



Illinois Health and Hospital Association

Quality Essential Skills Training (QuEST) Session 4: Implementation of PDSA Cycles and Bringing it All Together

Support

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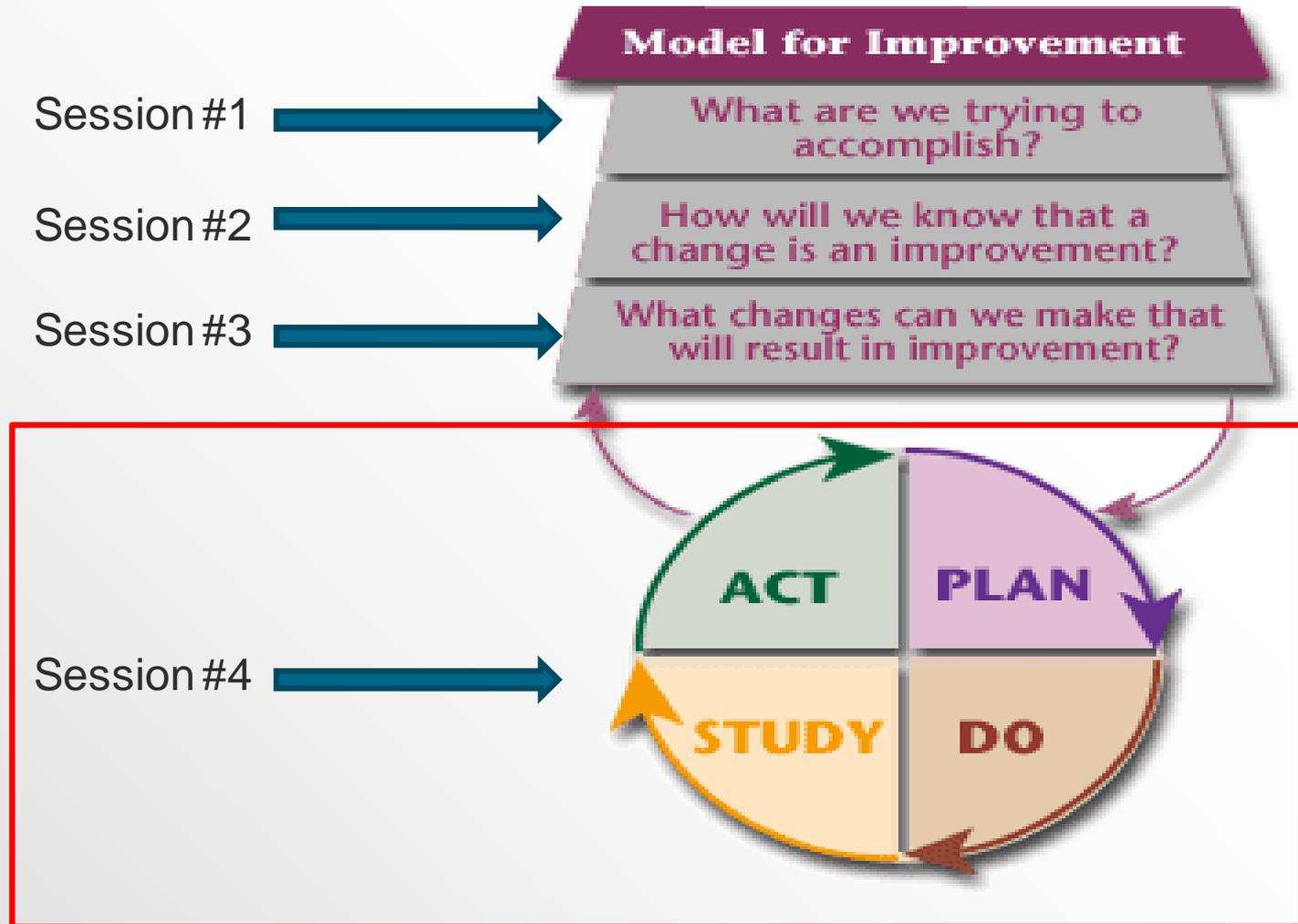
Agenda

1. Session 3 Review
2. Testing our Change Ideas by Running PDSA Cycles
3. MFI Form and Toolbox
4. Thank You and Next Steps

Our Goal by the End of Session 4

1. Have a full understanding of the Model for Improvement (MFI)
2. Be equipped with the knowledge to use the MFI, and the tools provided, to guide your quality improvement projects moving forward
3. Have a completed Project Charter form

The Model for Improvement



Next Steps from Session 3

1. Complete the Test of Change section of the Project Charter
 - ❖ Reference the *Test of Change* document to help develop tests of change
2. Review the completed Project Charter with team members to reach consensus
3. Bring your Project Charter to Session 4



Model for Improvement Project Charter

This project charter clarifies expectations among the team and establishes the project's aim, measures, scope, timeline and team members.

QUESTION 1: WHAT ARE WE TRYING TO ACCOMPLISH?		
Aim Statement:		
QUESTION 2: HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?		
Outcome Measures	Current	Target
Process Measures	Current	Target
SCOPE		
In Scope:		Out of Scope:
QUESTION 3: WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT		
Small Tests of Change	Date	
Project End Date:		
TEAM		
Executive Sponsors:		
Team Members		

The Model for Improvement Form

- This form will be the operational tool that your teams use during the project
- This will be filled out after your charter is complete and once your team starts initiating tests of change
- The MFI form helps to keep your team on task and tracking your small tests of change

PLAN – DO – STUDY – ACT PLANNING DOCUMENT

AIM Statement: *What are we trying to accomplish?*

Measures: *How will we know that a change is an improvement?* *How Much?* *By When?*

1.		
2.		

Tests of Change: *What change can we make that will result in improvement?*

PLAN What changes are to be made? What is our Question? What is our Prediction?	DO Carry out the Plan-Document the results	STUDY Complete data analysis-Compare to your Prediction	ACT Adapt? Adopt? Abandon?



DESIGN PLAN FOR SMALL TESTS OF CHANGE

Initiative: _____ Intervention: _____

Smallest Change: _____ Scope: _____ Total # of Staff Impacted: _____

Planned Testing Timeframe: _____ Total # of Staff to Test: _____

	Test Description	Test Plan	Testers	Lesson(s) Learned	Decision	Adaptation
1					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
2					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
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Model for Improvement Form

Model for Improvement



PLAN – DO – STUDY – ACT PLANNING DOCUMENT

AIM Statement: *What are we trying to accomplish?*
 Reduce readmissions of patients discharged to home to Med-Surg 4 achieving a 12% reduction by December 31, 2019

Measures: <i>How will we know that a change is an improvement?</i>	How Much?	By When?
1. A consistent phone script will be used for 100% of follow-up calls.	At least 90% of follow-up calls made between July 1 and Aug 31 will have a documentation of the standard script being followed.	August 31, 2016
2. Each patient discharged to home will receive a follow-up call within 72 hours of discharge	90% of patients discharged to home will have received a call from the discharging RN.	November 15, 2016

Tests of Change: *What change can we make that will result in improvement?*

PLAN What changes are to be made?	DO What do we predict? Plan?	STUDY Document observations:	ACT What is next?
1. Develop standardized phone script for discharge calls	Staff feedback is needed for new script. Pilot script on the unit and gather feedback.	60% of nurses have trialed and approved the new script.	Implement new script with all nurses making discharge calls.
2. Discharging RN will call patients, discharged to home, within 72 hours of discharge	Develop and trial a process that makes it easy for nurses to make these calls every time.		

Small Test Design Plan

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



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Small Tests of Change

DESIGN PLAN FOR SMALL TESTS OF CHANGE

Initiative: Readmission reduction Intervention: Develop standardized phone script for discharge calls

Smallest Change: 1 RN Scope: All RN's on 4th Med Surg Total # of Staff Impacted: 40

Planned Testing Timeframe: August 1, 2016 to August 31, 2016 Total # of Staff to Test: 10

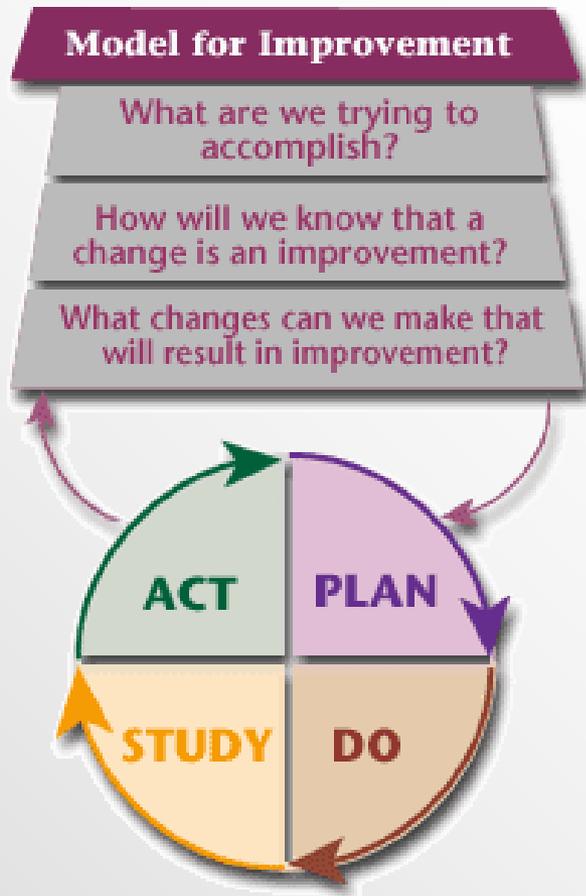
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Testing Change Ideas by Running PDSA Cycles



Illinois Health
and Hospital
Association

Running PDSA Cycles



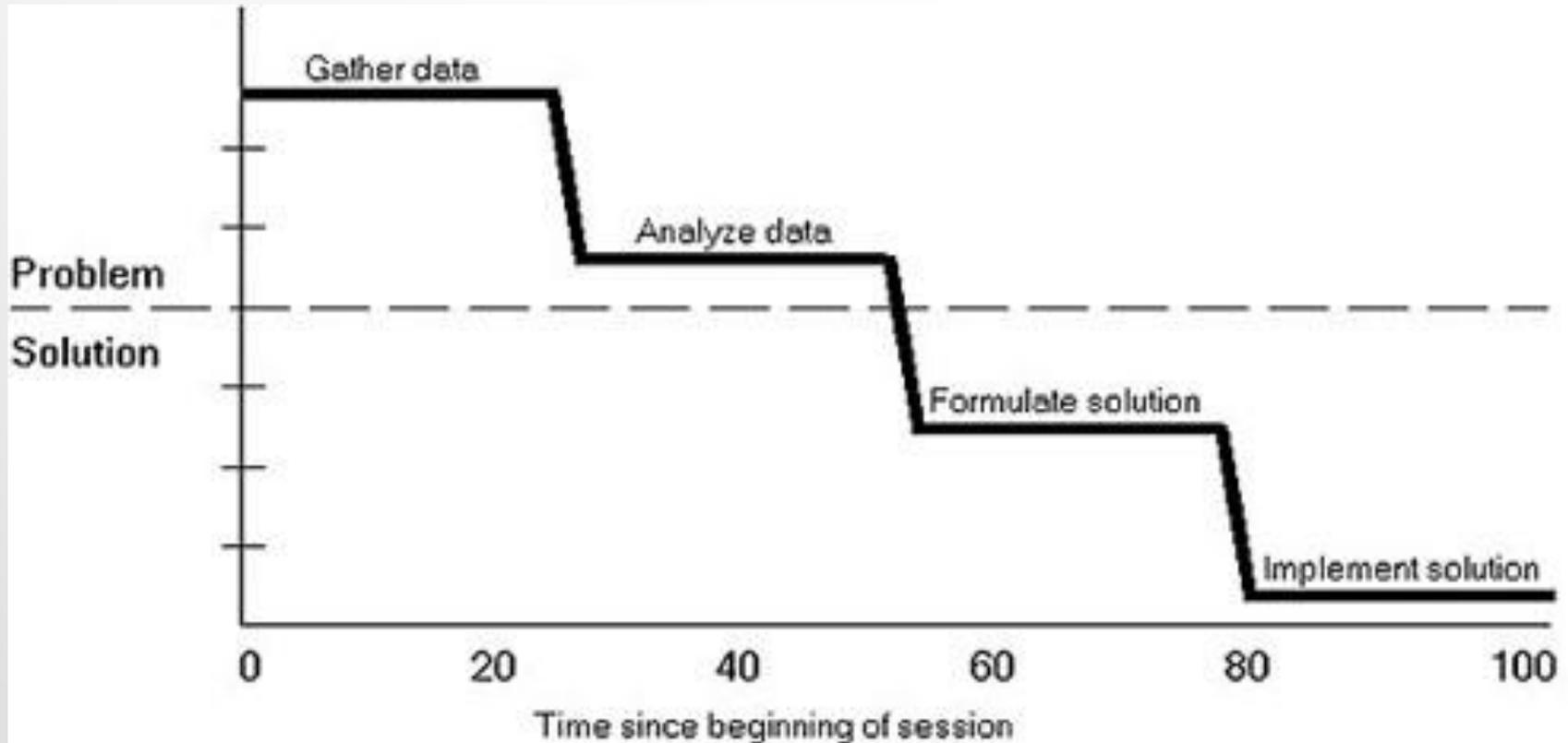
The secret? How I know someone **KNOWS** PDSA?

“we compare our DATA in the Study to our PREDICTION(s) in the Plan”

PDSA = The Scientific Method

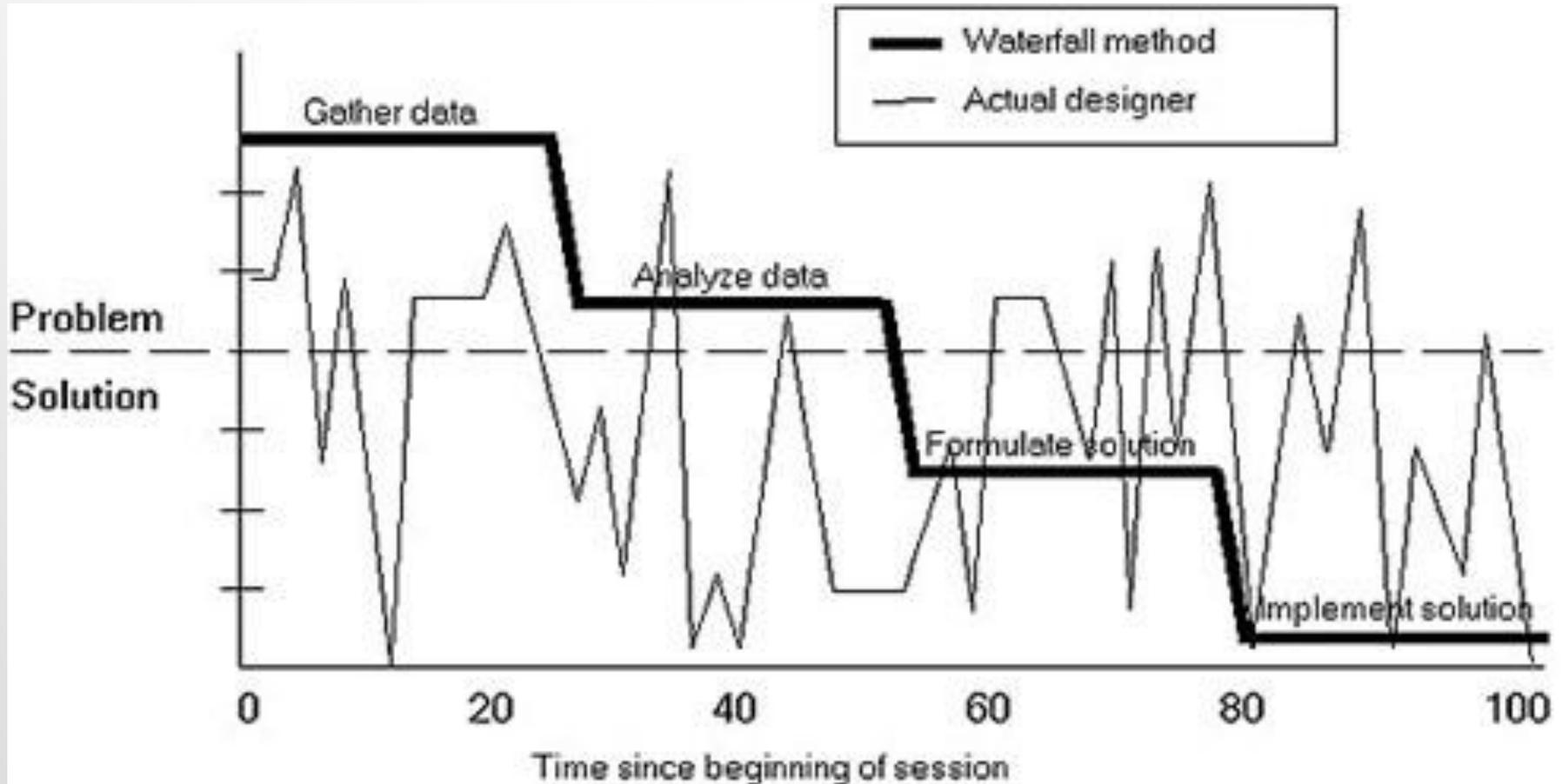
Why we test: Wicked vs. Tame problems ...

Linear model of problem solving (tame problems)

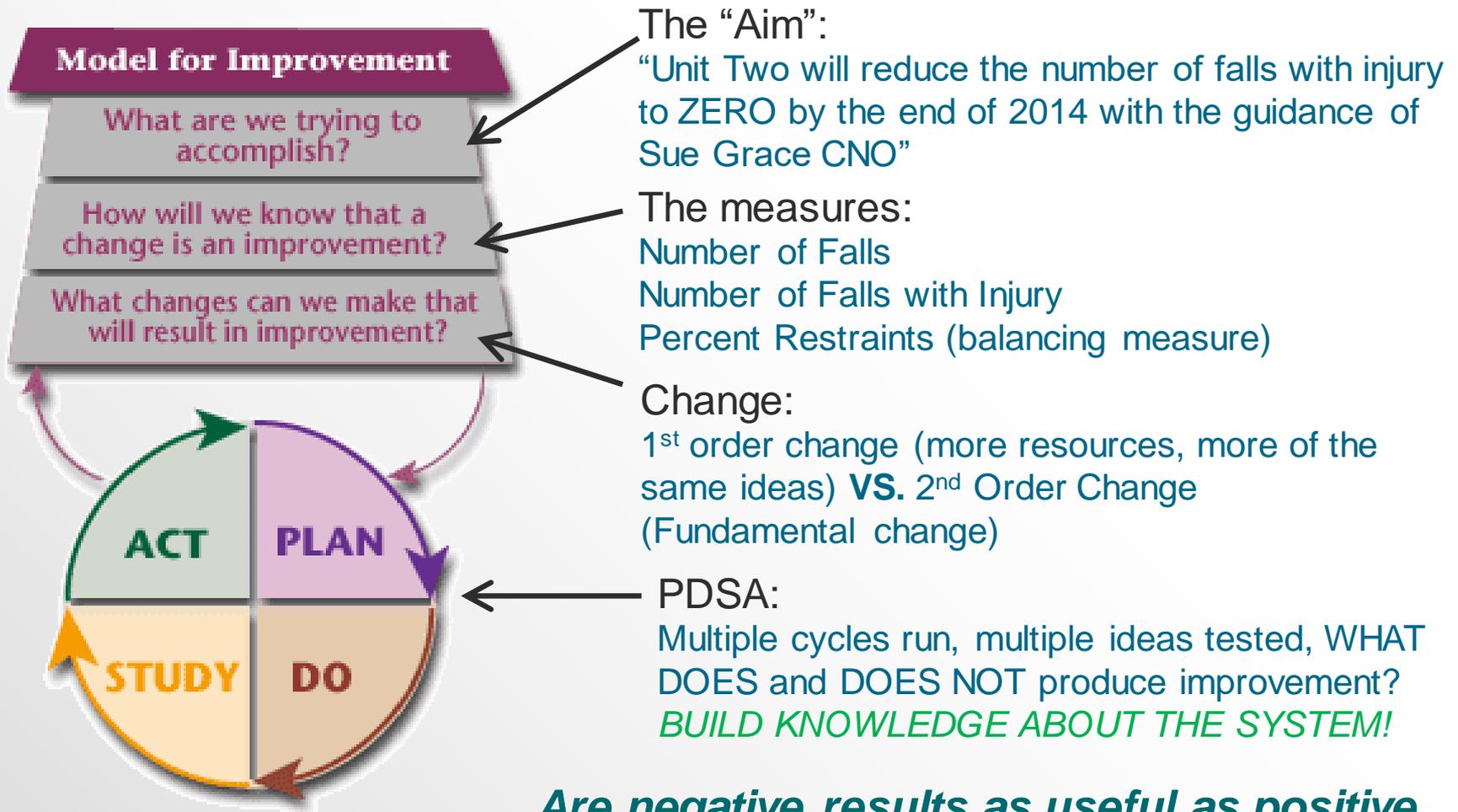


Why we test: Wicked vs. Tame problems ...

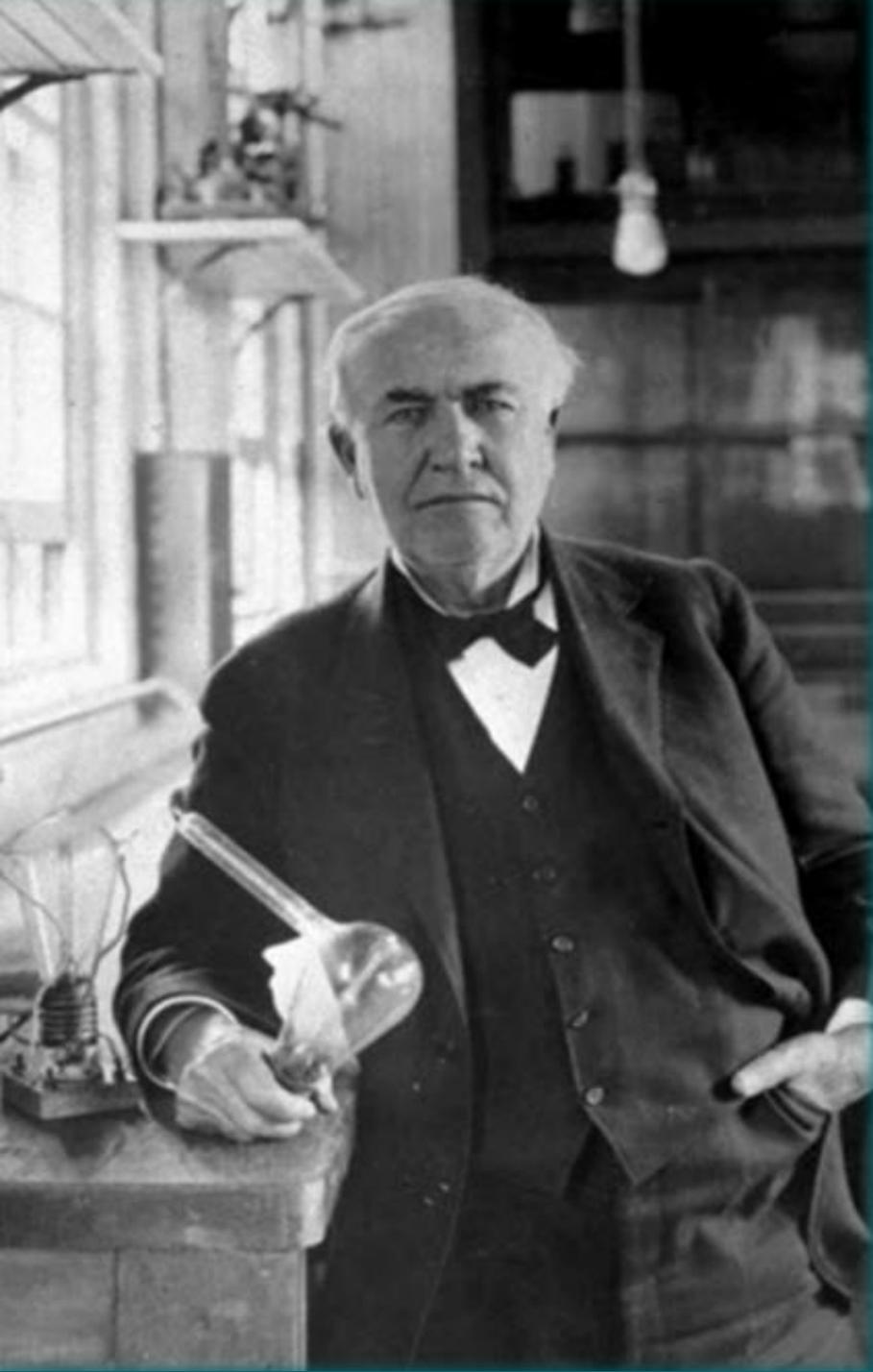
Linear model vs. reality (wicked problems)



Where “PDSA” fits in to the MFI



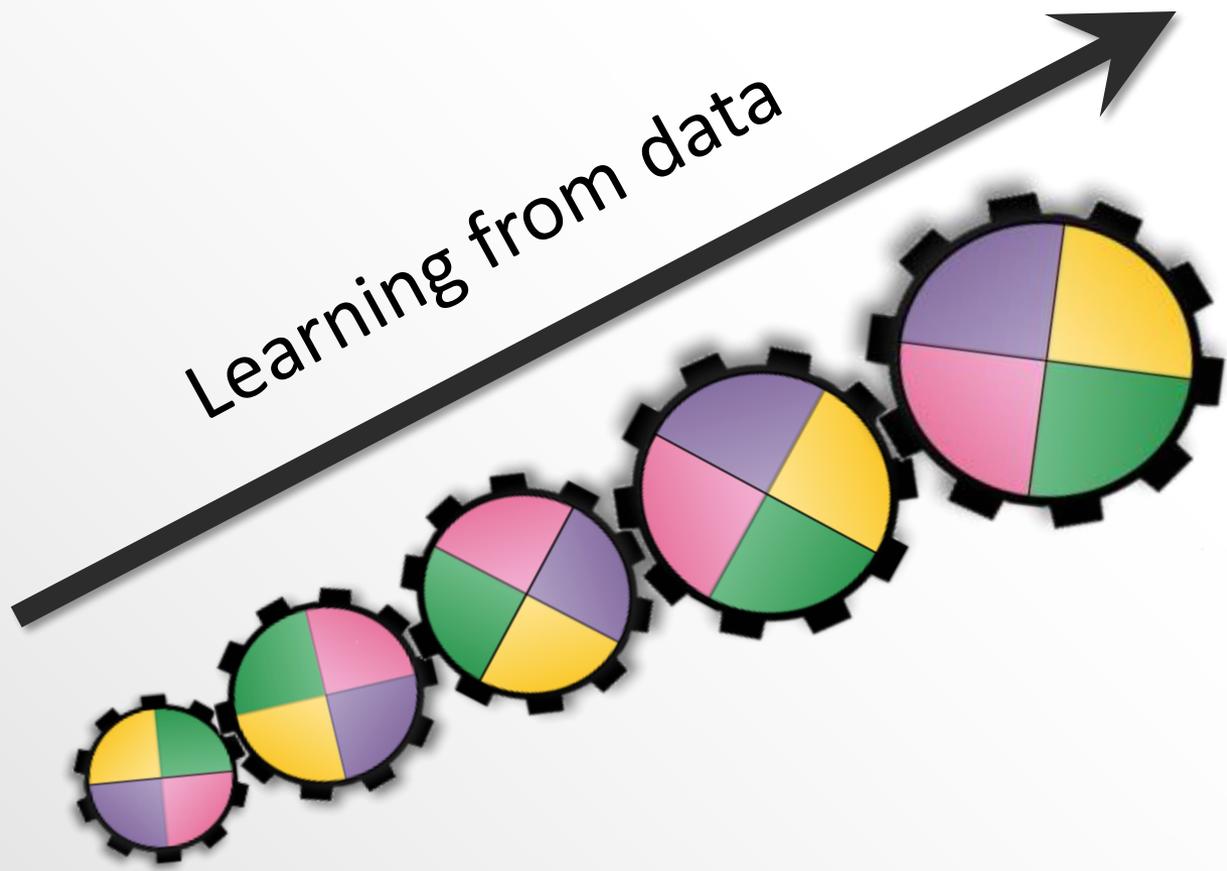
Are negative results as useful as positive results when caring for a patient?



“I did not fail one thousand times; I have found one thousand ways that won’t work.”

Thomas Edison

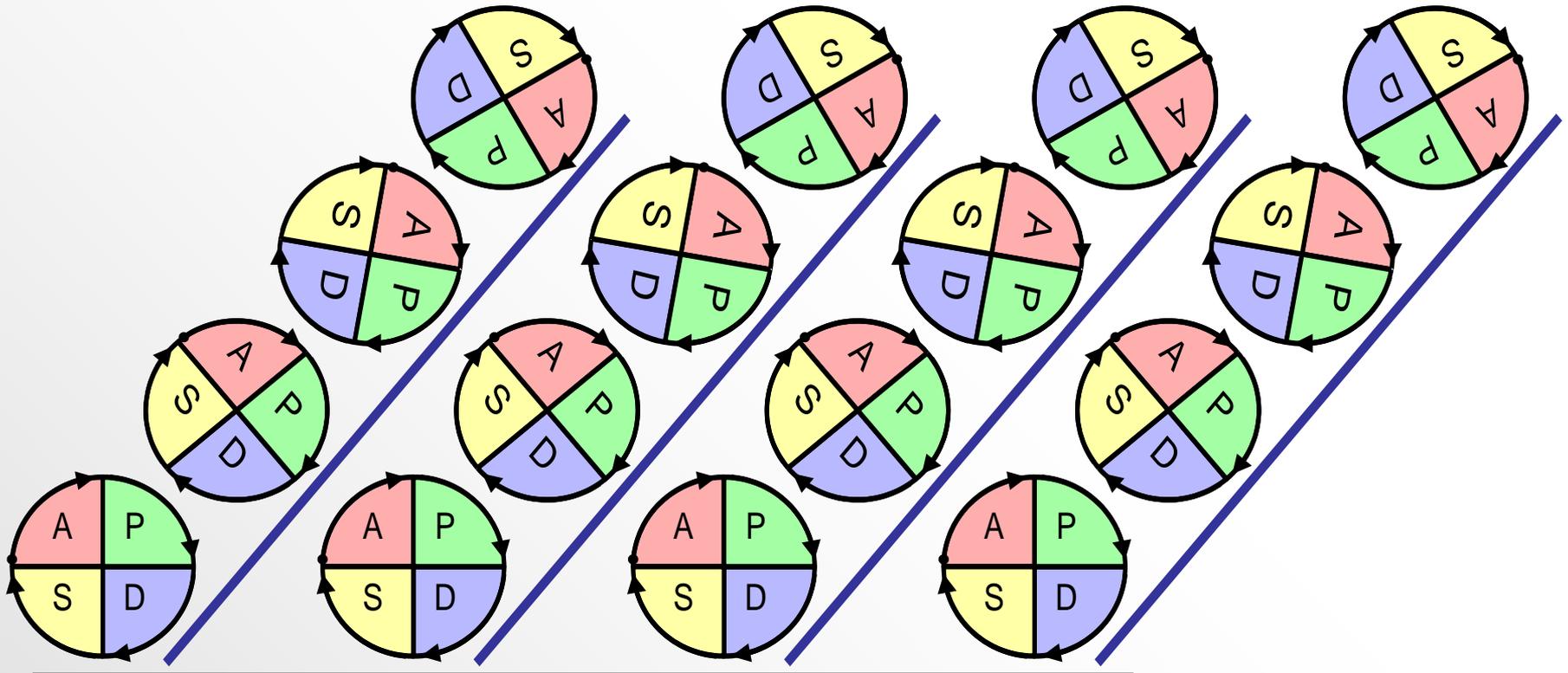
Cycles of Tests Build Knowledge and Confidence



Changes that will result in improvement

Proposals, theories, hunches, intuition

Working in Parallel on Multiple Change Ideas



Risk
assessments

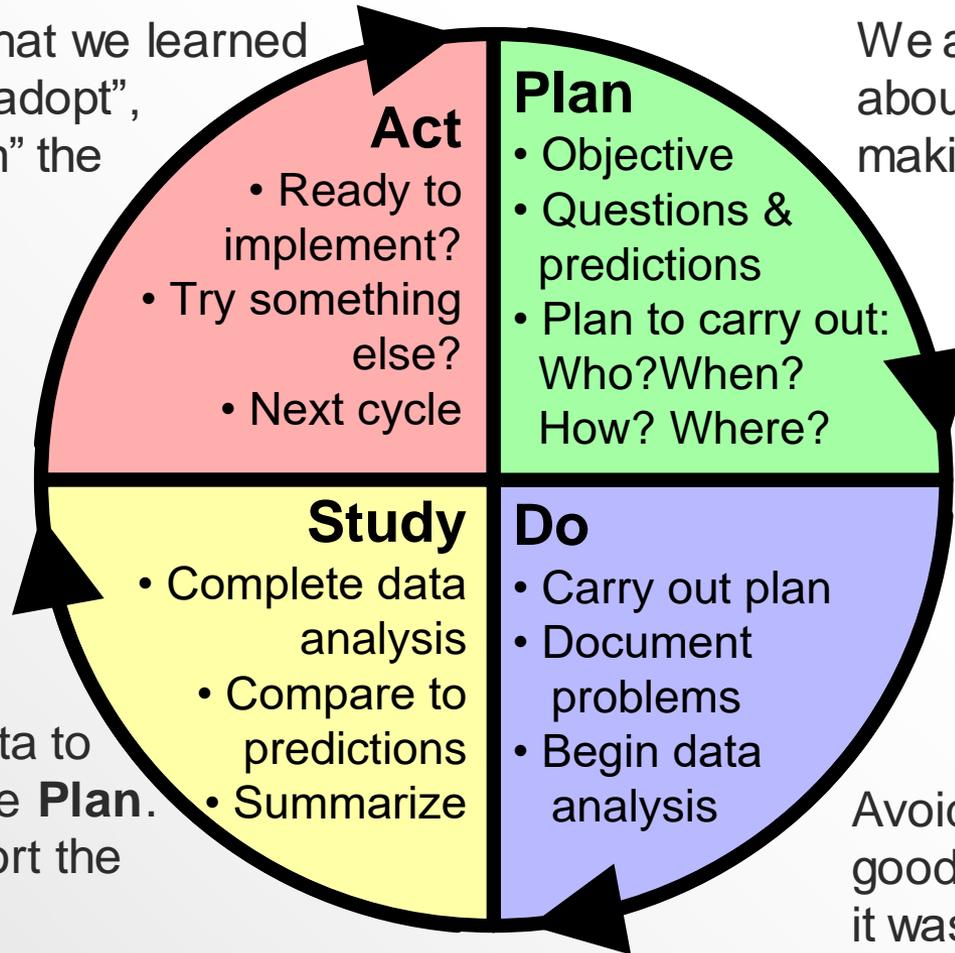
Clinical
management for
PTs with PUs

Caseload
cleansing and
management

Staffing levels

A quick breakdown of a cycle

We act based on what we learned in the **Study**. We “adopt”, “adapt” or “abandon” the idea.



We are asking a question about some change and making a detailed prediction

Avoid throwing out a good idea just because it wasn't tested as **Planned**

We compare our data to our predictions in the **Plan**. does the data support the prediction?

Test small: how small?

Conduct the next test

- in **1** facility
- in **1** office
- on **1** nursing floor
- with **1** nurse
- with **1** physician
- with **1** patient

Just get moving!
What can we test by
next Tuesday?



Benefits of “try B4 buy” ...

Jumping to implementation could potentially:

- Have a cost of failure is everything doesn't go smoothly
- Doesn't take into consideration expert opinion/ideas of staff
- Might not please medical or non-clinical staff
- “Unintentional Chaos” because people are well intentioned ...

Testing the idea would potentially:

- Lower resistance of nursing staff
- Lower resistance of medical staff
- Attract all involved to improvement, to empowerment!

Let's run a cycle ...

PLAN: the hardest part of STARTING a cycle



The **Plan** always, **ALWAYS**, contains a **question** and a **prediction** to the question!

Q *If we create a “sterile cockpit” during med pass, will nurses find value in not being interrupted? How can we reliably identify a nurse doing a med pass?*

(Prediction never Y/N, no learning in that! **WHY? WHY and HOW will it work? WHAT IS YOUR THEORY!**)

P *Interruptions can lead to errors. We had an error here from being interrupted that almost cost the life of a patient! Less interruptions will reduce the room for errors. The nurse doing the med pass will find this idea very attractive. I think we can identify the nurse doing med pass by using a brightly colored hat.*

... and then list **ALL** the gory details! **ALL!**

When: btw Monday 9/1 and Wednesday 9/3, 9:30 pass only.

Where: Unit One only, **Who:** Michelle Roberts all 3 days

Data: **vocal feedback** from Michelle, RNs on duty, MDs rounding and any staff who visit unit one, **# of interruptions**

How: nurse will place hat on when entering med room. The only interruptions allowed are emergencies. Unit clerk will educate staff not involved with test about rules of hat.

Let's run a cycle ...

DO: tweak the PLAN & make sure PLAN is followed



The **DO** is the part when we execute on our **PLAN**

- Note any tweaks made to **PLAN** in order to not cancel test. Reality usually breaks a **PLAN**
- Are we testing the idea as laid out in the **PLAN**?

DO

9/1/2014: initial response from Michelle is very positive. "I don't get anxious when someone walks by. Normally I would think "someone is looking for me""

9/2/2014: another RN noted that she gets interrupted by PTs too. She made her own script that reduces this

9/2/2014: test followed plan

Let's run a cycle ...

STUDY: compare data to predictions



The **STUDY** is where we compare our data to our predictions. **Does the data support our predictions?**

- Data can be soft (qualitative), can be the opinions and observations of SMEs
- Data can be hard (quantitative), can be hard numbers like the # of interruptions

Best practices is to use both hard & soft data in cycles!

STUDY

Michelle absolutely loved the huge reduction in interruptions. She counted 6 interruptions over the 3 days, a number she insisted was way lower than without the hat on. All the interruptions were from staff not aware of the details of the test going on. She recommends the hat be switched to a sash bc the hat isn't that comfortable and will probably fall off depending on hairstyle. Michelle forgot how often PTs interrupt med pass with simple concerns (5 times). RN Lilly noted she asks her patients a set of questions aimed at reducing simple requests while she does med pass. All 3 doctors and staff visiting unit thought the idea was great.

Let's run a cycle ...

ACT: Adapt? Adopt?
or Abandon?



ACT is where decide our next steps based on the data being compared to the prediction

- **Adapt:** is trying again a different way the next cycle
- **Adopt:** is making the change permanent
- **Abandon:** is not pursuing the idea any more

ACT

Based on the number of interruptions, and vocal feedback from all, this idea is worth pursuing. One more cycle is needed to gather enough data to make the case for change compelling for the other three nursing units. For the next cycle, the hat is out and Michelle is going to create 3 sashes each with "Please do not disturb in med pass" stenciled on the front in large letters. All three nurses on Unit One will use the sashes during med pass for the next three weeks. RN Lilly is going to run a cycle with two other nurses to try her script she uses on PTs before the med pass. If we can verify with data the script works at reducing interruptions on the PT side then we will have hard data to support adopting it house wide. We don't know how many interruptions happen during a typical med pass so a cycle will be run to collect this data to use to sell the idea house wide (and maybe spread to our sister hospitals)

Let's run a cycle ...

ACT: Adapt? Adopt?
or Abandon?



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So after **ONE** cycle we:

- Know hat won't work and we will use a labeled sash
- The idea brings value as shown in hard/soft data
- Uncovered the idea of patient med pass interruptions
- Found out RN Lilly has her own script that reduces PT interruptions so we will test (cycle) a few nurses using it to see if it works and to find the "best fit script" that reduces minor PT requests during med pass
- Learned we don't know how many interruptions happen so a cycle of learning will be used to find out (use this data to sell)
- Got a lot of people involved in thinking, in improvement, we made improvement an attractive thing
- We reduced resistance to a new change because a lot of staff were involved. Staff will hone final change. **EMPOWERMENT!**

More Tips for Testing

- **Beg, borrow, steal!** Don't reinvent the wheel!
- Involve entire team in formulation of PLAN (email)
- Test with the willing, don't waste time trying to convert people/sell people on the idea
- Talk to people about what you are doing!
- Collect useful data during each test (qual/quan)
- As cycles proceed, test over a wide range of conditions



Another cycle to learn from ...

PLAN: the hardest part of running a cycle



A large nursing home that wants to purchase \$12,000 of floor mats to reduce falls.

This environmental services employee was aware that a couple of bad falls had occurred because of missing floor mats. They were missing because after cleaning the floors they had to dry for 15 minutes before the mats are placed back down on floor.

Environmental Services employees sometimes wait > 15 minutes because of competing priorities/requests.

Another cycle to learn from ...



Plan continued, the gory details:

WHAT: *Four of Meyers part # 23746, “SwabDeck Perforated No-Slip Mat” will be placed at the side of residents beds*

WHERE: *in rooms 202, 204, 206 and 208.*

WHO: *Environmental services staff Andre Torksen will place mats immediately after the end of floor cleaning.*

DATA: *All four residents ambulate and are currently assigned to Mary Swanson till the end of the month. She will obtain feedback from the assigned CNA (Todd Carson) and residents on their perception of the value of the new mats.*

WHEN: *New mats come in Monday June 23rd. This test will start on June 25th with the first floor cleaning around 4:00 P.M. and run through the last floor cleaning Friday at 4:00 P.M. (for a total of three cleaning cycles).*

Another cycle to learn from ...



Do

Plan was carried out as detailed with the exception that CNA was assigned to another unit on second day of test. Mary Swanson educated different CNA Liz Petrowski on the test and will ask her for feedback on the mats as well as Tod Carson

Environmental Services has said it is way easier on them to clean and place floor mats. It is one less round they have to make. Also don't have chance to be pulled in another direction before placing mats back down

Environmental Services also brought up that many times they have to move personal belongings out of the way when cleaning floors. Falls have happened because of personal items.

Another cycle to learn from ...

Study

Mary observed no falls during the 3 days and environmental Services said it is way easier on them to clean and place floor mats. It is one less round they have to make. Also don't have chance to be pulled in another direction before placing mats back down. **This test made them aware they often move personal belonging in order to clean floor. Moved items during all cleanings.**

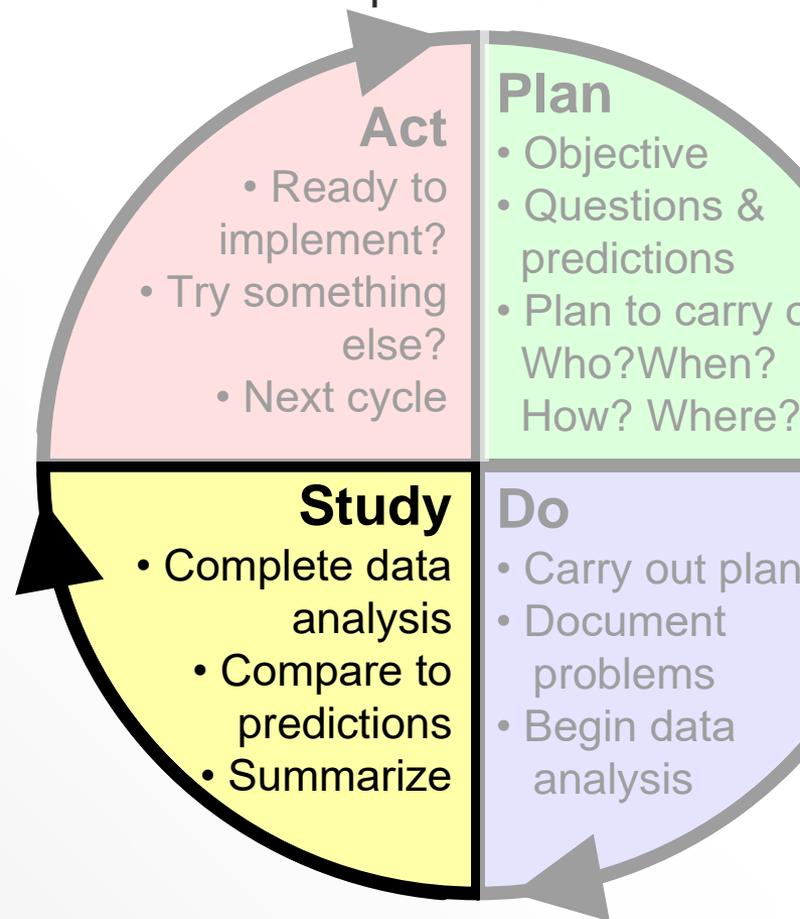
Residents commented on 3 occasions that having the mat down at all times was nice.

CNAs said it was nice to know they wouldn't slip on wet floor. One CNA said they had almost fell before bc of a wet floor around resident's bed.

Mold cannot form under mat due to material used.

More falls have occurred here due to personal items versus the missing floor mats.

STUDY: compare data to predictions



Another cycle to learn from ...

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or Abandon?



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Act

Although no falls occurred during the 3 floor cleanings, the “discovery” that residents' personal items are often moved by environmental services leads us to put a hold on this idea and pursue testing ideas for change related to stowing and organizing these items.

Mary, Todd, the residents and environmental services have been asked to brainstorm ideas for change related to personal belongings.

Floor mat idea shelved until this area of opp is worked.

So after one cycle we:

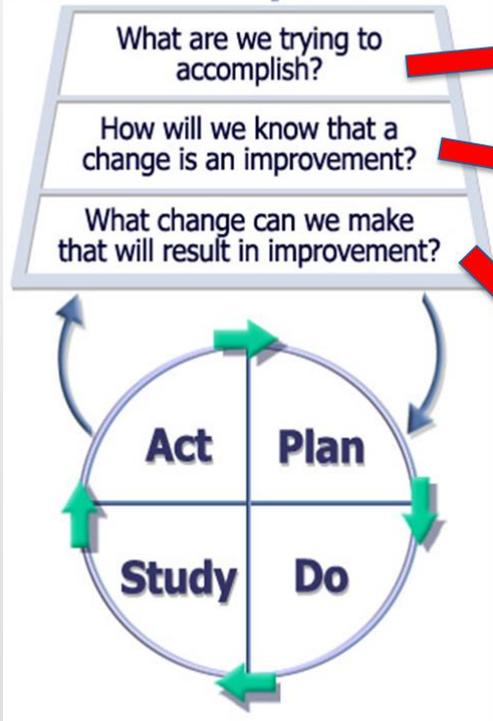
- Found another larger area for opportunity to reduce falls
- Discovered this test of a change idea led to another idea because environmental services was asked for feedback

In summary...

- Best indicator of a projects success is the # of cycles run
- PLAN is the longest part to generate
- PLAN must have a change, question & a prediction in detail
- PLAN must have some sort of data to learn from
- PLAN also must have all the gory details, who, what, when ...
- DO is used to record last minute changes, are we testing what...
- STUDY is used to compare our data to our predictions from PLAN
- ACT is used to abandon, adapt, adopt change
- ACT typically leads to another test
- THE MAIN GOAL IS TO BUILD KNOWLEDGE ...
- ... which eventually leads to MORE and MORE improvement!

Model for Improvement Form

Model for Improvement



PLAN – DO – STUDY – ACT PLANNING DOCUMENT

AIM Statement: *What are we trying to accomplish?*
 Reduce readmissions of patients discharged to home to Med-Surg 4 achieving a 12% reduction by December 31, 2019

Measures: <i>How will we know that a change is an improvement?</i>	<i>How Much?</i>	<i>By When?</i>
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Tests of Change: *What change can we make that will result in improvement?*

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Small Test Design Plan

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Small Tests of Change

DESIGN PLAN FOR SMALL TESTS OF CHANGE

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Smallest Change: 1 RN Scope: All RN's on 4th Med Surg Total # of Staff Impacted: 40

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5					<input type="checkbox"/> Adapt	

The Model for Improvement Form

- Take some time to fill out the MFI form and start writing out your test descriptions/plans
- Once this is completed you will be ready to start testing!

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Next Steps

- ❖ Session 1: Focus on the MFI & Question 1 of the MFI - *Complete*
- ❑ Before beginning Session 2: Complete the aim statement and team section of the Project Charter
- ❖ Session #2: Focus on Data/Measurement & Question 2 of the MFI - *Complete*
- ❑ Before beginning Session 3: Complete the metrics and scope sections of the Project Charter
- ❖ Session 3: Focus on Tests of Change & Question 3 of the MFI – *Complete*
- ❑ Before beginning Session 4: Identify 3 changes ideas you would like to test and complete that section of the Project Charter
- ❖ Session 4: Bringing it all together & Implementation – *Complete*
- ❑ **Use this knowledge, MFI Toolbox and get some projects going!**

Our Toolbox

1. The Project Charter
2. The Run Chart Template
3. The Model for Improvement Form

The Project Charter

- A great method to run a project by and a great way to START a project!
- A “Charter” is a statement of work (SOW) that defines the “what” and “why”
- A Charter is a short document we use to build support for and scope out a project that supports the purpose of the project
- It is the first 3 questions of The Model along with a short narrative building a case for support
- Should be shared, built as a team

 GREAT LAKES PARTNERS FOR PATIENTS		
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PLAN What changes are to be made? What is our Question? What is our Prediction?	DO Carry out the Plan-Document the results	STUDY Complete data analysis-Compare to your Prediction	ACT Adapt? Adopt? Abandon?



DESIGN PLAN FOR SMALL TESTS OF CHANGE

Initiative: _____ Intervention: _____

Smallest Change: _____ Scope: _____ Total # of Staff Impacted: _____

Planned Testing Timeframe: _____ Total # of Staff to Test: _____

	Test Description	Test Plan	Testers	Lesson(s) Learned	Decision	Adaptation
1					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
2					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
3					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
4					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
5					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	
6					<input type="checkbox"/> Adapt <input type="checkbox"/> Adopt <input type="checkbox"/> Abandon	



Next Steps

If you have questions or would like feedback on what was covered during this or previous sessions please email our IHA Team at:

IHAFlex@team-iha.org

Thank you!



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