## Performance Improvement (PI) Chapter

### PI.01.01.01

**Current Requirement Text:**
The organization collects data to monitor its performance.

### New EP Text:
As part of performance improvement, leaders do the following:
- Set priorities for performance improvement activities and patient health outcomes
- Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities
- Identify the frequency of data collection for performance improvement activities
- Reprioritize performance improvement activities in response to changes in the internal or external environment

(See also PI.01.01.01, EP 2; PI.02.01.01, EP 1)
### PI.02.01.01

**Current Requirement Text:** N/A  
**Revision Type:** New

#### EP.01.01

**Current EP Text:** N/A  
**Revision Type:** New

**New Requirement Text:**  
The organization has a performance improvement plan.

**New EP Text:**  
Performance improvement priorities established by organization leaders are described in a written plan that includes the following:
- The defined process(es) needing improvement, along with any stakeholder (for example, patient, staff, regulatory) requirements, project goals, and improvement activities
- Method(s) for measuring performance of the process(es) identified for improvement
- Analysis method(s) for identifying causes of variation and poor performance in the process(es)
- Methods implemented to address process deficiencies and improve performance
- Methods for monitoring and sustaining the improved process(es)  
(See also LD.03.07.01, EP 2)

**Leadership reviews the plan for addressing performance improvement priorities at least annually and updates it to reflect any changes in strategic priorities and in response to changes in the internal or external environment.**

### PI.03.01.01

**Current Requirement Text:** Moved  
The organization compiles and analyzes data.

**New Requirement Text:**  
The organization compiles and analyzes data.

**New EP Text:**  
The organization uses statistical tools and techniques to analyze and display data.

**The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.**
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<tbody>
<tr>
<td>PI.02.01.01</td>
<td>The organization uses the results of data analysis to identify improvement opportunities. (See also PI.03.01.01, EP 2)</td>
<td>Moved</td>
<td>The organization uses the results of data analysis to identify improvement opportunities. (See also PI.04.01.01, EP 2)</td>
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<tr>
<td>PI.02.01.01</td>
<td>When the organization identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, organizations may also wish to examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation, training, and education. Note 2: Organizations may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues.</td>
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<td>PI.02.01.01</td>
<td>When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the organizationwide patient or resident safety program (as addressed at LD.03.09.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). (See also LD.03.05.01, EP 3)</td>
<td>Moved</td>
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<td>PI.02.01.01</td>
<td>At least once a year, the leaders responsible for the organizationwide patient or resident safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. (See also LD.03.09.01, EP 10)</td>
<td>Moved</td>
<td>At least once a year, the leaders responsible for the organizationwide patient or resident safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. (See also LD.03.09.01, EP 10)</td>
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<td>PI.02.01.01</td>
<td>Current EP Text: The organization analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients or residents (for example, percent of patients/residents with complete assessment/reassessment data and percent of patients/residents meeting treatment goals).</td>
<td>EP: 18</td>
<td>Revision Type: Moved</td>
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<tr>
<td>PI.02.01.01</td>
<td>Current EP Text: The organization monitors the use of opioids to determine if they are being used safely (for example, tracking of adverse events such as over-sedation). (See also LD.01.06.01, EP 16; LD.04.03.13, EP 1)</td>
<td>EP: 19</td>
<td>Revision Type: Moved</td>
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<td>PI.02.01.01</td>
<td>Current EP Text: The organization provides incidence data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians on multidrug-resistant organisms (MDRO).</td>
<td>EP: 21</td>
<td>Revision Type: Moved</td>
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<tr>
<td>PI.03.01.01</td>
<td>Current Requirement Text: The organization improves performance.</td>
<td>Revision Type: Moved</td>
<td>PI.04.01.01</td>
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<td>PI.03.01.01</td>
<td>Current EP Text: The organization takes action on improvement priorities. (See also MM.08.01.01, EP 6; PI.02.01.01, EP 8)</td>
<td>EP: 2</td>
<td>Revision Type: Moved and Revised</td>
</tr>
<tr>
<td>PI.03.01.01</td>
<td>Current EP Text: The organization uses improvement tools or methodologies to improve its performance.</td>
<td>EP: 3</td>
<td>Revision Type: New</td>
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<td>PI.03.01.01</td>
<td>EP: 4</td>
<td>PI.04.01.01</td>
<td>EP: 5</td>
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<td><strong>Current EP Text:</strong></td>
<td><strong>Revision Type:</strong> Moved and Revised</td>
<td><strong>New EP Text:</strong></td>
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<td>The organization takes action when it does not achieve or sustain planned improvements.</td>
<td></td>
<td>The organization acts when it does not achieve or sustain planned improvements.</td>
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