Quality Improvement Initiative (QII) PDSA Worksheet

Facility Name: _____

CCN#: _____

Date: _____

Goal Setting: Describe the problem to be solved

State the problem ex: who, what when, where, how, how long

Through Root Cause Analysis (RCA) we have identified an opportunity for improvement with communication prior to potential transmissions of care to the emergency department. RCA identified some transfers to ED could have been evaluated/ treated at the facility. Implementation of the Stay Here or Go to the Hospital Decision Guide will be utilized in this PLAN to improve this communication process and potentially reduce preventable emergency department transfers.

☐ 1. Training staff with the Stay Here or Go to the Hospital Decision Guide will increase their knowledge and skills with discussions between them and the resident and/or caregivers.

☐ 2. Including the Stay Here or Go to the Hospital Decision Guide in the admission welcome packet with an overview of the flyer from the Admission staff member will enhance the awareness of interventions that can be provided at the facility thus reducing the experience of a preventable transfer.

☐ 3. Building a QAPI PIP team to engage with area hospitals during the development of this new process.

☐ 4. Create a process to order/print the guide and have it available in various areas in the facility where staff / residents/ and caregivers can access them.

☐ 5. Build training of the guide into new staff and contract staff onboarding/orientation.

☐ 6. Integrate discussion of current risks for readmission and the Hospital Decision Guide into all care conference agendas.

What do we want to accomplish/ what idea do you want to test? Identify the goal and estimated timeframe for resolution **Specific -** What do you want to achieve? Increase knowledge and understanding of vaccine benefits and EUA process/ create small groups for education and communication opportunities to decrease feelings of pressure/ print new material in different languages/ overcome misinformation with facts and My Why vaccination stories of vaccinated staff. **Measurable** - What data will you review? Vaccination rates/ staff feedback/ pre and posttests/ **Attainable** - Goal rate (start small and set reach goal too) **Relevant/Realistic** - is this topic needed and why? Low rate of vaccination number/ staff feeling pressured/ misinformation impacting decisions. **Time-Bound** - set monthly goals and a goal to complete by date.	SMART goal here **Sample SMART goals:** ☐ 1. Within (time frame) all staff will be provided education on the use of the Go To The Hospital or Stay Here? A Decision Guide for Residents, Families, Friends and Caregivers. After this initial education the use of the guide is expected to increase the confidence of staff in facilitation change in condition conversations between staff and residents/caregivers. This enhanced communication should lead to reductions in preventable ED visits and increase in the care interventions provided at the facility. ☐ 2. Within (time frame) the Hospital Decision Guide will be included in the admission packet. Admission staff will discuss the flyer and the goal of reducing preventable transfers in efforts to alleviate stress from these types of interventions during each admission session. Providing this information at admission will increase the knowledge of the use of the guide and the goal of the facility to each new resident/caregiver. ☐ 3. Within (time frame) the QAPI PIP team will have contacted each referring hospital and explained the new process of utilizing the guide at the facility. Team will express this is an intervention aimed at reducing avoidable ED transfers by utilizing interventions at the facility. This communication with the referring hospitals is expected to produce a collaborative approach to reducing preventable transfers. ☐ 4. Within (time frame) all Care Conference team members will be educated on the content and use of the guide and strategies for integrating discussion on current readmissions risks and the guide into care conference agendas.
What change can be made that will result in improvement? e.g., safety, effectiveness, patient-centered care, timely, efficiency, equitability, etc.	What are you going to change based on your RCA that you feel will result in improvement? 1. Change in education processes to add education on the contents and use of the Decision Guide 2. Change in Admission processes to include addition and review of the Decision Guide 3. Change in Care Conference process to include discussion of the Decision Guide and current readmission risks
Who will be affected by accomplishing the goal?	Staff, Residents, Families, Caregivers

Plan: Describe the change (intervention) to be implemented	
What exactly will be done? e.g., initial intervention(s), expected outcome for each intervention, goal(s), and expected overall outcome goal rate in a percentage format	List interventions you will provide and your expectations for improvement rates. Sample= ☐ 1. **Training staff with the Hospital Decision Guide will increase their knowledge and skills with discussions between them and the resident and/or caregivers.** = This intervention is expected to reduce preventable ED transfers and increase interventions provided at the facility. ☐ 2. **Including the Hospital Decision Guide in the admission welcome packet with an overview of the flyer from the admission staff member** = This intervention will increase the understanding and enhance the awareness of interventions that can be provided at the facility thus reducing the experience of a preventable transfer. ☐ 3. **Building a QAPI PIP team to engage with area hospitals** = This intervention is expected to enhance communication with area hospitals while building a collaborative approach to reducing preventable ED transfers. ☐ 4. **Create a process to order/print the guide to have available in various areas/languages in the facility where staff, residents and caregivers can access** = This process will ensure access to the guide during communication regarding changes in condition and potential ED transfers ☐ 5. **Build training of the guide into new staff and contract staff onboarding/orientation** = This intervention will ensure all new staff and contract staff are aware of and compliant with guide use. ☐ 6. I**ntegrating discussion of readmission risks and the decision guide into care conferences** = This intervention will further embed the focus on care planning for and reducing readmission risks and prepare patients, families and caregivers for conversations with changes in condition occur.
Who will be responsible for implementing the change?	Identify the individual(s) in facility who can lead implementation of this change. (e.g. member of the QAPI team, Staff Educator, Social Work, Admissions or Care Management). One or more individuals can share the responsibility as lead(s)
Where will it take place?	Where and when will you provide the interventions listed? **Sample**= Stay Here or Go to the Hospital guide will be shared at time of admission or shortly thereafter with resident/caregiver. **Sample**=Small group meetings will take place at the facility in the ABC room from 4:00 p.m. to 4:30 p.m. each Friday and Saturday for two weeks, where all staff will be educated on the guide and expectations of use. **Sample**= During discussions with the resident/ caregiver of need for interventions/care for the resident when these interventions/care can be provided at the facility.

What will be measured / Describe the measure(s) to determine if prediction succeeds?	What data or outcome will you measure? Samples= 1. Pretest and Post test from staff training on the guide and expectations of use 2. Number of guides provided during admissions each month (the total number of admissions and total number of guides used should match) 3. Number of ED visits will be measured over 30d/60d/90d to determine if rate of ED visits have decreased in comparison to previous time frame 4. Number of guides printed/ordered each month and placed in appropriate areas of the facility. (Audit by surveillance rounds) 5. Number of new or contract staff compared to number of completed trainings of the guide during orientation/onboarding. 6. Number of care conferences with documentation of discussion of readmission risks and the Decision Guide
Who will be responsible for measuring the data?	This can be a group or an individual.
How will the data be collected / computed / analyzed?	Examples: 1. After staff training all pretests and posttest will be reviewed. Staff not at 100% on posttests will be provided additional training on questions missed. 2. Monthly comparison of guides ordered/printed and number of admissions. 3. Electronic health record for transfers and/or discharges to ED will be reviewed by QAPI committee monthly to identify possible preventable transfers that occurred and successful use of the guide that assisted in avoiding the preventable ED transfer. 4. Surveillance audits of locations of the guide will be conducted (daily/weekly) to ensure availability during time of communication with resident/caregivers. 5. Audits of new staff orientation/onboarding monthly by QAPI committee to ensure all new and contract staff have been educated. 6. Care Conference documentation will be reviewed for integration of readmission risks and reference to the Decision Guide
What is the current data figure for that measure? e.g., count, percent, rate, etc.	1. Baseline Data = number of staff trained on the Stay Here or Go to the Hospital Guide 2. Baseline data= number of guides ordered/printed at start of process development 3. Baseline Data=number of preventable ED transfers at start of process 4. Baseline Data = number of transferring hospitals communicated with about the guide 5. Baseline data= number of guides placed in locations throughout the facility. 6. Baseline data= staff pretests and post test results after first training sessions
What should the number increase/decrease to in order to meet the goal?	Goal rate should be above your baseline rates-

Did you base the measure or figure you want to attain on a particular best practice/ average score/ benchmark?	Based on best practice of the Hospital Decision Guide as it has been successful in reducing preventable ED transfers with improved communication of services/interventions that can be provided at the facility.

Do: Implement Change

Enrollment in upcoming learning collaborative. The learning collaborative will provide group technical assistance using a data driven, action-oriented approach. Unlike individual learning, people engaged in learning collaborative events capitalize on one another's resources and skills.

Alliant Quality Registration Page for all events - https://www.alliantquality.org/virtual-educational-events/

Alliant YouTube Channel- https://www.youtube.com/channel/UC9mITtil3mHpVNd87vaxD6w

Was the plan executed?	Here you will enter when the plan started.
How long was the plan executed?	Here you will enter when it started and how long it lasted.
Document any unexpected events or problems	This can be many things so add every event that was unexpected.
Describe what actually happened when you ran the test e.g., the indicators measured, the adoption of the change by staff, process change, etc.	Did you see improvement in reducing preventable ED transfers? How did your staff/ residents/caregivers respond to the use of the guide?

Study: Review and Reflect on Results of the Change

Schedule monthly reviews of the changes being made

Describe the measured results and how they compared to the predictions State at least 1 or more interventions that contributed to the improvement of the problem	When you review what you have implemented you will add notes here on what you felt was the most effective in moving toward improvement. Example: Utilizing the guide empowered our staff to have conversations with residents/caregivers regarding the interventions the facility can provide. This helped reduce our preventable ED transfers and provided person centered care to our residents.
Graphically illustrate data improvement comparison from baseline to current data in percentage(s)	Here you will enter data for the length of the PDSA. You should see movement toward your goal rates.

Is this change likely to continue? Identify at least one or more of the continued sustainable interventions that addresses the problem	Yes, what are some of the interventions that helped the change effort? Example: placing the guide in locations throughout the facility increased the availability and awareness of the guide.

Act: Determine the Action Needed Based on Results of the Change	
Monitor data and adjust interventions/tactics.	
What will you take forward from this PDSA?	Adopt, Adapt, or Abandon PDSA PLAN?
Describe what modifications to the plan will be made from what you learned	If you Adopt the PLAN will you modify to -spread further- move to a stretch goal? If you are Adapting the PLAN what changes will you make and list, why? If you Abandon the PLAN possibly list, why here.

Intervention/Improvement Details:			
Action Step	**Person Responsible**	**Completion Date**	**Outcome**
Attended/Watched Recording Alliant Quality ED Affinity Group Meetings	List who attended or watched recorded		
Review recording of Alliant Quality Webinar demonstrating the tool Alliant Quality Hospital Decision Guide Webinar with Dr. Ruth Tappen			
Join Alliant Quality ED Affinity Group Hospital Decision Guide Office Hours (join 1, 2 or 3 sessions) on October 14th, October 21st, October 28th at 10:00 – 10:30 CST/ 11:00 – 11:30 EST **Registration links for Office Hours:** October 14th: https://alliancehealthgroup.webex.com/alliancehealthgroup/onstage/g.php?MTID=e06c348128eed82d437110b0e46498776 October 21st: https://alliancehealthgroup.webex.com/alliancehealthgroup/onstage/g.php?MTID=ebe64ac0109c52db7394114289590355b October 28th: https://alliancehealthgroup.webex.com/alliancehealthgroup/onstage/g.php?MTID=e48ff27e022a818c9b22933da3a1a3d5d			

Findings from the Root Cause Analysis:

Category	Barriers Identified

Communication/Notes:

This material was developed by Alliant Quality, the quality improvement services group of Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW-AHSQIN-QIO-TO1-NHCC-900-09/20/21