

Common Quality Improvement Tools

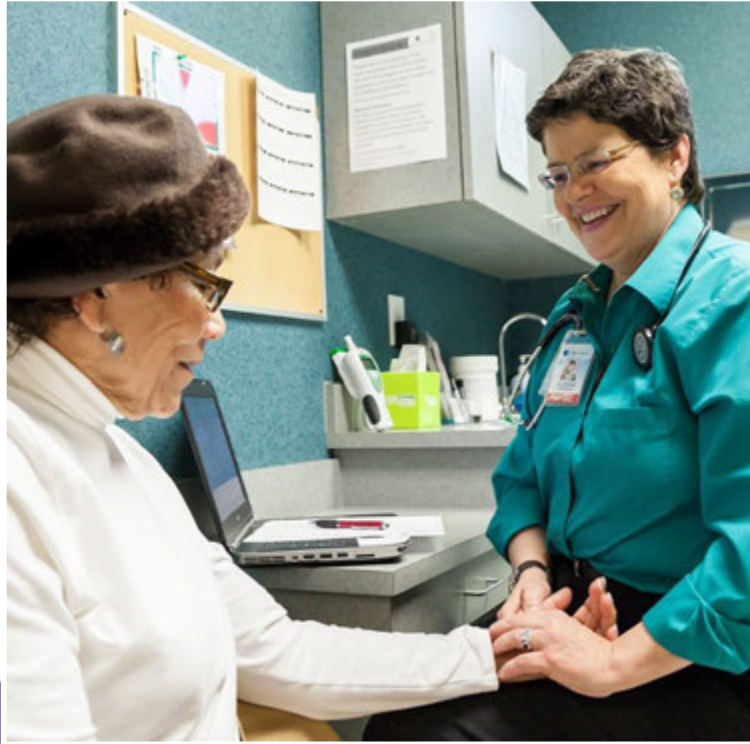
2019 Unified Quality Symposium

John Kohler, MD, MBA

Amy Campbell, PhD(c), MSN, RN, LSBB

Tim Reeder, MD, MPH



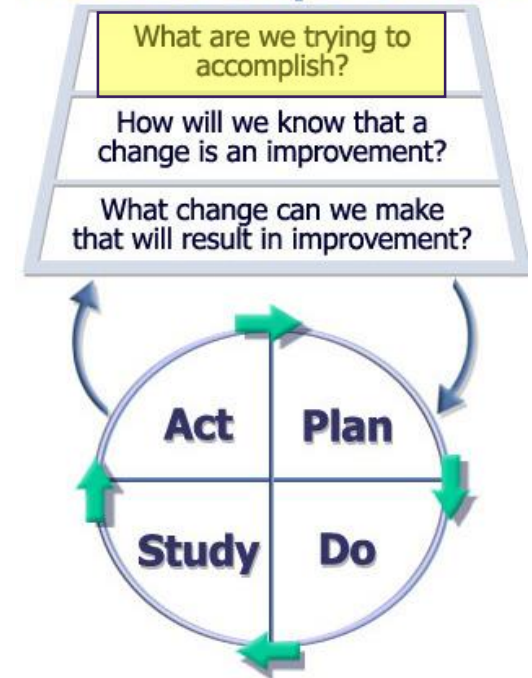


We have no significant conflicts of interest relevant to this presentation.

- Aim Statements and Measures
- Process Maps
- Fishbone Diagrams
- PDSA cycles
- Case Study

- What's the issue?
- Why is status quo no longer good enough?
- Not too easy, not too hard
- Common pitfalls:
 - Too big
 - Too broad or lacks focus
 - Outside team's ability to influence
 - Achieving 100% (or 0%) may not be feasible
- **S-M-A-R-T**

Model for Improvement



S- Specific

M- Measurable

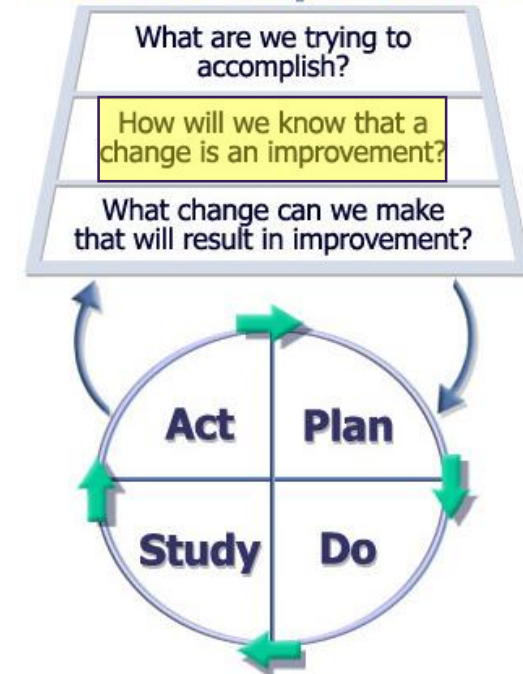
A- Actionable

R- Relevant

T- Time-Bound

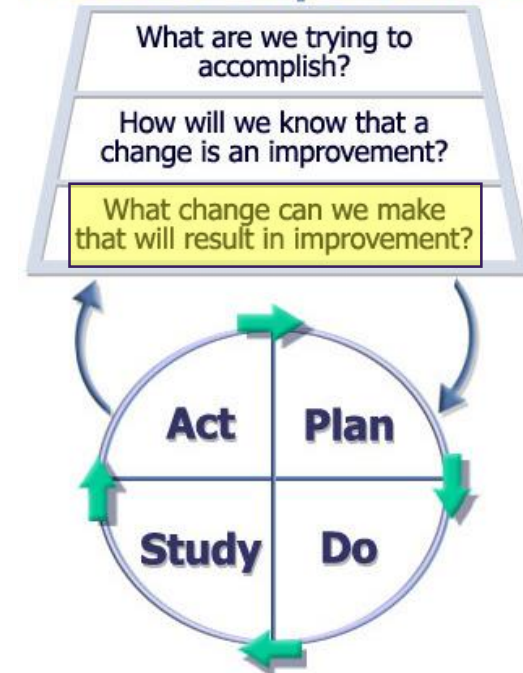
- Keep measures useful and meaningful
- Common mistakes:
 - Cannot easily collect data
 - Not related to aim
 - Numerator/denominator not properly defined
- Collect baseline data
 - Run Charts
 - Control charts
- Process, Outcome, Balancing

Model for Improvement

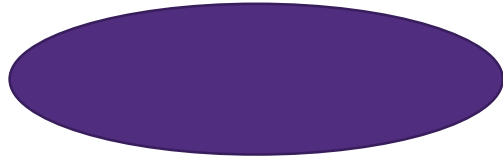


- Illustrates steps in a process to concisely document process flow, enables identification of strengths and weaknesses
- Documentation is no substitute for observation
- Means not an end
- Multidisciplinary team should create the map
- Use level of detail that is useful for project

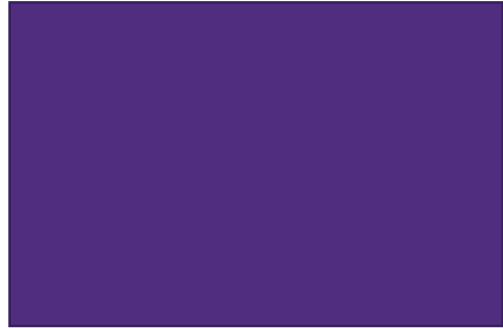
Model for Improvement



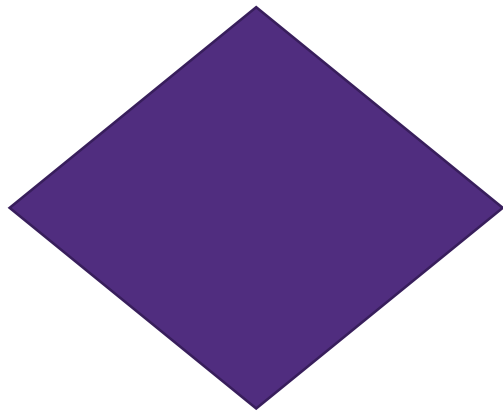
1. Get the “right” people in the room
2. Start by defining the first and the last step in the process — define boundaries
3. Write each step on sticky note
4. Document what is actually done, not what is supposed to be done.
5. Arrange the sticky notes with your team
6. Review the process to check for accuracy and completeness.
7. Convert to standardized chart with shapes
8. When the flowchart is complete and accurate, analyze it, use it, revisit it, and keep it up to date.



Start and end of a process

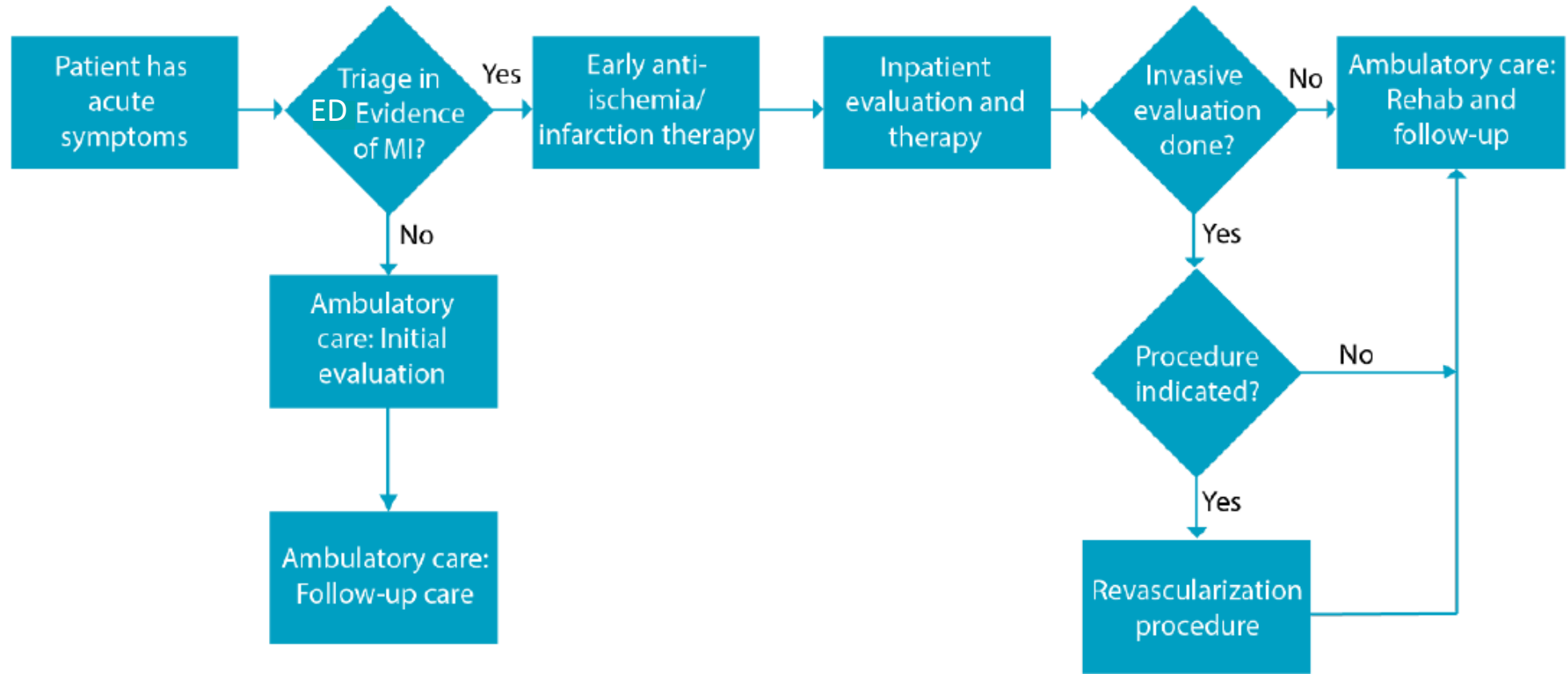


Activity or task



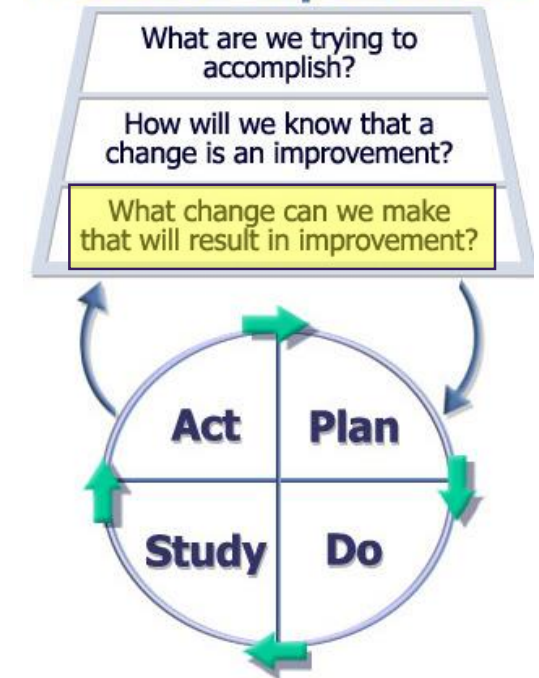
Decision point (yes/no question)

Process Map

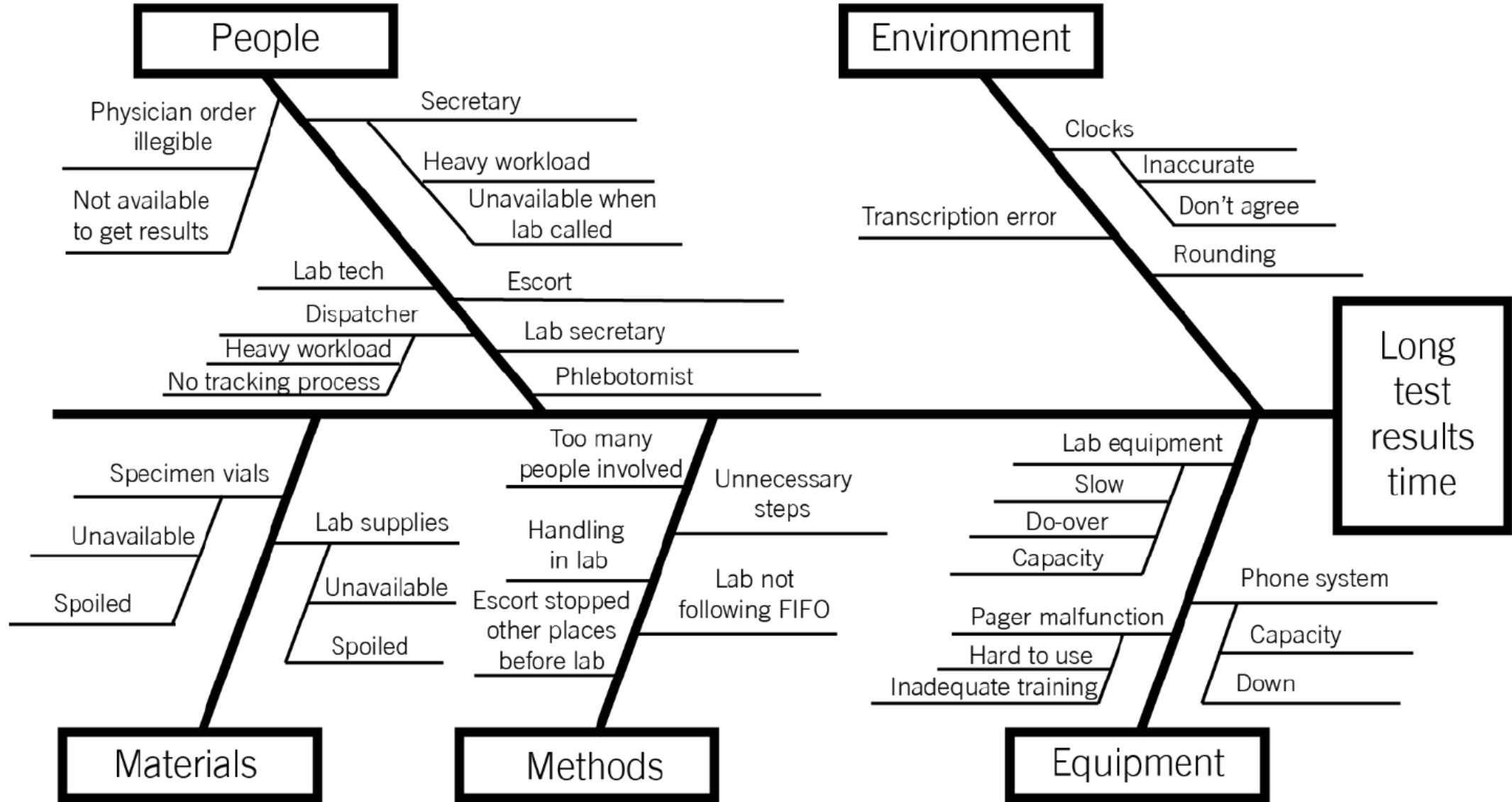


- Helps to generate ideas about where changes can be implemented to change outcome
- Process that enables the visualization of multiple causes to an effect
- Encourages broad thinking
- Particularly useful when have good handle of what is the problem

Model for Improvement



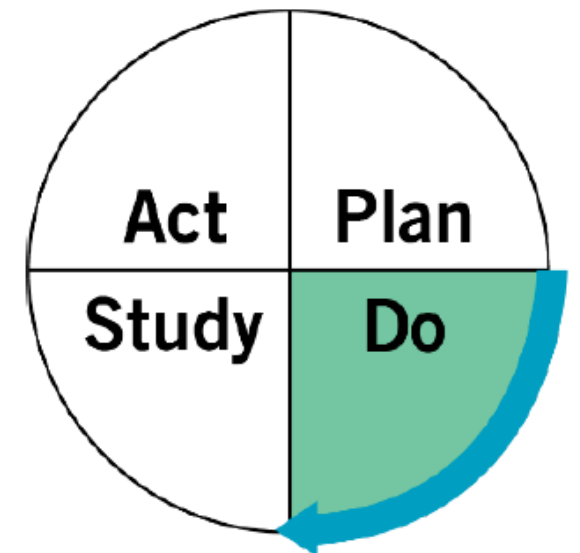
1. Write the effect you wish to influence in a box on the right-hand side of the page
2. Draw a horizontal line across the page to the left, starting at the box you just drew
3. Decide on five or six categories of causes for the effect
 - Materials, Methods, Equipment, Environment, and People.
4. Create “fishbones,” and label each line at the end with one of the categories you have chosen
 - Draw a box around each label.
5. Generate list of the causes that contribute to the effect on “branch bones”



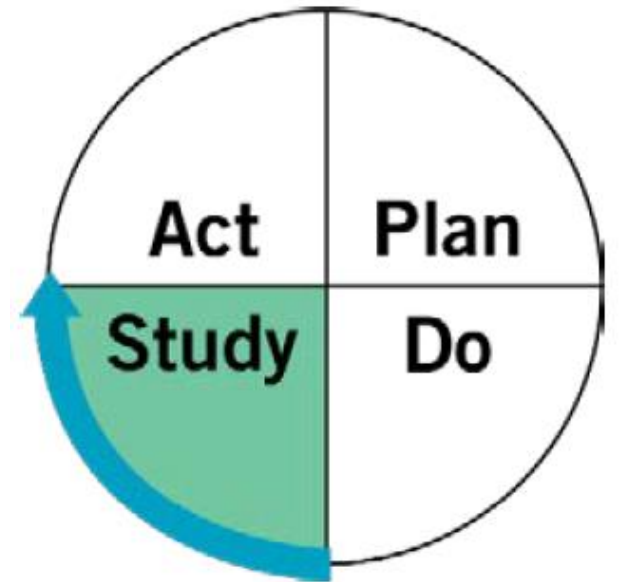
- Plan the test, including a plan for data collection
- State the question you want to answer
- Develop a plan to test the change
 - Who? What? When? Where?
- Identify what data you will need to collect



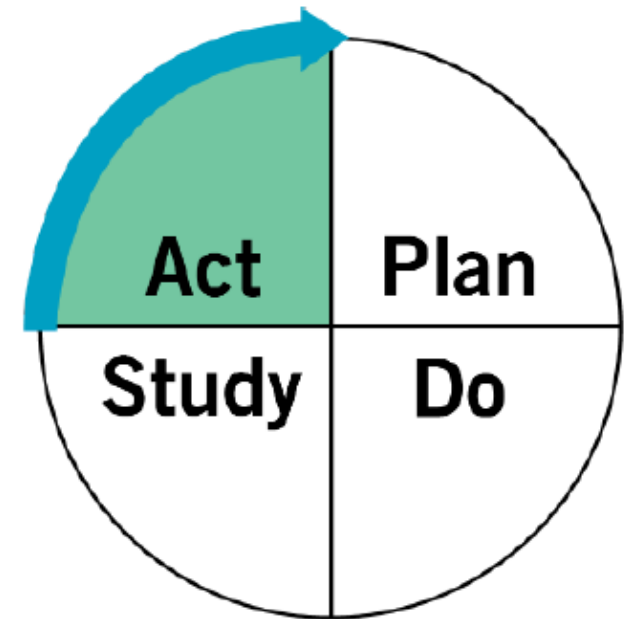
- Run the test on a small scale
- Carry out the test
- Document problems and unexpected observations
- Collect and begin to analyze the data



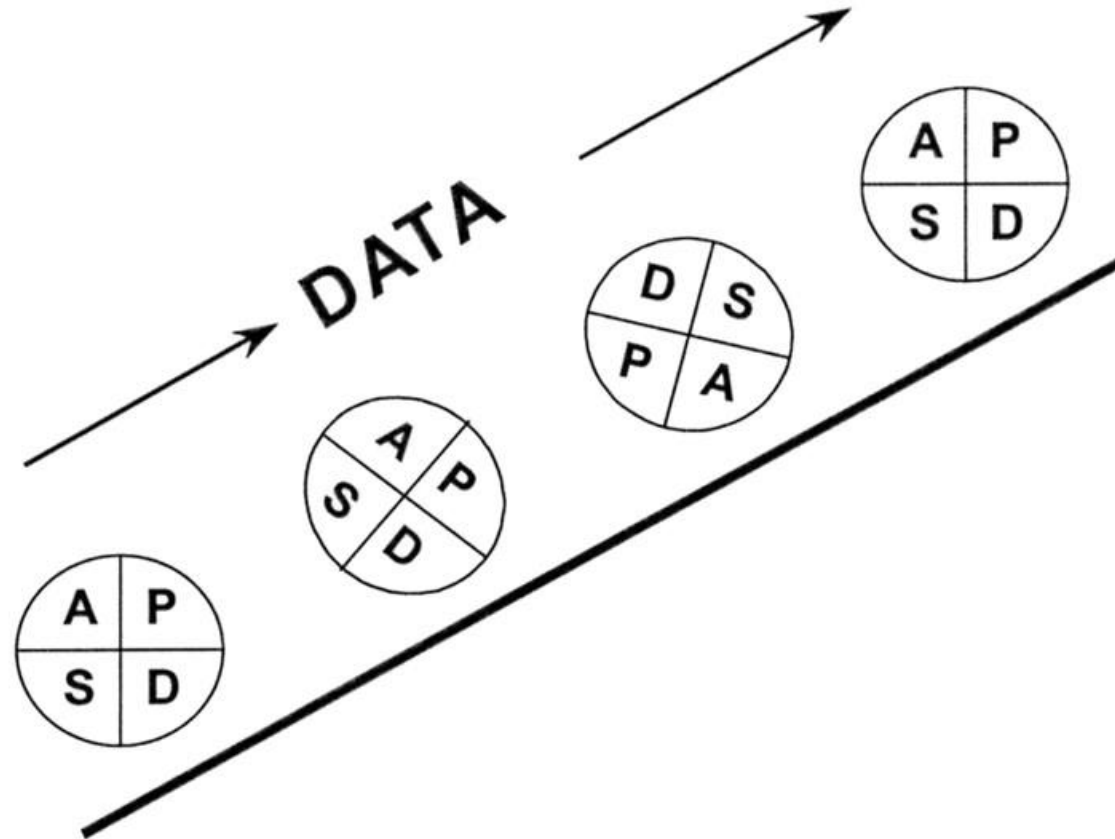
- Analyze the results and compare them to your predictions
- Summarize and reflect on what you learned



- Based on what you learn, make a plan for next step
- Adapt, adopt, or abandon
- Prepare a plan for the next PDSA



Hunches
Theories
Ideas



Changes That
Result in
Improvement

Case Study

