

# Planning for testing

Karen O'Keefe, quality improvement advisor

Mental health and addiction quality improvement programme

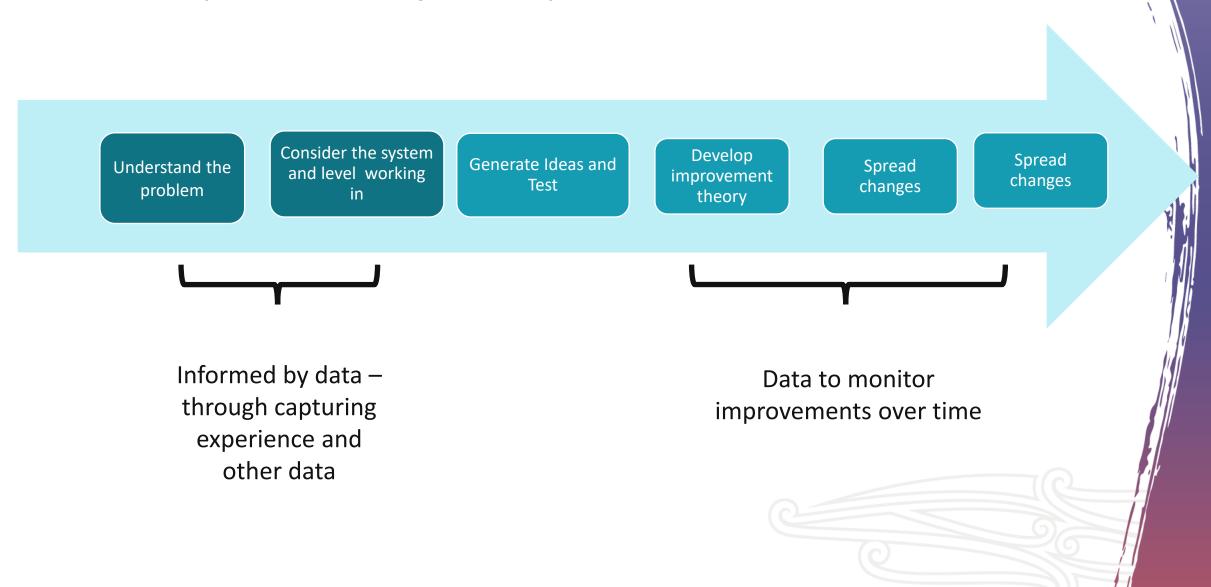


#### Core concepts of improvement

#### Theory of knowledge

- Need to be able to articulate what you believe about why things are the way they are (what do you know about your system, how do you know?).
- Describe what changes you think will make the difference toward the outcome you desire.

#### The improvement journey



### Engaging the team and building will

Shared purpose goes way deeper than vision and mission; it goes right into your gut and taps some part of your primal self. If you can bring people with similar primal purposes together and get them all marching in the same direction, amazing things can be achieved.



## How is a theory different from a belief?

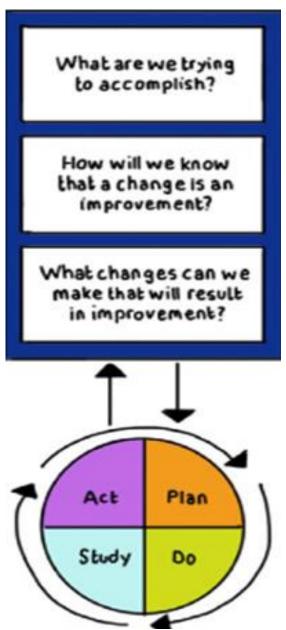
• From a scientific perspective, a theory can be tested (we can examine its validity).

#### How is a theory different from a belief?

- From a scientific perspective, a theory can be tested (we can examine its validity).
- We use theories to make predictions about the future, what we expect will happen, what we expect to observe, etc.

## Theory for improvement

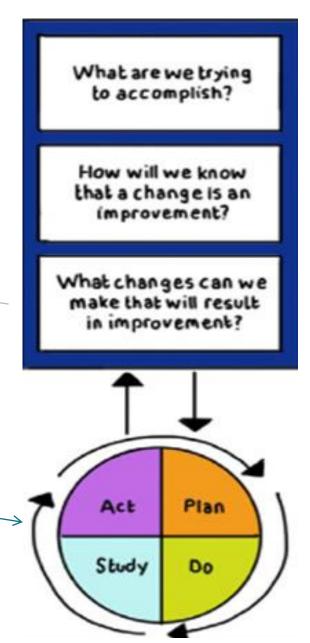
 Develop an understanding of how things work now and how they might be improved – driver diagram



## Theory for improvement

 Develop an understanding of how things work now and how they might be improved – driver diagram

• A driver diagram is a tool for building a testable hypothesis; it consists of stakeholders' shared expertise and knowledge.

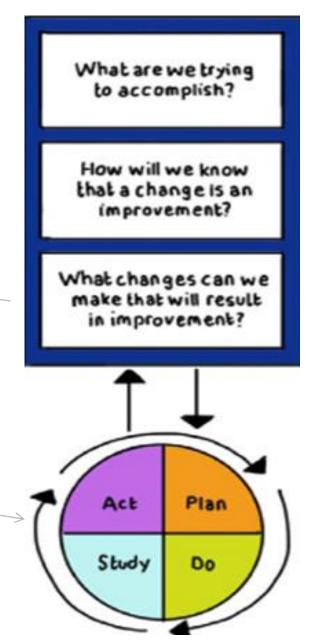


## Theory for improvement

 Develop an understanding of how things work now and how they might be improved – driver diagram

 A driver diagram is a tool for building a testable hypothesis; it consists of stakeholders' shared expertise and knowledge.

 A broad prediction of the changes required to achieve the aim or outcome.



#### **Driver diagram Te whakanui** ake i te hauora ā-tinana **Maximising physical health** project (Feb 2023)

Aim: To increase the rate of screening for cardiometabolic risk to 90 percent for consumers at risk due to antipsychotic medication treatment (clozapine and intramuscular injection) by 1 May 2024

#### National outcome measures

- 1. Percent of cohort prescribed metformin or other hypoglycaemic medication
- 2. Percent of cohort dispensed lipidlowering medication

#### **National process measures**

- physical health screening
- 2. Percent of cohort enrolled with general practitioner

#### **Secondary drivers** Project changes that will affect the primary driver **Primary drivers** System components that contribute to Tino rangatiratanga/shared achieving aim decision-making Effective **Engaged sponsor** leadership for organisational Middle manager support change Resourced team Using data to Seamless access to relevant clinical information support improvement Equity data and equity Support workers Workforce development Compassionate care models Whānau included in care Access to māturanga Māori Equitable, practitioners person- and whānau-centred Health literacy care provision Accessibility Standardised, reliable processes

Effective

'joined-up' care

**Change ideas**Small, specific ideas linked to drivers

Populate following co-design process - example change ideas

Time and space to work on improvement

Recording metabolic screening

Equipment available for monitoring

Visibility of data for learning

Make better use of existing data sets - where is the biggest need?

Link with health improvement practitioners and coaches

> Training in empathetic communication

Welcoming whānau in care and treatment decisions

Access to rongoā Māori

Information on nutrition, smoking cessation, physical activity

> **Extended consultations** in primary care

Clear roles and responsibilities for staff involved

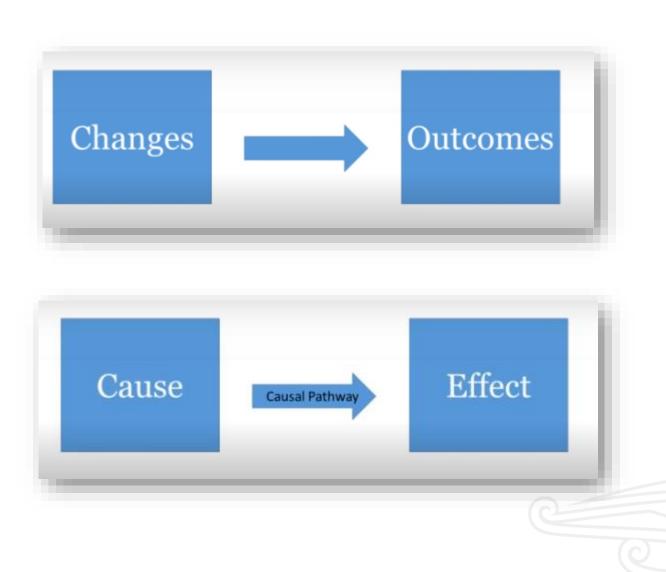
Warm handover processes

- 1. Percent of cohort who receive

Shared care plans

Te Pou o te Whakaaro Nui Equally Well. 2021. Using New Zealand data to understand health inequities - the physical health of people with mental health problems.

# Linking theory to change ideas



#### Processes and process measures

- Processes refer to workflow how things are accomplished, what steps are taken in what order to complete a task.
- Process measures: voice of the workings of the system
  - measures that capture the changes your quality improvement efforts make to the inputs or steps that contribute to system outcomes

**Example**: percentage of consumers who have completed training modules.

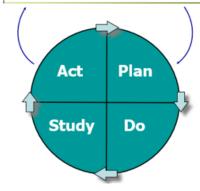
#### Introducing plan-do-study-act (PDSA) cycles



What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in the improvements that we seek?



A cycle for learning and improvement

The model for improvement was developed by Associates for Process Improvement (USA, available at www.apiweb.org) and builds on the original Plan, Do, Study, Act (PDSA) cycle created by Walter Shewhart in the 1930s

## Why test?

- Forces us to think small.
- Increases belief that the change will result in improvement.
- Provides opportunities for learning without affecting performance.
- Helps teams adapt good ideas to their specific situation.

#### Linking PDSA cycles and tests of change

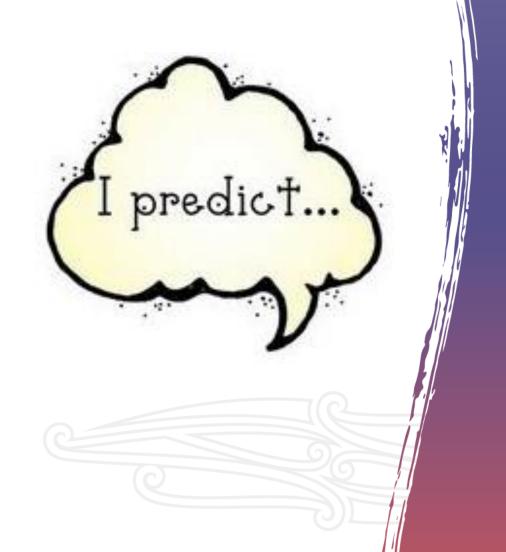
- Testing changes is an ongoing process: the completion of each PDSA cycle leads directly into the start of the next cycle.
- From the test, a team learns:
  - what worked
  - what didn't work
  - what should be kept, changed or abandoned.

#### Linking PDSA cycles and tests of change

- This new knowledge is used to plan the next test the team continues linking tests in this way, refining the change until it is ready for broader implementation.
- People are far more willing to test a change when they know that changes can and will be modified as needed.
- Linking small tests of change helps overcome an organisation's natural resistance to change and encourages team buy-in.

#### Why predict?

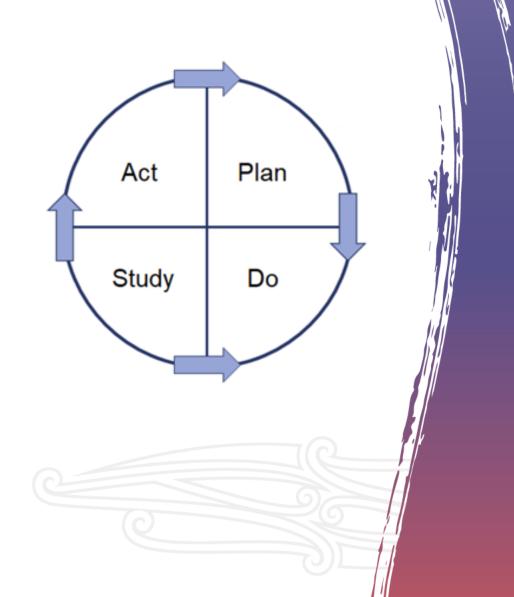
- Predicting is the most important part of any PDSA cycle.
- When predicting, ask yourself, 'What do I expect to happen?'
- Making a prediction will help in anticipating what might come next and whether or not the cycle was a success.
- If the test of change didn't work, it is important to take the time to understand why (study).



#### Three options after test

Three options after reviewing results from PDSA test:

- X abandon (glad we did a small test)
- adopt (as tested; test at larger scale?)
- adapt (and test again).



## **Tools**

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Plan	Do \
Act	Study
-	
PLAN:	

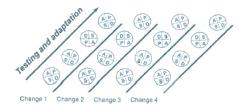
#### PDSA WORKSHEET

DO: Test the changes.

	Team Name:	Date of test:	Test Completion Date:			
Overall team/project aim:						
	What is the objective of the test?					

Briefly describe the test:	Was the cycle carried out as planned? □ Yes □ No				
	Record data and observations.				
How will you know that the change is an improvement?	What did you observe that was not part of our plan?				
What driver does the change impact?					
	STUDY: Did the results match your predictions?   Yes  No				
What do you predict will happen?	Compare the result of your test to your previous performance:				
PLAN					
Person List the tasks necessary to complete responsible	What did you leam?				
this test (what) (who) When Where					
1.					
2.	ACT: Decide to Adopt, Adapt, or Abandon.				
3.	Adapt: Improve the change and continue testing plan. Plans/changes for next test:				
4.					
5.	Adopt: Select changes to implement on a larger scale and develop an implementation plan and plan for sustainability				
6.	Abandon: Discard this change idea and try a different one				
Plan for collection of data:					

#### PDSA Tracker Worksheet: Use with each change you are testing



Title of PDSA: Aim statement:

	PLAN				DO		STUDY	ACT
PDSA Cycle No.	What <i>change</i> are you testing?	What have you learned from previous PDSAs?	What do you predict will happen?	What data will you collect to know how it's working?	Date(s) of test	What did you do?	What did you <i>learn</i> ?	What will you do next?  (ex. forget it, more testing, ready to implement, ready to teach others)
1								

#### Scale of test

#### **Staff Readiness to Make Change**

Current Situati	ion	Resistant	Indifferent	Ready
Low Confidence that change	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
idea will lead to Improvement	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that change	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
idea will lead to Improvement	Cost of failure small	Small Scale Test	Large Scale Test	Implement

#### Tips for working with plan-do-study-act cycles

- No PDSA cycle is too small.
- Plan multiple cycles for a test of change, and think a couple of cycles ahead.
- PDSA cycles help you learn from your work.
- Just do it! what can we do by next week?
- Keep it simple.
- Remember that you will learn as much from things that don't go well as those that do.

# Thank you – reflections or questions

