

Guide for Quality Assurance (QA) in Adult Care Facilities

The purpose of this guide is to serve as a resource to assist Adult Care Facility (ACF) administrators, operators and staff with understanding the basic principles of QA/Quality Improvement (QI) and to assist them with applying these principles when developing and implementing their QA/QI plan(s) for each area of operation in their facility.

I. Quality Assurance Regulatory Requirements

Chapter 735, Section 1 of the Social Service Law 461-a(2)(c), effective August 2, 1994, requires operators of an “Adult Home or Residences for Adults to develop, biannually update and implement plans for quality assurance activities for each area of operation. Quality assurance activities include but are not limited to, development and maintenance of performance standards, measurement of adherence to such standards and to applicable state and local laws and regulations, identification of performance failures, design, and implementation of corrective action.”

Adult Care Facility Regulation 18 NYCRR 487.10(d)(5)(ix) requires “at a minimum, the operator shall maintain records documenting the development, implementation and, at a minimum, the bi-annual updating of quality assurance activities for each area of facility operation. These must include, at a minimum, the development and maintenance of performance standards, measurement of adherence to such standards and to applicable state and local laws and regulations, identification of performance failures, design and implementation of corrective action.”

II. Effective Quality Assurance

Quality Assurance is a system for evaluating performance that focuses on structure, process and outcomes to reduce or resolve identified problems or improve operations. Quality Assurance Programs are planned, objective, comprehensive, systematic, measurable and ongoing.

Quality Assurance:

- is an ongoing process and acts as a system of “checks and balances” for the organization through the development of standards with measurable goals, documentation of policies and procedures, staff training and review of data associated with standards;
- assist in adhering to standards and regulations;
- includes monitoring activities to assure or improve the quality of care and services through:
 - identification of areas in need of improvement;
 - development of corrective actions to address areas of deficiencies and

- follow-up monitoring to ensure effectiveness of corrective actions taken to rectify concern(s).

III. Quality Assurance Plan

The Quality Assurance Plan provides a framework to ensure delivery of quality care and services and to facilitate the establishment of quality assurance activities. The Quality Assurance Plan should define objectives, roles and responsibilities along with planned monitoring activities that are updated twice per year.

IV. Quality Assurance Committee (Recommended Not Required)

The Quality Assurance Committee meets periodically to review findings from monitoring activities, evaluate effectiveness of corrective actions, and identify trends and improvement activities. Committee representation may include the administrator, operator, employee from each area of operation, and the Resident Council President or other resident representative. Information obtained from QA/QI activities is also shared with staff.

V. Quality Assurance Process

Plan, Do, Check, and Act is one method of approaching QA. The **Plan, Do, Check, and Act** method includes four steps:

1. **Plan.** Recognize an opportunity for improvement and plan a change (e.g. specify problem areas for improvement based on the root cause obtained from the analysis).

Root Cause Analysis:

- a) What is the problem?
 - b) Why did the problem happen (the causes)? Drill down each cause to its root by asking Why? Why? Why?
 - c) What specifically should be done to overcome the problem or to prevent the problem from happening again?
2. **Do.** Identify, develop, implement and test corrective actions (e.g. change process based on recommended corrective actions, develop new policies based on revised process, inservice staff, implement revised process and identify person responsible for monitoring).

Keep it simple and communicate your actions to all staff!

3. **Check.** Review findings (with QA Committee members, staff involved in the review process, etc.), analyze the results of corrective actions and identify

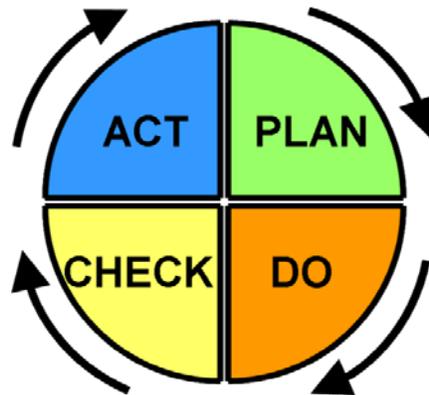
what you've learned (e.g. evaluate the effectiveness/ineffectiveness of corrective interventions).

4. **Act.** Take action based on lessons learned. If the change did not work, perform the cycle again with a revised plan based on findings and lessons learned. If you were successful, incorporate what you learned into other areas of the facility's operations where applicable (e.g. food services, environmental, medication assistance, case management, facility records). Use what you learned to plan new improvements, beginning the cycle again. (Monitor and modify services and operations on an ongoing basis based on lessons learned).

Don't wait for the DOH to issue a finding or violation!

Plan–Do–Check–Act Example

Steps for Continuous Improvement



VI. PLAN:

1. Identifying Areas for Improvement

Possible sources:

- Resident Council minutes
- Food Committee minutes
- Resident Suggestion Box
- Employee Suggestion Box
- Family meetings, suggestions, grievances
- Informal conversations with residents, family, staff
- DOH Inspection Reports

2. Prioritizing

-Identify and list all areas in need of improvement. -Prioritize areas in need of improvement and re-list in order of importance; the most important first, the least important last.

-Identify solutions (corrective actions) for each of the areas including resources: money, equipment, training, personnel (including experts from the community), time commitment, and any other factors that may be helpful.

- Identify monitoring measures (e.g. state inspection reports, resident satisfaction).

- Identify reporting process for monitoring activities (Committee, Administrator, etc.).

3. Do

-Obtain necessary resources to implement corrective actions. For example, trainers for staff training, exterminator for bedbugs, new equipment, etc.).

-Develop educational information, policies, procedures, etc. pertinent to corrective actions.

-Educate and train staff, residents, and families (as necessary) to the upcoming corrective actions (changes). Engage your local ombudsman.

-Develop monitoring forms if indicated and implement monitoring activities (record reviews, observations, satisfaction surveys, checklists).

-Implement corrective actions as planned.

4. Check

-Observe effects of corrective action(s). Did the actions resolve the problem or improve the areas in need of improvement as intended?

-Are there any undesired effects related to the implementation of the corrective action(s)? Is there a need for additional corrective actions? (If so, repeat the steps outlined in the planning section).

-Consult with residents, staff, families, resident council and food committee members, etc. Did the corrective action(s) result in change that met their expectations?

5. Act

-Continue with the corrective action(s) once the implementation/evaluation process is complete and reflects improvement in identified areas.

-Determine method to ensure ongoing effectiveness of corrective action. This should include periodic monitoring of each area as appropriate to confirm that continued improvement and/or correction is sustained (e.g. resident, staff and family satisfaction surveys; visual monitoring of operations; periodic review of

finance reports or medication records; or any other method for monitoring). Assign a monitoring timeframe for each area and person responsible for follow-up.

-Identify process for the operator/administrator to review effectiveness of corrective action(s) and provide feedback on next steps.

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Attachment I: Example of a Quality Assurance Plan

ACF (Name) Quality Assurance Plan

A. OVERVIEW

The (ACF Name) QA Committee is the forum for identifying areas for improvement and monitoring activities for the (ACF Name) QA Program. Areas for improvement will include, but are not limited to, any process or system areas that affect the quality of (ACF Name) services, activities and outcomes of the facility. QA monitoring activities and their findings are reviewed by the Committee to evaluate the overall quality and effectiveness of services provided by (ACF Name). The QA Plan is reviewed annually by the (ACF Name) QA Committee. A biannual written evaluation of the QA Program will be distributed to Committee members and staff (identify).

Findings from monitoring activities will:

- serve as the facility's benchmark to describe over time the quality, effectiveness, and consistency of services and activities provided.
- enable staff to continually identify areas in need of improvement.
- provide a mechanism for communicating quality to appropriate parties, including, but not limited to, administrative and executive staff; residents, family members, facility staff and New York State Department of Health (DOH) surveillance staff.
- serve as a mechanism for communicating accomplishments to appropriate parties including, but not limited to, Board of Directors, administrative and executive staff, residents, family members, facility staff and DOH.

Goals of the QA Program:

- improve facility operations, communication and the quality of resident life and services.
- improve effectiveness of staff through training, competency review and ongoing review and revision of policies and procedures.
- ensure (ACF Facility Name) is compliant with state statutes, regulations and facility policies and procedures.
- assist in early identification of trends and emerging issues (e.g. emergency/disaster events and/or new regulations, etc.) or concerns that may adversely affect (ACF Name) services, activities and/or operations.

B. COMMITTEE MEETINGS (optional; not required by regulation)

Periodic Quality Assurance Committee meetings are held to review findings from quality assurance monitoring activities and to identify future quality initiatives or areas in need of improvement. QA Committee membership consists of (identify individuals who will serve as Committee members). Meeting minutes, including quality assurance reports from monitoring activities, are distributed to committee members and (identify).

C. KEY QUALITY INDICATORS (areas for improvement and monitoring activities)

Compliance with Adult Care Facility Regulations (example):

- Periodic reviews are performed to assess compliance with Adult Care Facility Regulations for (identify area of regulation being monitored). Issues identified are discussed with (identify staff member) for follow-up and/or corrective action when indicated. Monthly compliance reports are provided to (identify) and discussed at the QA Committee meeting.

Compliance with Medication Documentation Standards (example):

- Periodic reviews are performed to assess medication documentation compliance with ACF Regulations. Issues identified are discussed with (identify) for follow-up and/or corrective action when indicated. Reports are provided to (identify) and discussed at the monthly QA Committee meeting.

D. QUALITY ASSURANCE MONITORS (examples for sources of information)

Resident Satisfaction:

- Periodic resident satisfaction surveys will be conducted to identify overall resident satisfaction with care, services and activities provided. Findings will be utilized to identify areas in need of improvement. Issues identified are discussed with staff and during the QA Committee meeting.

Incident/Complaint Reports:

- Monthly reports of incident and/or complaints received will be reviewed by the QA Committee to identify trends (e.g., incident/complaint type). Appropriate follow-up actions will be performed when indicated. Trending of incidents/complaints is performed for early identification and resolution of potential quality issues relating to the (ACF Name) provision of care, services or activities.

Focus QA Reviews:

- Focus QA reviews (identify area of operation) will be performed to identify compliance with ACF regulations. Issues identified are discussed with (identify) for follow-up and/or corrective action when indicated. Findings from focus review activities and follow-up actions will be discussed at the QA Committee meeting.

Attachment II: Additional QA Requirements for Adult Care Facilities under the conjoined jurisdiction of the NYS Department of Health and The Justice Center for the Protection of People with Special Needs

I. Article 11, Social Services Law §490 requires an Incident Management Program in which:

- all reportable incidents are identified and reported in a timely manner;
- all reportable incidents are promptly investigated;
- individual reportable incidents, and incident patterns and trends, are reviewed to identify and implement preventive and corrective actions, which may include, but shall not be limited to, staff retraining or any appropriate disciplinary action allowed by law or contract, as well as opportunities for improvement;
- patterns and trends in the reporting and response to allegations of reportable incidents are reviewed and plans of improvement are timely developed based on such reviews;
- information regarding individual reportable incidents, incident patterns and trends, and patterns and trends in the reporting and response to reportable incidents is shared, consistent with applicable law, with the justice center, in the form and manner required by the Justice Center and, for facilities or provider agencies that are not state operated, with the applicable state oversight agency which shall provide such information to the Justice Center;
- Incident Review Committees are established; provided, however, that the regulations may authorize an exemption from this requirement, when appropriate, based on the size of the facility or provider agency or other relevant factors. Such committees shall be composed of members of the governing body of the facility or provider agency and other persons identified by the Director of the facility or provider agency, including some members of the following: direct support staff, licensed health care practitioners, service recipients and representatives of family, consumer and other advocacy organizations, but not the Director of the facility or provider agency.
 - Incident Review Committees shall meet regularly to:
 - review the timeliness, thoroughness and appropriateness of the facility or provider agency's responses to reportable incidents;
 - recommend additional opportunities for improvement to the director of the facility or provider agency, if appropriate;
 - review incident trends and patterns concerning reportable incidents;

- make recommendations to the Director of the facility or provider agency to assist in reducing reportable incidents;
 - Members of the Committee shall be trained in confidentiality laws and regulations, and shall comply with section seventy-four of the Public Officers' Law.
- Notwithstanding any other provision of law, except as may be provided by section 33.25 of the mental hygiene law, records, reports or other information maintained by the justice center, state oversight agencies, delegate investigatory entities, and facilities and provider agencies regarding the deliberations of an Incident Review Committee shall be confidential, provided that nothing in this article shall be deemed to diminish or otherwise derogate the legal privilege afforded to proceedings, records, reports or other information relating to a quality assurance function, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, as provided in section sixty-five hundred twenty-seven of the Education Law. For purposes of this section, a quality assurance function is a process for systematically monitoring and evaluating various aspects of a program, service or facility to ensure that standards of care are being met.
- No member of an Incident Review Committee performing a quality assurance function shall be permitted or required to testify in a judicial or administrative proceeding with respect to quality assurance findings, recommendations, evaluations, opinions or actions taken, except that this provision is not intended to relieve any State oversight agency, delegate investigatory entity, facility or provider agency, or an agent thereof, from liability arising from treatment of a service recipient.
- There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person on account of participating in good faith and with reasonable care in the communication of information in the possession of such person to an Incident Review Committee, or on account of any recommendation or evaluation regarding the conduct or practices of any custodian that is made in good faith and with reasonable care.
- With respect to the implementation of incident management plans in residential schools or facilities located outside of New York State, each State oversight agency shall require that:
 - (a) the Justice Center, the applicable State oversight agency and any local social services district and/or local educational agency placing an individual with such facility or school or State agency funding the placement of an individual or student be notified immediately of any allegation of abuse or neglect involving that individual or student;
 - (b) an investigation be conducted by the justice center, or where that is not practicable, by a state agency or other entity authorized or required to

investigate complaints of abuse or neglect under the laws of the State in which the facility or school is located; and

- (c) any findings of such investigation be forwarded to the Justice Center and each placing entity or funding agency in New York State within ninety days. Failure to comply with the requirements of this section shall be grounds for revocation or suspension of the license or approval of the out of State facility or school.

II. Adult Care Facility Regulations:

- **18 NYCRR Part 487.14 (g)** requires that Incident Review Committees are established; provided, however, that the Department may consider and approve requests for exemptions on a case-by-case basis, based on the size of the facility or provider agency or other relevant factors. A request for an exemption must include a written justification. The facilities Incident Review Committee shall consist of persons identified by the Director of the facility, including some members of the following: at least two (2) direct support staff, two (2) licensed health care practitioners, two residents and two family members, but not the Director of the facility or provider agency. Such committee shall meet to:
 - (a) review the timeliness, thoroughness and appropriateness of the facility or provider agency's responses to reportable incidents;
 - (b) recommend additional opportunities for improvement to the Director of the facility or provider agency, if appropriate;
 - (c) review incident trends and patterns concerning reportable incidents; and
 - (d) make recommendations for the Director of the facility or provider agency to assist in reducing reportable incidents. Such meetings shall occur within one month following the issuance of findings associated with the investigation of an incident, and in the absence of such incident, no less than quarterly. Members of the Committee shall be trained in confidentiality laws and regulations, and shall comply with section seventy-four of the Public Officers' Law.
- **18 NYCRR Part 488.15 (g)** requires that incident review committees are established; provided, however, that the Department may consider and approve requests for exemptions on a case-by-case basis, based on the size of the facility or provider agency or other relevant factors. A request for an exemption must include a written justification. Such committee shall consist of persons identified by the Director of the facility, including some members of the following:
 - (a) at least two (2) direct support staff, two (2) licensed health care practitioners, two residents and two family members, but not the Director of the facility or provider agency.

- (b) such committee shall meet to review the timeliness, thoroughness and appropriateness of the facility or provider agency's responses to reportable incidents; recommend additional opportunities for improvement to the Director of the facility or provider agency, if appropriate; review incident trends and patterns concerning reportable incidents; and make recommendations for the Director of the facility or provider agency to assist in reducing reportable incidents.

- (c) such meetings shall occur within one month following the issuance of findings associated with the investigation of an incident, and in the absence of such incident, no less than quarterly. Members of the committee shall be trained in confidentiality laws and regulations, and shall comply with section 74 of the Public Officers Law.