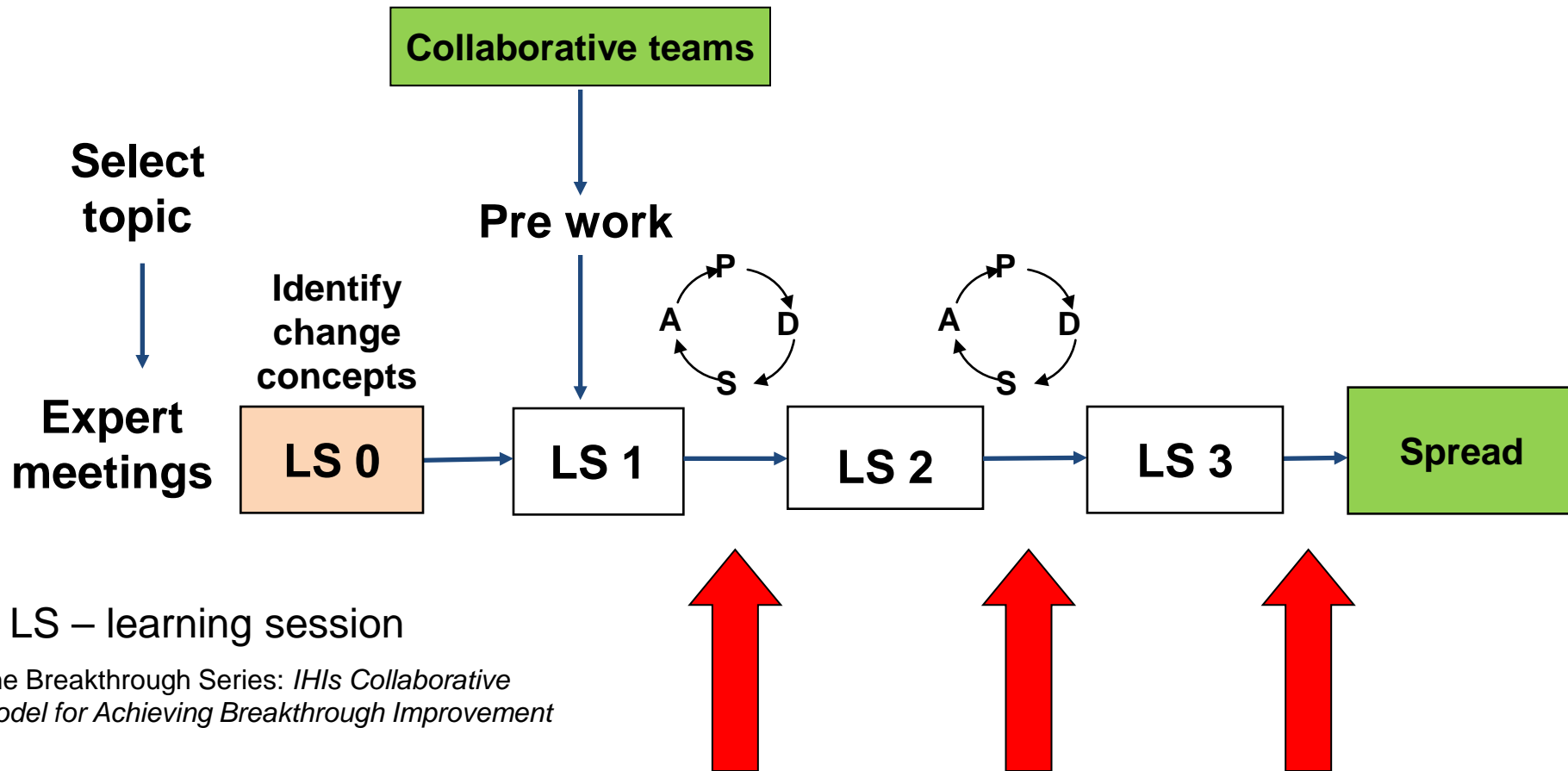


Quality improvement methodology

Model for Improvement

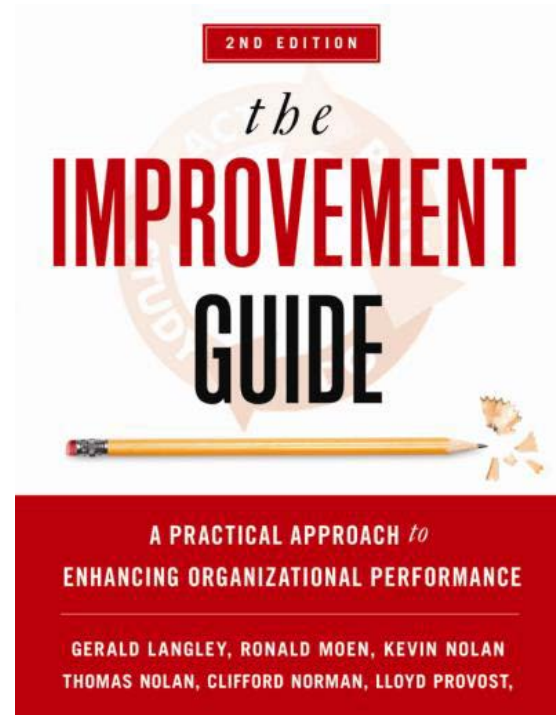
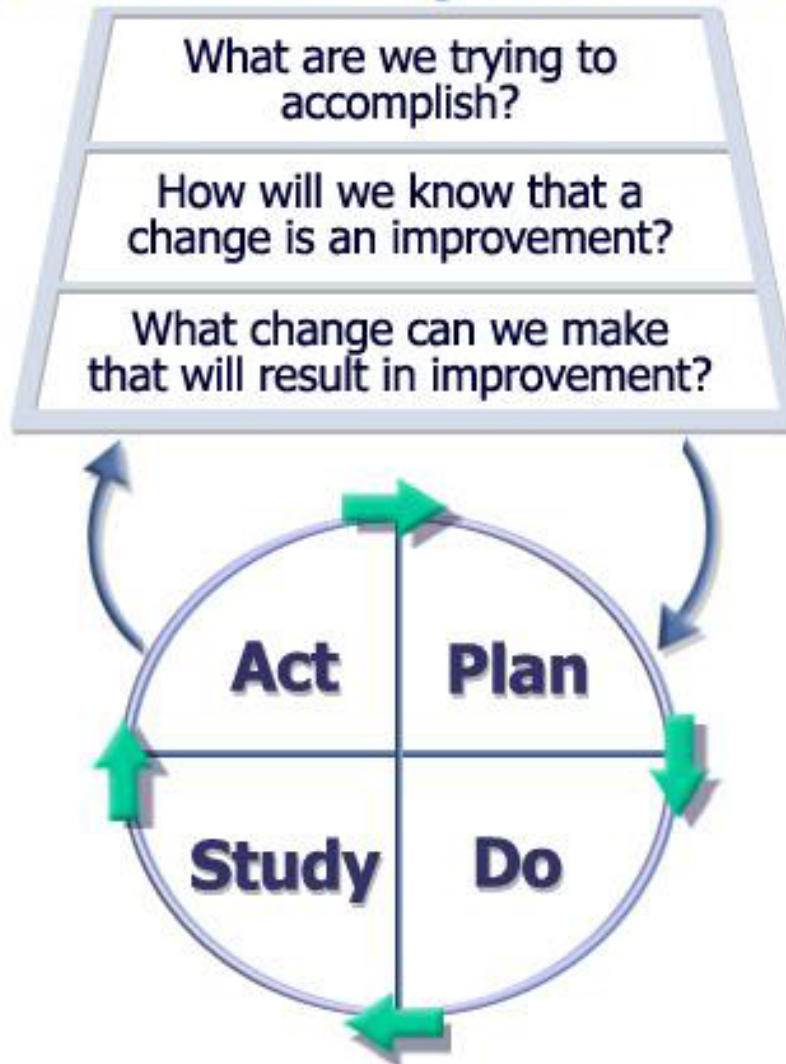
Prem Kumar

Collaborative methodology

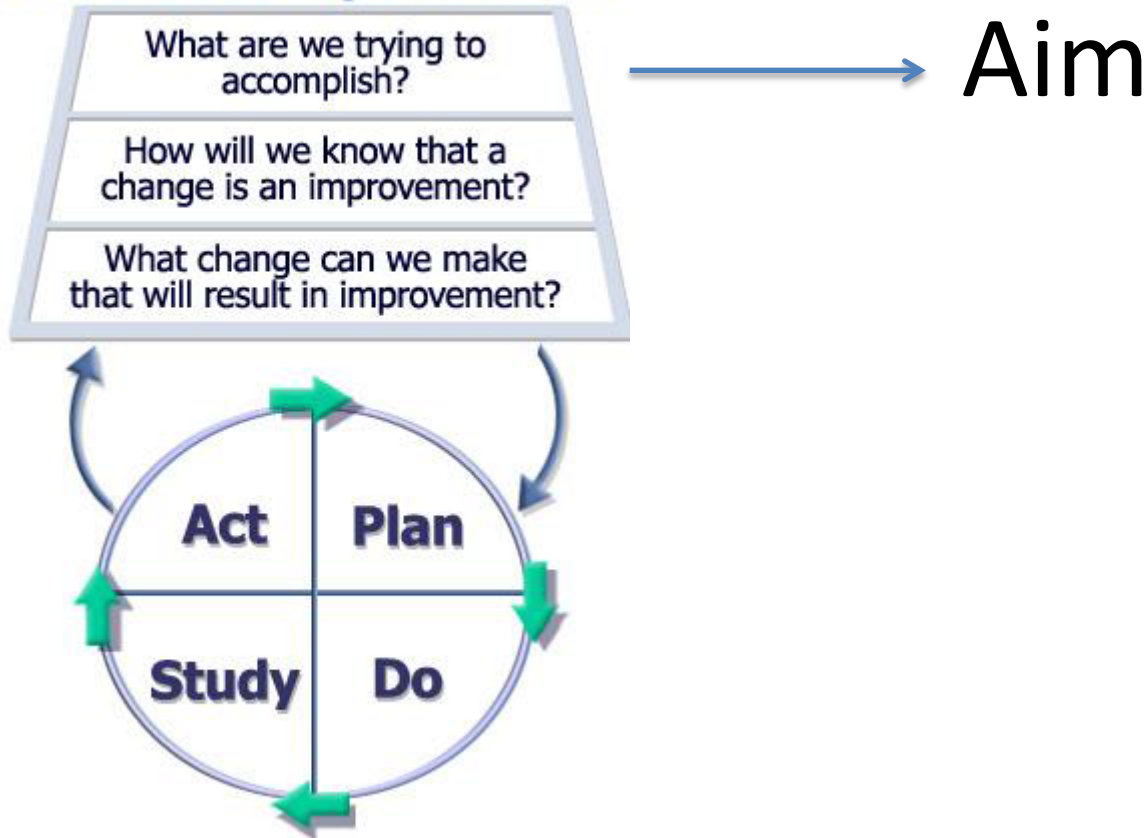


**Supports: emails/ visits/ reports/ sponsors /
meetings/ assessments / conference calls**

Model for Improvement

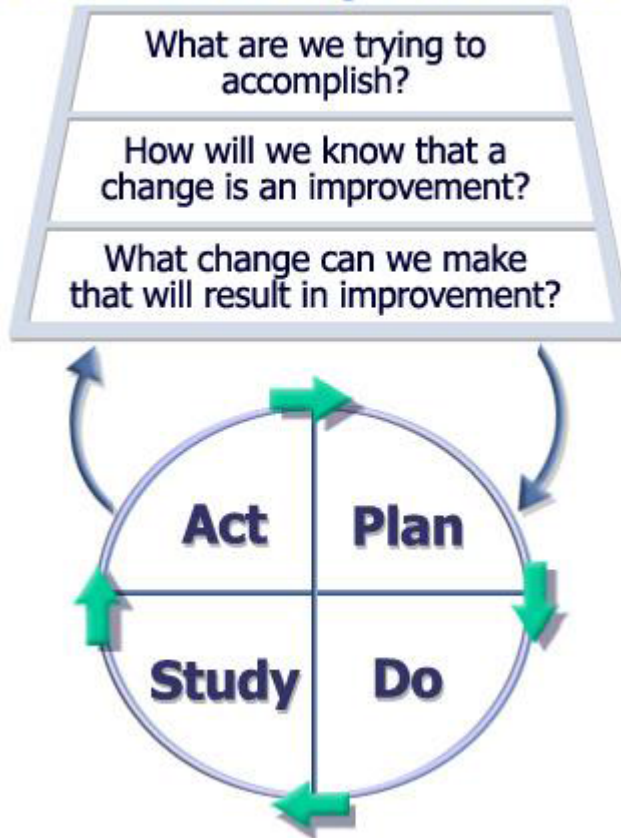


Model for Improvement



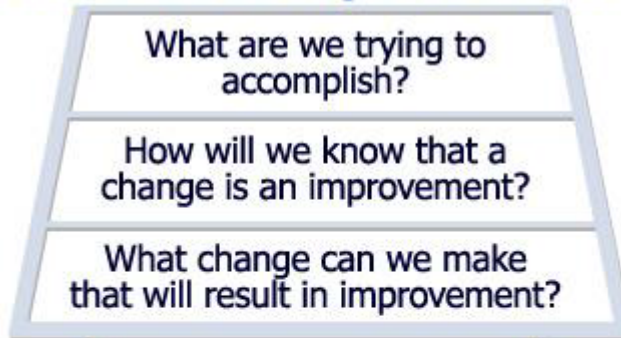
Associates in Process Improvement, 2009

Model for Improvement



Measurement

Model for Improvement



Change Ideas

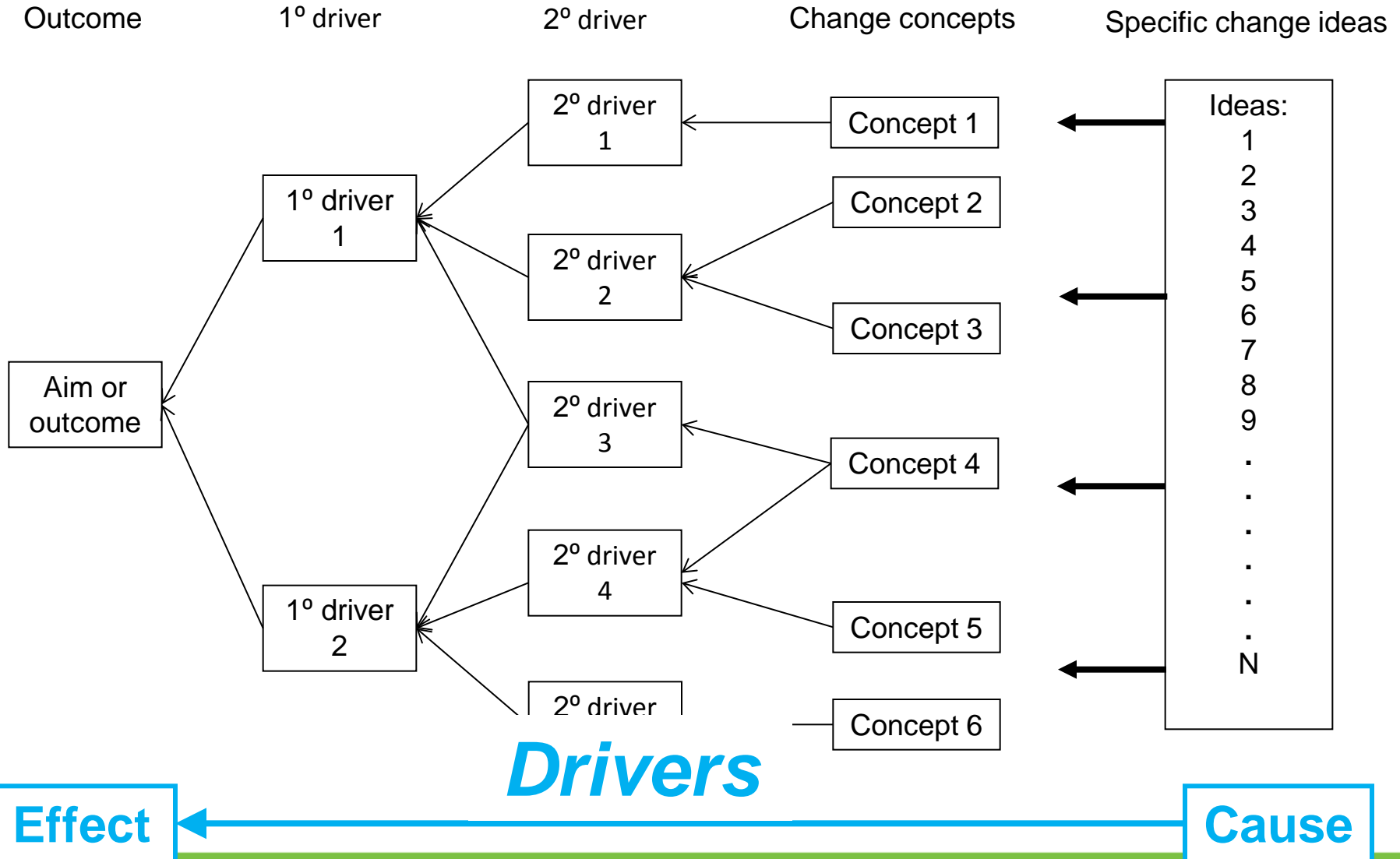


Associates in Process Improvement, 2009

All improvement requires change, but
not all changes result in
improvement.

How do we develop fundamental change
that will result in improvement?

Conceptual driver diagram



Malawi – Maternal Mortality

Secondary Drivers

Primary Drivers

Outcome

Goal: 50%
Reduction in
Maternal and
Neonatal Deaths

Family Friendly
Care

Effective
Support
Systems

Clinically
Excellent Care
for Women

Clinically
Excellent Care
for Newborns

Information
Driven Decision
Making

Individualized patient focused care

Respect and dignity of women maintained
throughout care

Proactive interpersonal communication

Floor Stocks Available

Blood Availability

Motivated staff

Prompt ID of Obstructed Labour

Prompt ID of need for CEOC

Control infection through protocols

Timely treatment of bleeding

Active management of 3rd stage

Prompt recognition and treatment of asphyxia

Routine classification to identify and track risk

Prevention, prompt recognition, and treatment
of infections/sepsis

Safe care to avoid hypothermia & promote b.f.

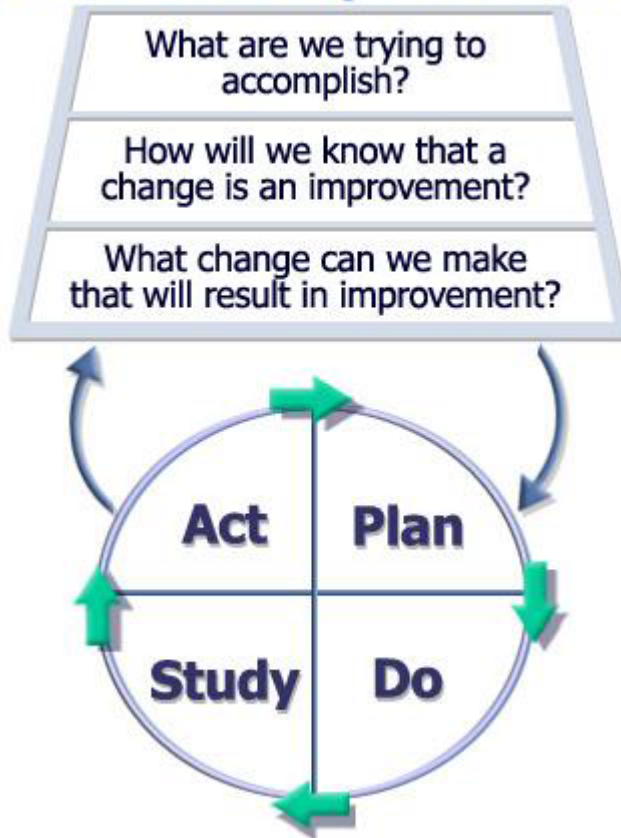
Maternal death and near miss audits

Measure patient, guardian, staff satisfaction

Regular collection/analysis of key data

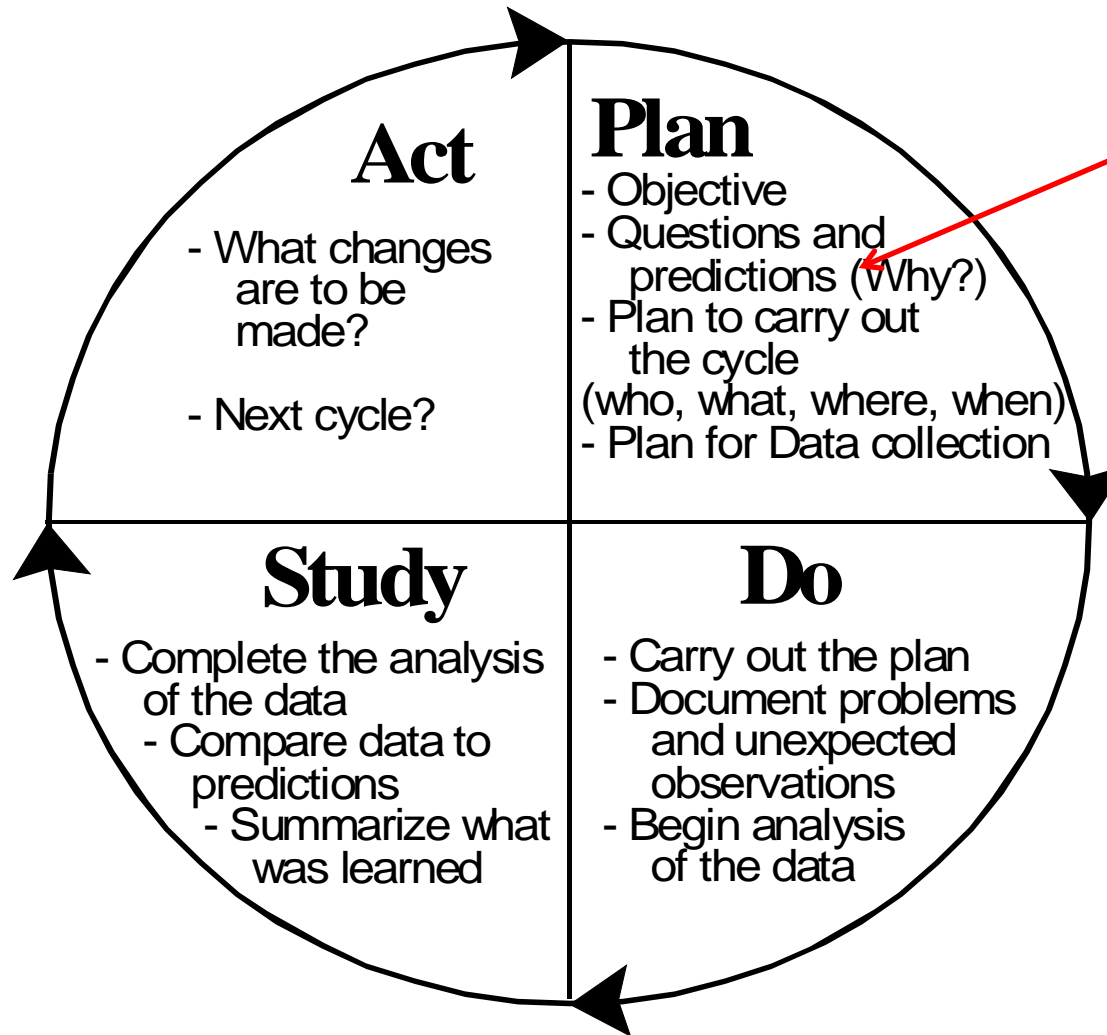
Accurate and complete patient records

Model for Improvement



PDCA cycle
Learning cycle

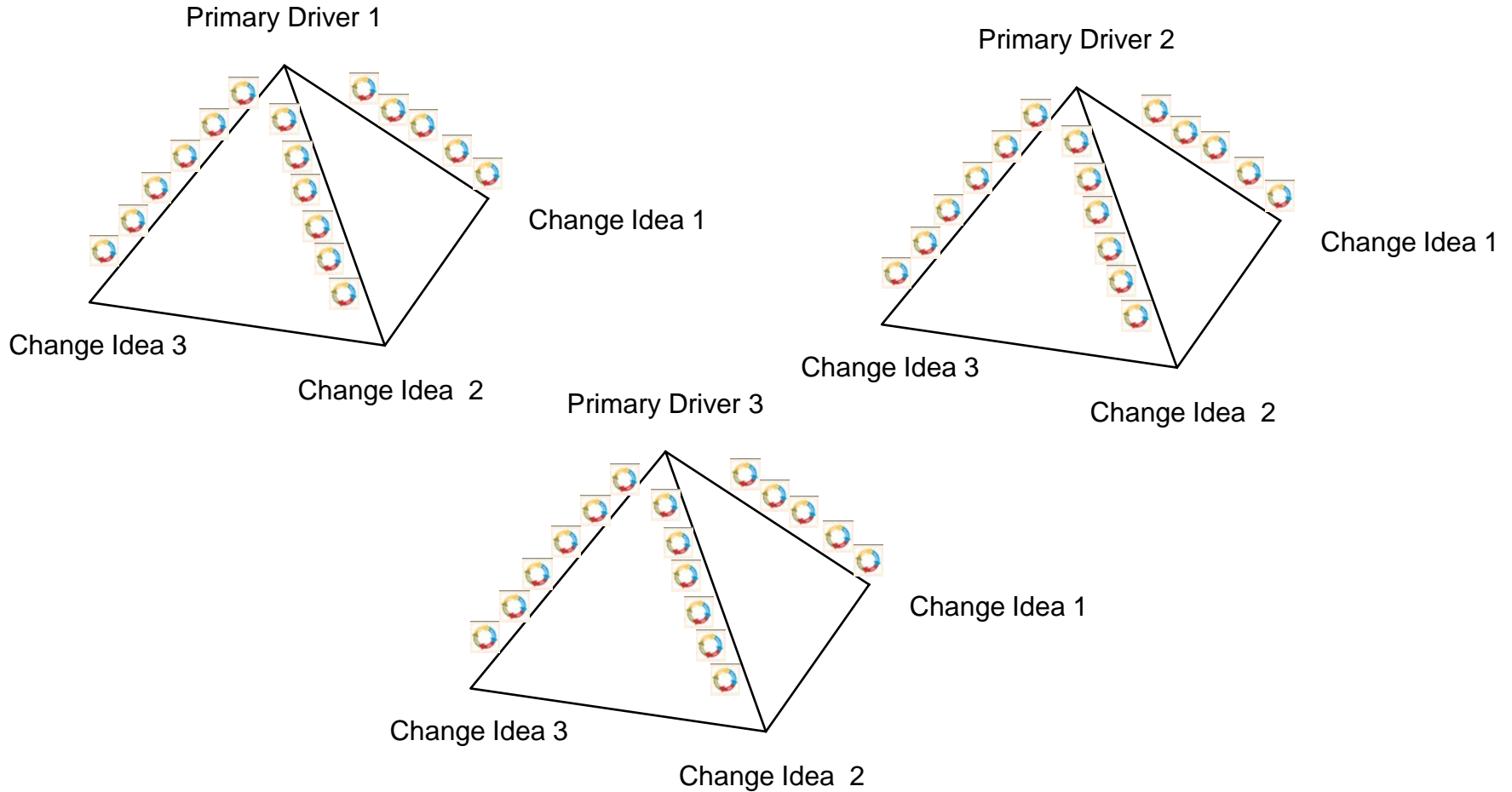
The Plan-Do-Study-Act cycle



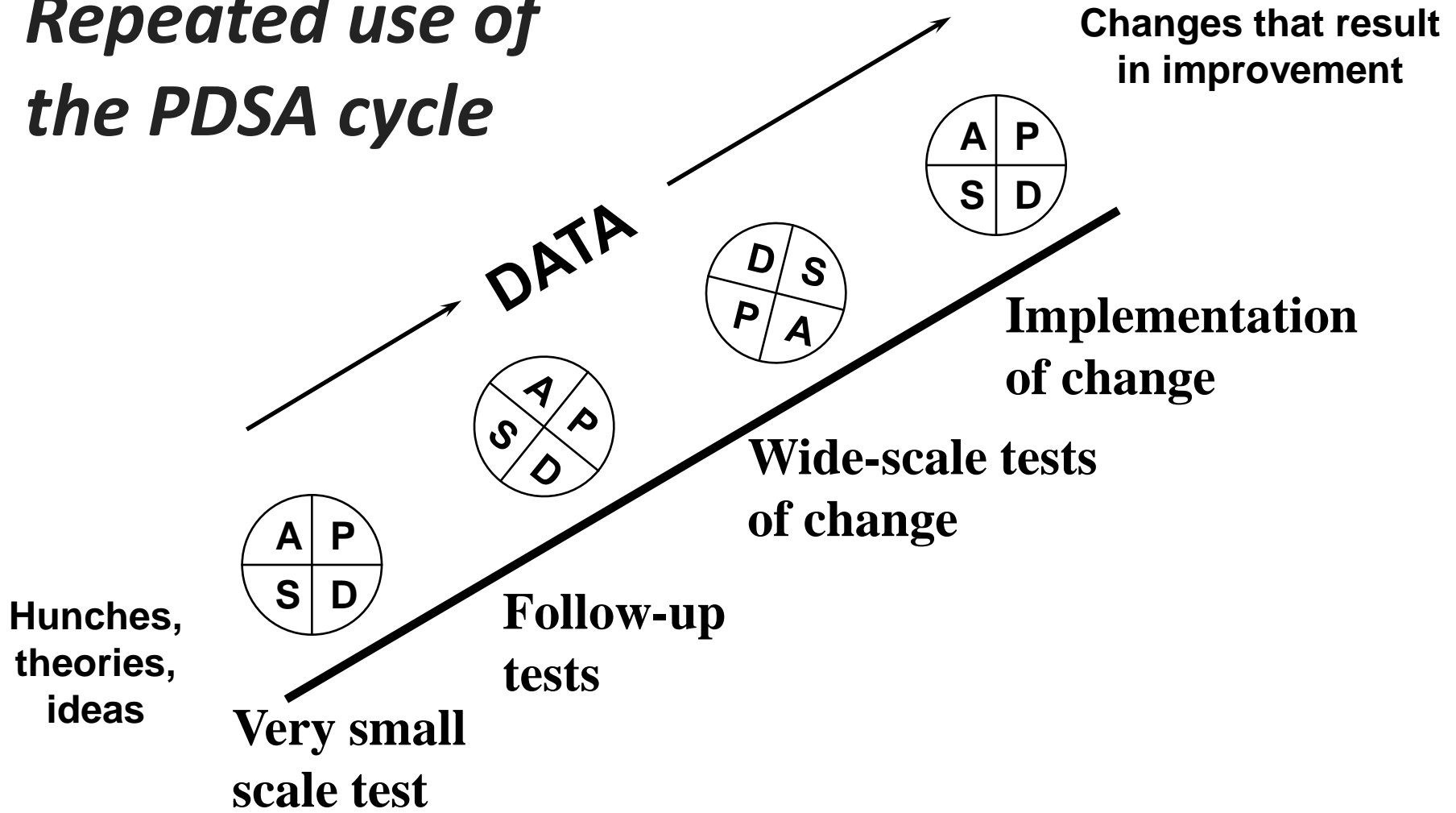
Most Important part of a PDSA cycle

Because without it we don't have a comparison for the purpose of learning.

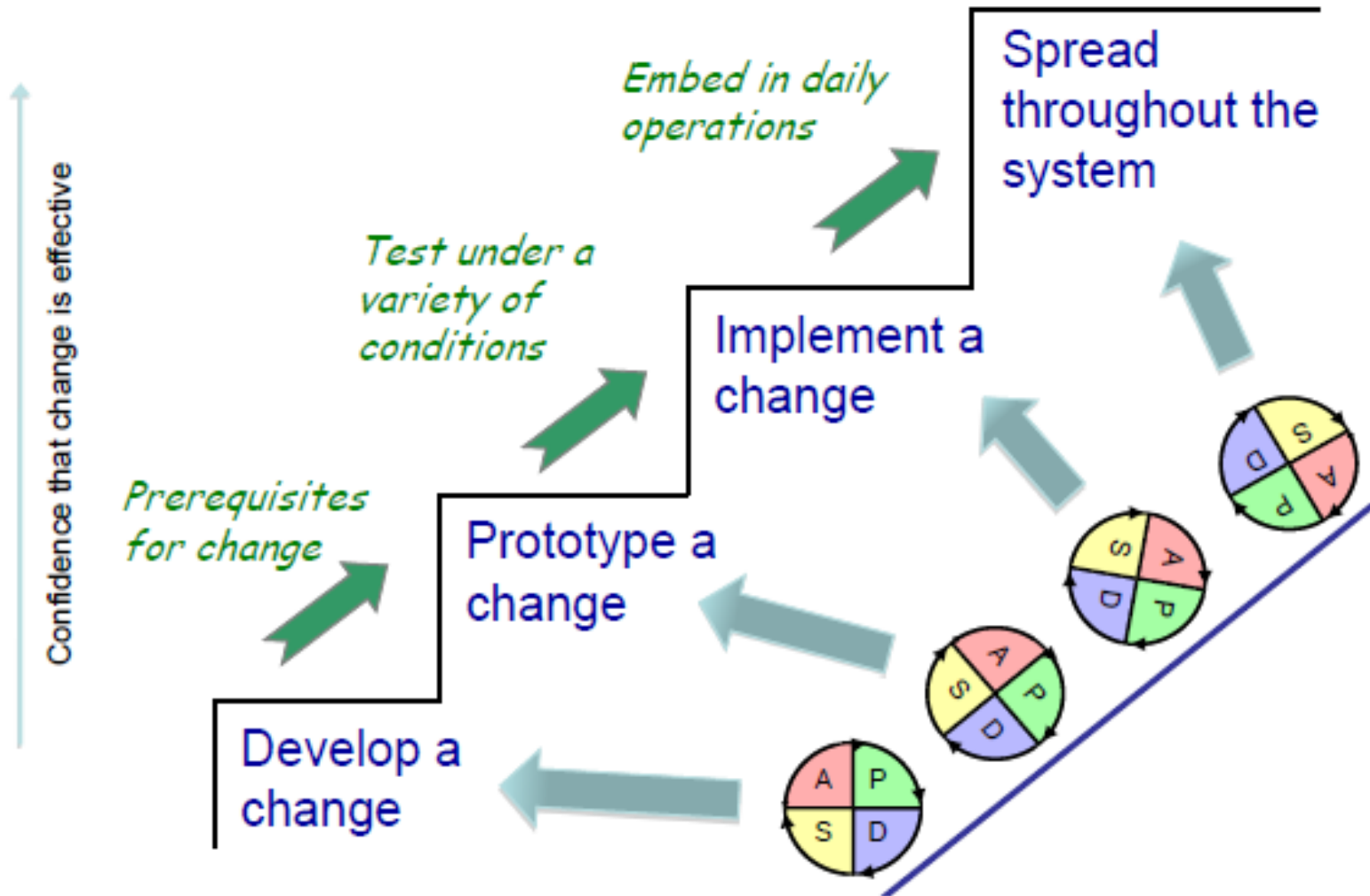
The work of improvement



Repeated use of the PDSA cycle



The steps to change





SAFETY
NEW ZEALAND

Plan for Improvement

What are we trying to accomplish?

My aim is to reduce the time baby cries at night

How will we know that a change is an improvement?

Total crying time
Healthy baby

What change can we make that will result in improvement?



Aim

Movement

Rocking motion

Distraction

Bright lights
Moving lights

Technology

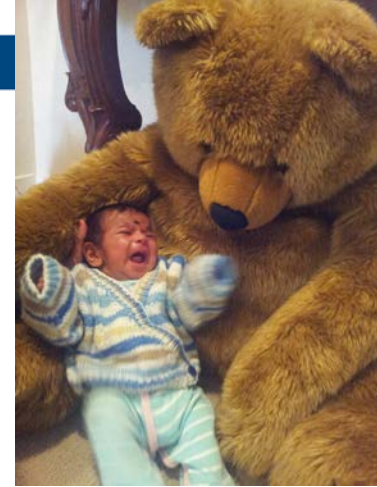
Soft music
Rock music
Lullaby

Hunger

Provide food

Others

Give it to someone



Project charter

Aim:

What are we trying
to accomplish?

Project scope:

Areas of testing (ward, division, hospital)
What is included?
What is excluded?

Area(s) of focus for
opioids collaborative
(harm):

Type of harm

Team:

Project lead:
Clinical lead:

Project team:

Identify the teams

Patient:

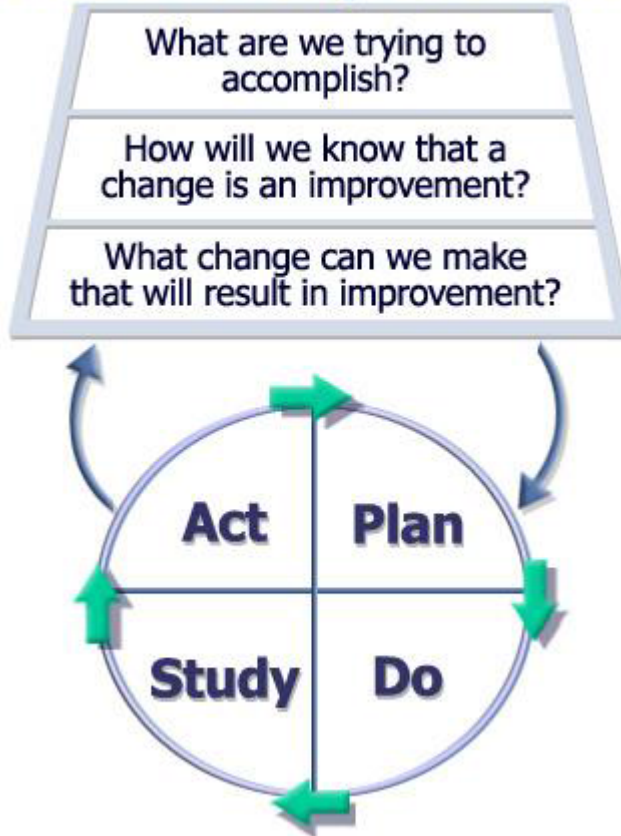


Measures & data



'And this is the period when the cat was away.'

Model for Improvement



Why do we need
measures?

Three types of measures

Outcome measures

Process measures

Balancing measures

Measurement guidelines

To answer: “*How will we know that a change is an improvement?*” usually requires more than one measure:

1. A balanced set of a few (3–8) key measures
2. Integrate measurement into the daily routine
3. Think about balancing, process and outcome measures (be careful about overdoing process measures)
4. Plot the data in a time series

Methods of measurement

- Chart review
- Observation of behaviour
- Surveys
- Questionnaires
- Coding data
- Checklists

Outcome measures

Process measures

Balancing measure

Baseline

Any existing reports
Source of data
Collection method

