. | Strongly Disagree | Disagree | Agree | Strongly Agree | Don’t Know/NA |
| a. Staff re‐education is mainly all that is needed to prevent reoccurrence of a quality problem. |  |  |  |  |  |
| b. Quality improvement projects are typically carried out by our DON. |  |  |  |  |  |
| c. Quality improvement projects are carried out by improvement teams that are multidisciplinary. |  |  |  |  |  |
| d. The focus of our quality improvement projects is primarily to meet regulatory compliance. |  |  |  |  |  |
| e. During a quality improvement initiative, we use data to inform our actions or decisions. |  |  |  |  |  |
| f. Revising policies or procedures is mainly all that is needed to prevent reoccurrence of a quality problem. |  |  |  |  |  |
| g. Our quality improvement project action plans almost always include changes to a system or process related to the problem. |  |  |  |  |  |

**15. Does your facility have one or more specified models or approaches that are used for quality improvement?**

**No**

**Benefit**

**1 2 3**

**Great**

**Benefit**

**4 5**

 Yes

 No/Don’t Know

***IF NO/DON’T KNOW, SKIP TO QUESTION 16***

**15a. What model(s) do/does your facility use? *SELECT ALL THAT APPLY***

 DMAIC (Define‐Measure‐Analyze‐

Improve‐Control)

 Failure Mode Effect Analysis

(FMEA)

 Focus (Find, Organize, Clarify,

b. Critical thinking skills c. How to prioritize

quality improvement

projects

d. How to hold effective meetings

e. Teamwork

f. Communication strategies

g. Leadership skills

    

    

    

    

    

    

Understand, Select) PDCA or

h. Admission practices     

PDSA

 Lean

 PDCA or PDSA (Plan‐Do‐Check‐Act or Plan‐Do‐Study‐Act)

 Rapid Cycle Quality Improvement

 Six Sigma

 SMART (Specific, Measurable, Attainable, Realistic, and Timely)

 10‐Step method from the Joint

i. Discharge practices

j. How to work with health care providers in other settings

k. What to do when an adverse event occurs

ASSISTANCE WITH DATA

l. Data collection

    

    

    

Commission

 Other (Specify):

    

methods

m. Knowing where to find

**16. Select the extent to which your facility or staff would benefit** **from** **technical** **assistance in the following areas. Select a number from 1 to 5, where 1 means “No Benefit” and 5 means “Great Benefit.”**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **No Great**  **Benefit Benefit** | | | | |
| **1** | **2** | **3** | **4** | **5** |
| BEST PRACTICES | | | | | |
| a. Training in quality improvement  concepts and methods |  |  |  |  |  |

appropriate comparison data

n. How to determine which data are important to track for quality monitoring

o. How to interpret data p. How to set

benchmarks

q. How to do a root cause analysis

r. Other (Specify):

    

    

    

    

    

    

**17. Please select the extent to which the following items are a challenge or barrier to the implementation or functioning of your**

**facility’s quality activities. Select a number from 1 to 5, where 1 means “Not a Barrier” and 5 means a “Significant Barrier.”**

**18. How long has the current *Nursing*** ***Home***

***Administrator* (NHA) been employed…**

**a. As the NHA in your nursing home?**

 Less than 1 year

 1 year to less than 2 years

**Not a**

**Barrier**

**Significant**

**Barrier**

 2 years to less than 3 years

 3 years to less than 4 years

RESOURCES

a. Financial or other resources

b. Time to complete quality activities

**1 2 3 4 5**

    

    

 4 years to less than 5 years

 5 years to less than 10 years

 10 or more years

 Don’t know

**b. As an NHA in another nursing home?**

 N/A

c. Staff turnover     

d. Leadership turnover     

e. Physician support in

 Less than 1 year

 1 year to less than 2 years

 2 years to less than 3 years

quality improvement activities

KNOWLEDGE

f. Finding knowledgeable staff with quality improvement skills

g. Deciding what to include in a quality program

h. Sustaining improved results over time

i. Knowing which data to track

j. Interpreting what the data mean

k. Having autonomy to make decisions related to our

quality program l. Other (Specify):

    

    

    

    

    

    

    

    

 3 years to less than 4 years

 4 years to less than 5 years

 5 years to less than 10 years

 10 or more years

 Don’t know

**19. How many different Nursing Home Administrators of Record (NHA/AOR) have served in your facility during the past 3 years (including current NHA and interim NHAs if known)?**

Enter NUMBER:

 Don’t know

**20. How long has the current *Director*** ***of*** ***Nursing***

**been employed…**

**a. As the DON in your nursing home?**

 Less than 1 year

 1 year to less than 2 years

 2 years to less than 3 years

 3 years to less than 4 years

 4 years to less than 5 years

 5 years to less than 10 years

 10 or more years

 Don’t know

**b. In any other prior position in your nursing home?**

 N/A

 Less than 1 year

 1 year to less than 5 years

 5 years to less than 10 years

 10 or more years

 Don’t know

**21. How many different Directors of Nursing have served in your facility during the past 3 years (include current DON and interim DONs if known)?**

Enter NUMBER:

 Don’t know

**22. Does your nursing home follow any culture change/person‐centered care practices?**

 Yes

 No ***IF NO, SKIP TO QUESTION 23***

**22a. If “Yes,” select all that apply:**

 Small Houses

 Households/Neighborhoods

 Consistent Assignment

 Use of Artifacts of Culture Change for self‐assessment

 Other (Specify):

**23. What is your facility’s affiliation?**

 Independent, free‐standing

 Hospital system, attached

 Hospital system, free‐standing

 Multi‐facility nursing home organization (chain or corporation)

**24. If your nursing home is part of a multi‐facility organization, approximately how many nursing homes are affiliated with the parent corporation?**

 N/A

 1 ‐ 2

 3 ‐ 5

 6 ‐ 10

 11 ‐ 25

 26 ‐ 100

 More than 100

**25. What is your title?**

 Administrator

 Director of Nursing

 Other (Specify):

***Thank you very much for your time to respond to this questionnaire. Your participation will help support all nursing homes.***