A10. How to effectively use a PDSA cycle for sustainable improvement

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We have no conflicts of interest to declare.

Learning Objectives

- 1. Understand rapid-cycle PDSA testing
- 2. Experience PDSAs in action
- 3. Emerge with concrete ideas to use PDSAs for sustainable improvement

What are PDSA's?





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Where does it fit in the Model for Improvement





My problem....



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Why Test a Change?





A cycle for learning and improvement





Your turn: touch the tennis ball



Aim

Decrease the time it takes for 5 people to touch the tennis ball in <u>alphabetical order</u> from a baseline of X seconds to Y seconds in 6 attempts.

Let's get started

Measures

Outcome: Time in seconds for 5 people to touch the tennis ball (measured on phone stopwatch)

Balancing: Accuracy score for alphabetical order (1 to 5)

Rules

Must be done in alphabetical order Each person can touch the ball once A timekeeper (6th team member) will measure time taken from start to finish and record on flipchart paper

Split into groups of 6 and identify recorder/timekeeper

- 1. Plan: Players have 30 seconds to plan test (first test will be your baseline)
- 2. Do: Run your test and record time taken and note down observations
- 3. Study: Review the time taken and observe the situation; discuss with team what worked well & what didn't
- **4.** Act: Decide how to adapt your approach before running another PDSA cycle; what will you adopt, adapt, abandon?



Reflections

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PDSA Example: Getting patients out of bed for lunch

Problem statement:

• Patients admitted to hospital are at risk of deconditioning, acquiring pressure ulcers and becoming incontinent because they spend more time in bed.

Aim statement:

• By June 2026 we will increase the percentage of patients sitting out of bed for lunch from an average of 33% to 60% on Deming ward.

Outcome measure:

• % of patients sitting out of bed by 12 o'clock

Change Idea to test:

• Share daily count of patients sitting out of bed for lunch with all staff on ward.





What are we trying to accomplish?

How will we know if a change results in an improvement?

What changes can we make that will result in an improvement?





PDSA Example: Sharing number of patients sitting out of bed

MES lotivating, however this was a very

limited number.

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Percentage of patients sitting out of bed for lunch

Impact

100%

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Guide for scale of testing PDSA's

		Staff Readir	le l	
Current Situation		Resistant	Indifferent	Ready
Low Confidence that current change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Very Small Scale Test	Very Small Scale Test
	Cost of failure small	Very Small Scale Test	Very Small Scale Test	Small Scale Test
High Confidence that current change idea will lead to Improvement	Cost of failure large	Very Small Scale Test	Small Scale Test	Large Scale Test
	Cost of failure small	Small Scale Test	Large Scale Test	Implement

Case Study: From initial PDSA testing to sustainability & scale





Article

Preventing and Treating Pain and Anxiety during Needle-Based Procedures in Children with Cancer in Low- and Middle-Income Countries

Michael J. McNeil ^{1,2,*}, Ximena Garcia Quintero ¹, Miriam Gonzalez ¹, Yawen Zheng ¹, Cecilia Ugaz Olivares ³, Roxana Morales ³, Erica Boldrini ⁴, Débora Rebollo de Campos ⁴, Daiane Ferreira ⁴, Kamalina Coopasamy ⁵, Joliza Caneba ⁶, Maria Louisa Padernilla ⁶, Stefan Friedrichsdorf ⁷, Justin N. Baker ⁸ and Paola Friedrich ¹

Procedural pain in pediatric patients is common, underrecognized, and preventable!



Our Theory of Change (Driver Diagram) to reach our aim



All PDSAs linked to this overall Theory of Change across drivers



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Percentage of teams testing and assessing degree of belief per change idea N=20 teams

0%

20%

40%

60%

80%

Stock sucrose with procedure supplies Rescheduling of provides to ensure support for procedural pain interventions Workshop for identifying barriers and opportunities to implementation Use of hospital clowns, child life, etc - leveraging resources beyond clinical staff Provide published literature and experience on procedural pain interventions Hold parent/patient workshops in housing or in hospital regarding GCP Highlight employees who are consistently applying Comfort Promise Principles (nurse of the month) Use of breastfeeding orsucrose Highlight patient stories during education and re-education Document preferred locations for needlestick and preferred distraction and positioning techniques Identify individuals who will champion project within their institution Have parents and patients provide testimonials to educate workforce Train patients and parents on techniques prior to procedural intervention Establish central location for supplies near point of intervention/ procedure and keep stocked Clear identification of roles and involvement Regular educational sessions/updates/refreshers for new and existing staff Create standard space for needlesticks "Comfort Promise Corners" where supplies are readily seen and available Conduct audit of current procedural process Signs for staff and patients as reminders to utilize Comfort Promise principles Provide education and cueing for parents for appropriate holding and comfort Have patient and parent champions to educate other patients and parents Establish document for pain assessment and interventions Have nurse champions on each unit of the hospital to lead implementation in their respected areas Engage hospital volunteers to help with staffing and ensure support for implementation Create and utilize checklist of procedural pain process Training session for providers involved in procedures Coordination or thring of approximations are considered exception medication for institution the facility Consistent language to use beforeoducintrameliafthethropeneodure to guide both the patient and Apply topical anesthesia in 2 locations in case 1 location does not work Provide parent/patient satisfaction survey for immediate feedback post-needle-stick. Ensure clinical space for procedural interventions Use of effective communication (praise & reward) Use of topical anesthetics Use of comfort positioning techniques Use of age appropriated distraction techniques

Adoption

60% of the change ideas were tested by ≥50% of teams

100%

Through iterative rounds of PDSA testing, we analyzed degree of belief for specific change ideas

Primary Drivers

Secondary Drivers



Change Ideas

Score (1-5)



From PDSAs to results...



From results to sustainability and scale





Let's get practical!

Our top tips for getting into (and staying in!) action.



START SMALL. THINK BIG. LEARN FAST. INVOLVE OTHERS.



Start small & test your way up the PDSA ramp.



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BE WILLING TO GET UNCOMFORTABLE. THERE'S NO SUCH THING AS FAILURE. KEEP GOING.



Because let's get real... early PDSA tests



Source: A case study of translating ACGME, to a comprehensive curriculum improvement projects as the key component requirements into reality: systems quality practice-based learning and improvement, A M Tomolo, R H Lawrence and D C Aron, *Qual Saf Health Care*2009 18: 217-224

Getting into Action: Now What?



What's ONE PDSA you would like to do (in your work or in your life) by next Tuesday?

And if it's something you can't do by next Tuesday, that's your sign to make it even smaller!

Share with the person next to you.

- What PDSA will you test?
- When?
- Who will you involve?



What questions do you have?

Reflections?





Feedback for us (this is <u>our</u> PDSA! :)



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How to effectively use a PDSA cycle for sustainable improvement

11:00 – 12:15pm (75 minutes) _

Format: Workshop

Stream: Foundations

Content filters: Recommended for those new to quality improvement

The PDSA cycle (Plan-Do-Study-Act) is a framework for testing and implementing changes in healthcare processes. It is the bedrock of many quality improvement initiatives, but all too often used in isolation the PDSA method can lead to projects being reduced in scope with limited impact, longevity and scalability.

In this interactive workshop we will get back to basics on the power of the PDSA method when used correctly, and how it must be integrated into wider QI tools and methodology to ensure your projects have real world impact for patients and communities at scale.

Karen Turner Royal Free London NHS Foundation Trust; England

Tricia Bolender Institute for Healthcare Improvement (IHI); USA

Timing (75 min)

Section	Timing	Slides	Lead
Welcome & Intros	4 min	4, 5	Tricia
PDSAs: What it is (including audience participation)	15 min	6, 7, 8, 9, 10	Karen
Tennis Ball Activity	25 min including intro & debrief	12-13	Karen to introduce Both to support exercise Both to debrief
Implications: real-word setting	8 min	14, 15, 16, 17	Karen
Case Study: Linkage to sustainability & scale	8 min	18, 19, 20, 21, 22, 23, 24, 25, 26, 27	Tricia
Tips & Commitment (including share outs)	15 min	28, 29, 30, 31, 32	Both (interview style)