



# Plan-Do-Study-Act

Driving Continuous Quality Improvement at Health PEI

# Session Overview

**Part 1:** Why Continuous Quality Improvement Matters

**Part 2:** Understanding the PDSA Cycle

**Part 3:** Applying the PDSA Cycle

**Part 4:** PDSA Cycle and LEADS



# Quality Improvement (QI)

- A systematic, structured approach to improve care
- Data-driven decision making
- Identifies gaps and tests small changes
- There are a variety of QI tools – today we will focus on the PDSA cycle



# Continuous Improvement Matters

- Fosters a culture of curiosity, learning, and innovation
- Supports employment engagement and empowerment
- Encourages proactive identification of challenges
- Helps to improve safety and quality of care

PROGRESS <sup>is</sup> PROGRESS



# Small Change, Big Impact

Share one small change you've made in your work or home life that made things more efficient and effective.





# Health PEI

## Our Mission

Delivering high-quality, person-centered care to every Islander

## Our Vision

A leading rural health-care system, founded on robust primary care that is accessible to all

## Our Values

We demonstrate  
accountability

We act with care

We work together

We strive for  
excellence



# PDSA Strategic Alignment



# What is a PDSA Cycle

- PDSA stands for Plan, Do, Study, Act
- Tool used in healthcare to guide quality initiatives and drive improvement
- Allows organizations to break down complex challenges and test changes on a small scale before broader implementation





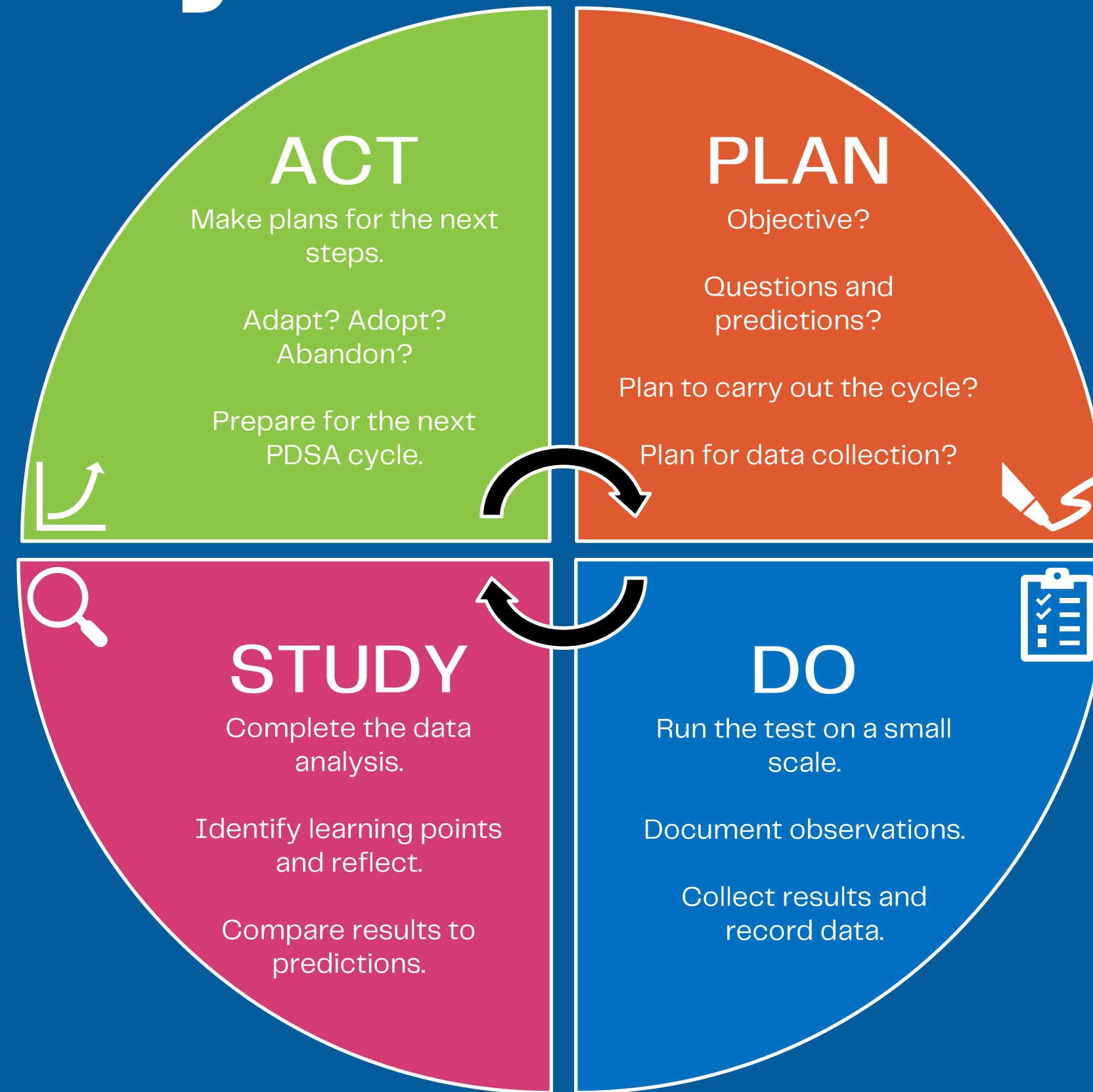
# Advantages of a PDSA Cycle



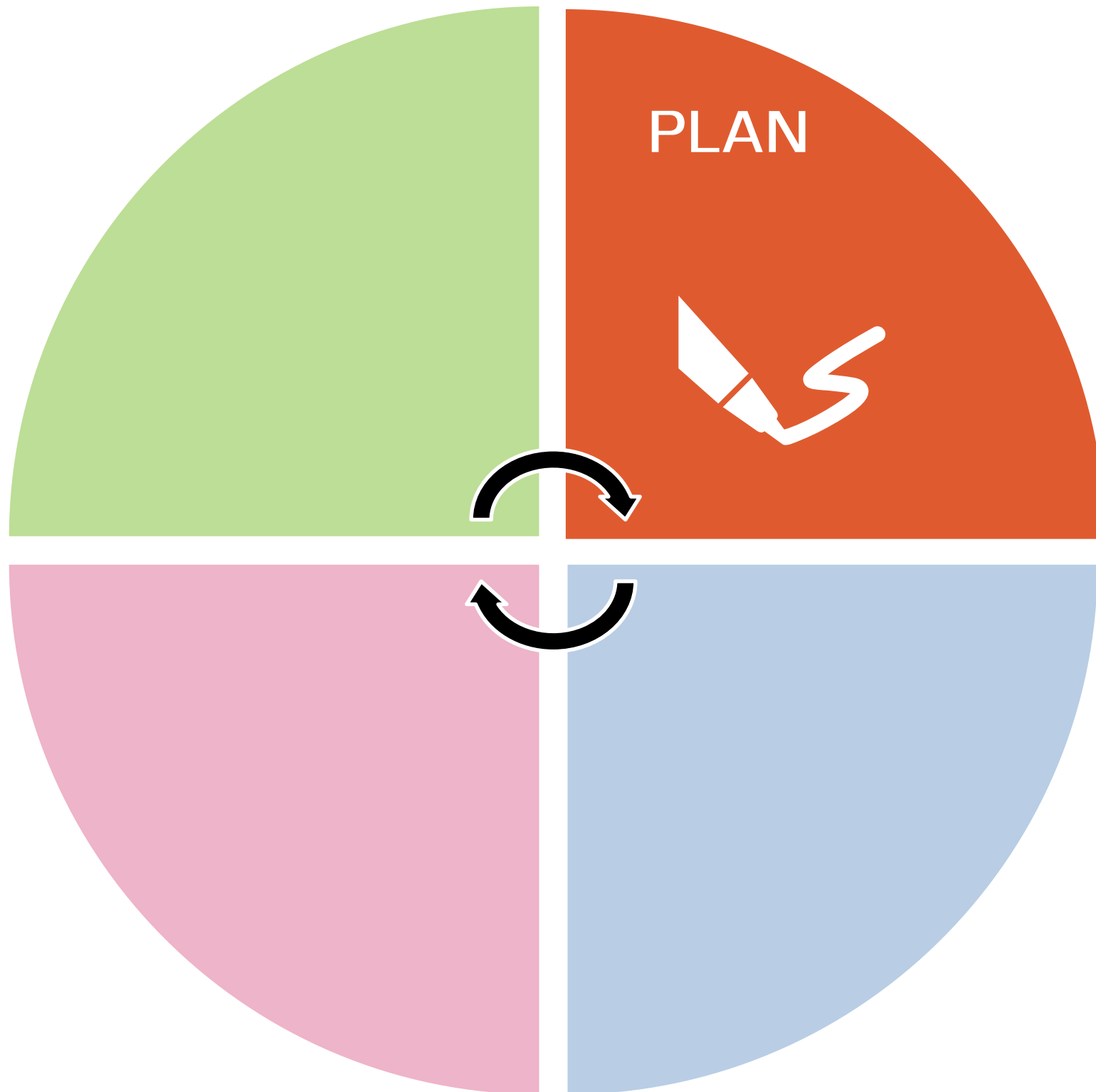
- Data-driven, allowing evidence-based decisions
- Empowers staff and promotes team work
- Promotes continuous quality improvement



# The PDSA Cycle



# Plan



A plan includes identifying what change will be tested and how.

- Identify a clear objective
- Develop a plan to test the change. Who? What? Where? When? How?
- Outline a plan for data collection. Is there baseline data available?
- Make predictions. What do you think will happen?



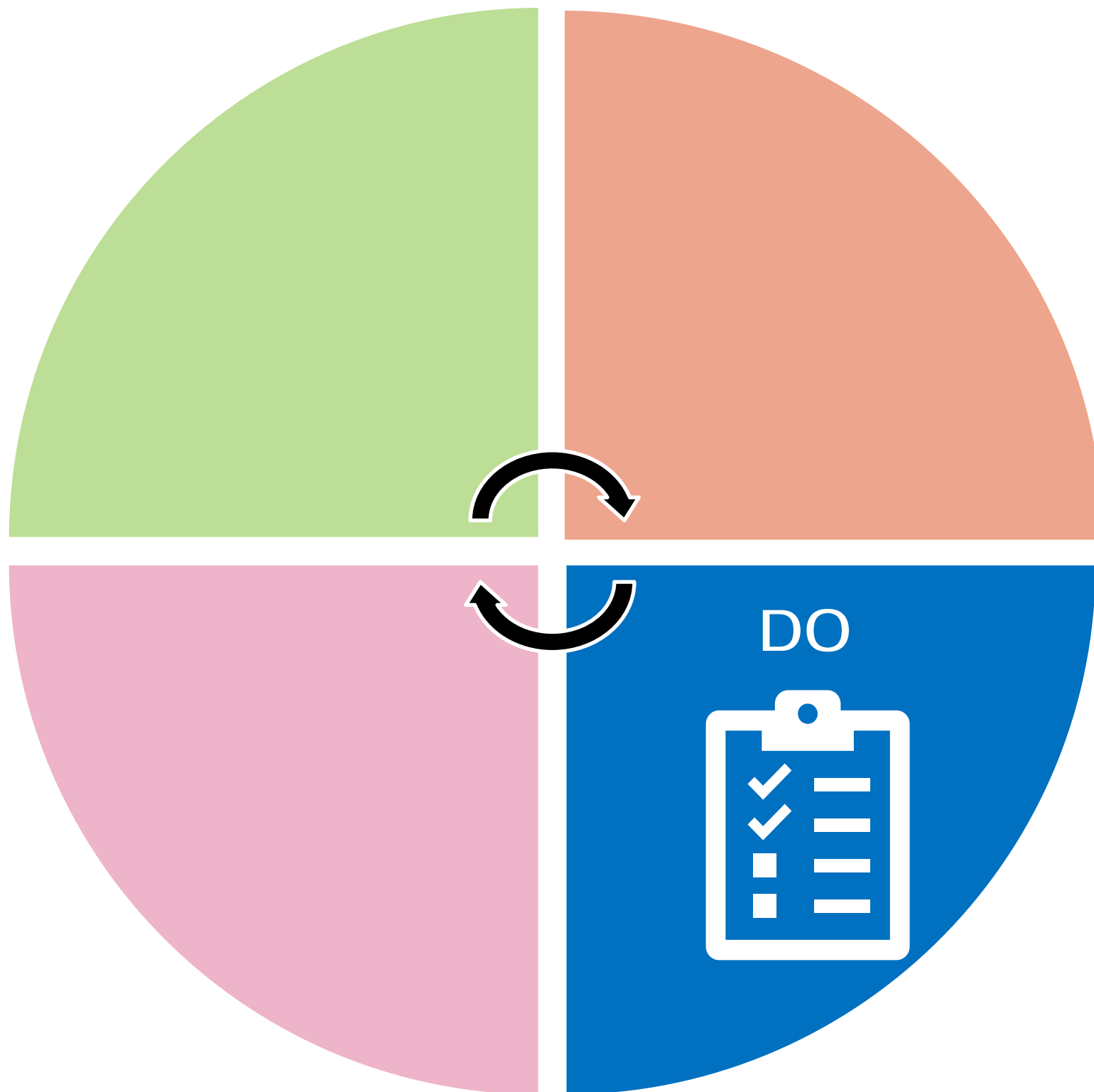
# Selecting the Project Team

A good project team (who):

- Involves individuals with knowledge of the challenge at hand
- Engages those directly involved in putting changes in practice
- Has approximately five to seven members
- Fosters a safe and transparent space
- Maintains open and regular communication



# Do



This step involves putting the plan into action.

- Run the test on a small scale
- Document problems and unexpected observations
- Keep detailed records of what happens
- Collect the data

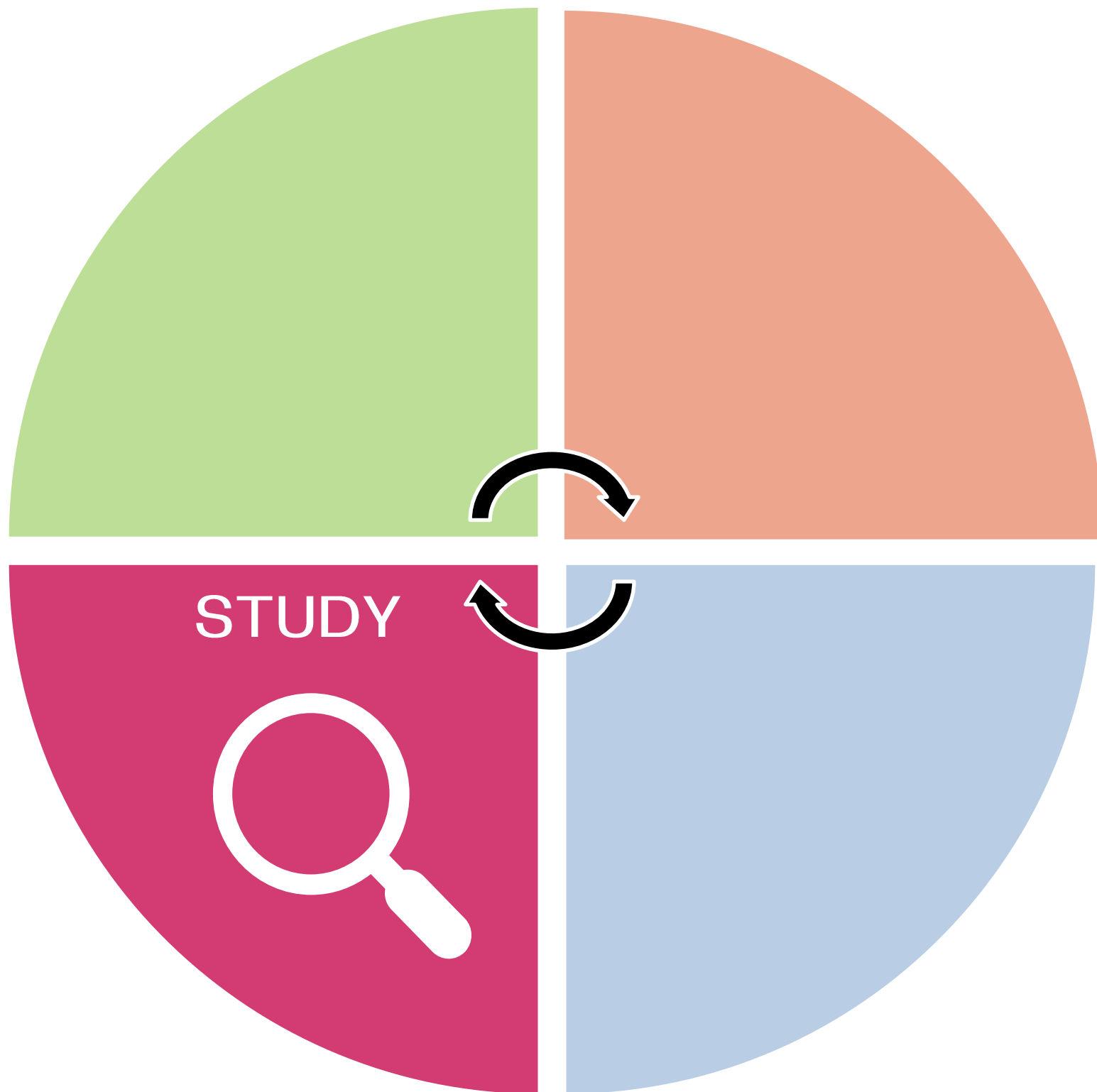




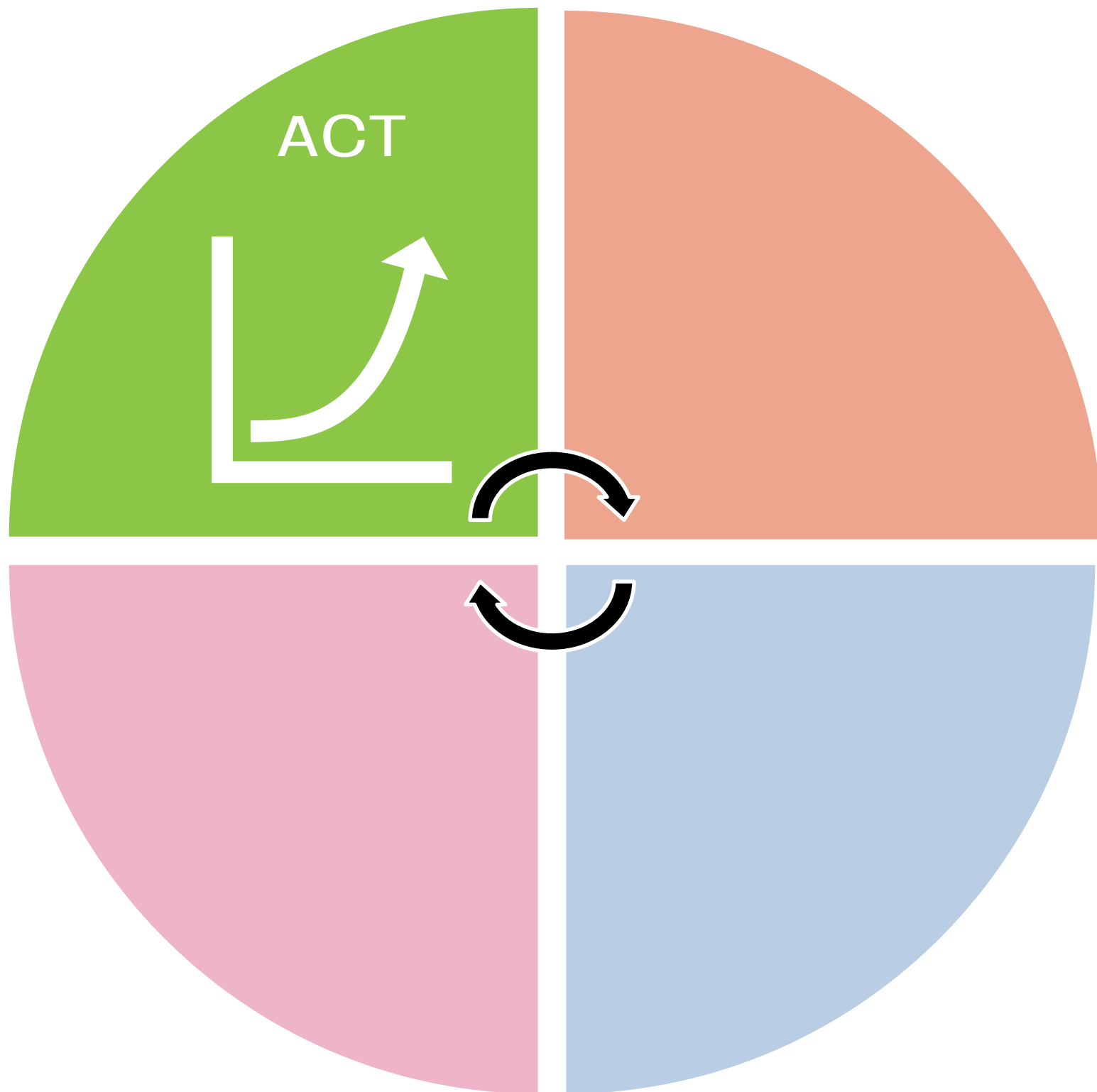
# Study

This step will involve analyzing the data collected.

- Review and analyze the data
- Compare the results to your predictions
- Identify and summarize what was learned. What worked well? What didn't?



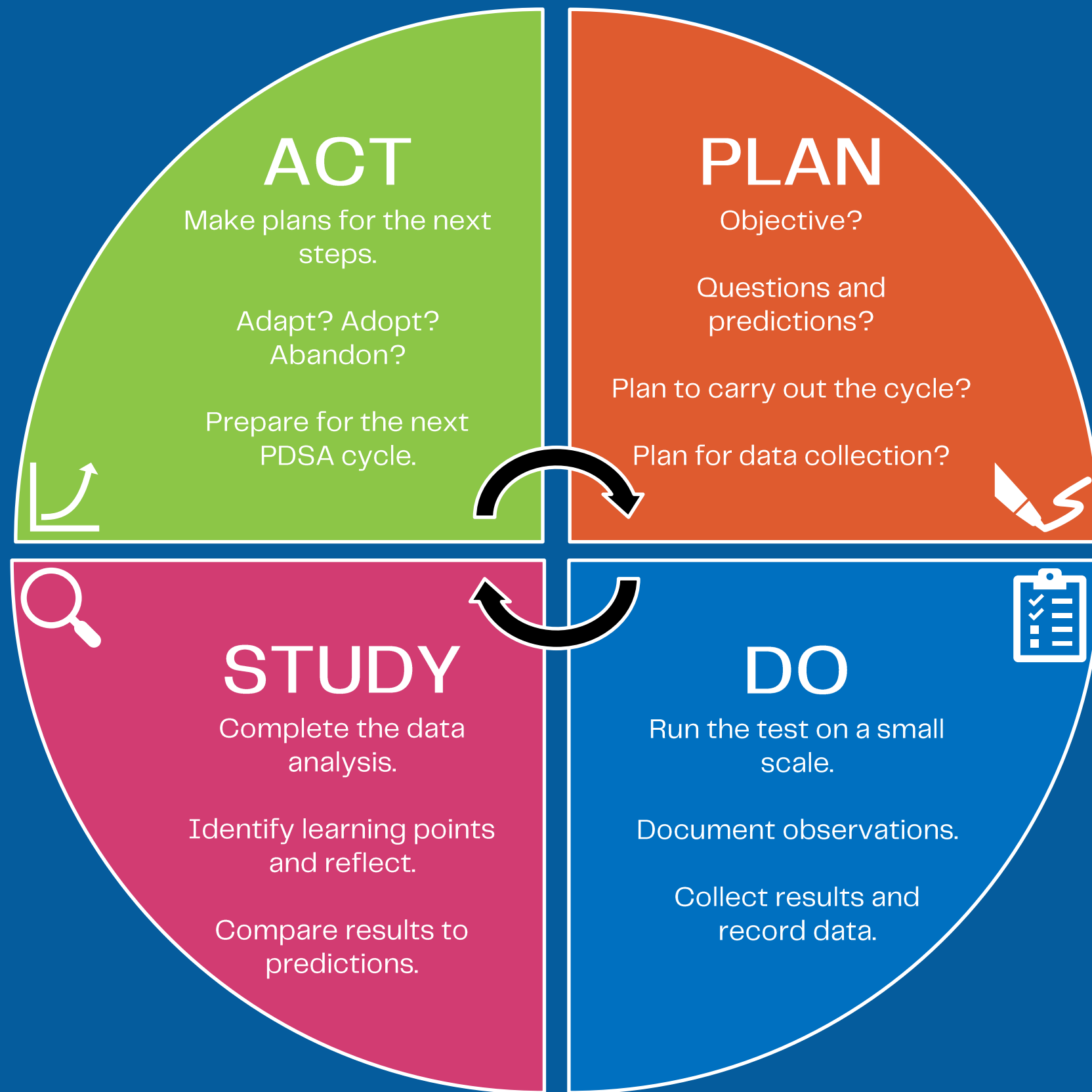
# Act



Based on what you have learned, begin to make plans for the next steps.

- Adapt?
- Adopt?
- Abandon?
- Prepare a plan for next PDCA cycle





# Advantages

- Promotes continuous learning and teamwork
- Enables evidence-based, data-driven decisions
- Empowers staff and enhances patient care





# Examples

- Implement 5P rounding for patients at high risk of falls
- Track missed appointments and introduce additional reminder methods
- Use huddles to improve awareness and reporting of hospital-acquired pressure injuries
- Standardize communication during care transitions
- Implement an audit tool to assess the quality of Best Possible Medication Histories (BPMHs)



# Tips

- Start small
- The data collected does not need to be complex
- Use SMART principles to help plan a clear objective
- Seek regular feedback
- Be flexible
- Ensure robust data collection mechanisms are in place before starting the cycle



# Discussion

1. Have you used the PDSA cycle in your area before?
2. Can you recall a quality improvement effort where a PDSA cycle would have been helpful?
3. Where do you see opportunities in your daily work to use the PDSA cycle?



# Practice

There is an increase in falls causing harm on an inpatient unit. The team wonders if implementing fall prevention safety huddles may help.

*How could we use the PDSA cycle?*



# Practice

## Plan

Team Members (Project Team):

Objective:

What:

Who:

Where:

When:

Plan for Data Collection:

Predictions:





## Plan

**Team Members (Project Team):** Manager, Educator, PT, LPN, RN, QPSC

**Objective:** To reduce the number of falls resulting in harm on the inpatient unit by 10% over the next 3 months

**Who:** RNs, LPNs, PCWs will participate in huddles – Educator will lead huddles

**What:** Fall Prevention Huddle – identifying high risk patients and their care plan interventions.

**Where:** Nursing station

**When:** At 0740 and 1940 each day – 5 mins max

**Plan for Data Collection:** Baseline and at 3 months

**Predictions:** There will be a 10% reduction in falls causing harm. Staff may find it hard to consistently implement



|       |                                                                                                                                                                                                                             |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Do    | Huddles were implemented. Data was collected on falls resulting in harm. <b>Observations/problems</b> – it was hard to formally evaluate staff feedback on the huddles as this wasn't outlined clearly in the plan section. |
| Study | Number of falls resulting in harm decreased by 5%.<br><i>Learnings?</i> This was slightly less than the initial prediction.                                                                                                 |
| Act   | <b>Adapt</b> – Will add in a 'fall risk board' to better guide discussions, identify how to collect staff feedback.                                                                                                         |





# Navigating Change with Your Teams





# Change – A Shared Journey

- Anchor change in purpose
- Co-create the path forward
- Communicate openly and often
- Equip and support your team
- Normalize resistance and change fatigue
- Use data as a guide, not a hammer
- Celebrate progress – Big and small



# Discussion

What strategies would you use to support your team through change when applying the PDSA cycle?



# LEADS in a Caring Environment

| Plan-Do-Study Act (PDSA) Cycle | LEADS Domain(s)                   | Rationale                                               |
|--------------------------------|-----------------------------------|---------------------------------------------------------|
| Plan                           | Lead Self; Achieve Results        | Self-awareness, evidence-informed planning, clear goals |
| Do                             | Engage Others; Develop Coalitions | Team engagement, communication, collaboration           |
| Study                          | Achieve Results                   | Data analysis, aligning decisions with evidence         |
| Act                            | Systems Transformation            | Scaling change, systems thinking                        |





# Next Steps





# Resources



## Quality Improvement - Education

### PDSA Cycle Resource

[PDSA Cycle Worksheet](#) <sup>[WORD DOCUMENT]</sup>

[PDSA Cycle Worksheet Example](#) <sup>[PDF]</sup>

[PDSA Cycle Resource](#) <sup>[PDF]</sup>



# Resources

## Plan-Do-Study-Act (PDSA) Cycle Worksheet

### Team members:

Click or tap here to enter text.



**Plan:** A plan includes identifying what change will be tested and how.

### Objective:

Click or tap here to enter text.

### Who, what, where, when:

Click or tap here to enter text.

### Plan for data collection:

Click or tap here to enter text.

### Predictions:

Click or tap here to enter text.

### How do I use the PDSA cycle?

Before beginning the first step of the cycle, it is important to determine who will be on the project team. A good project team involves stakeholders with knowledge of the clinical challenge at hand, and who will be involved in implementation. The optimal size of a project team is about five to seven individuals. The team should create a safe and transparent space, that is rooted in accountability and inclusivity.



**Plan:** A plan includes identifying what change will be tested and how.

- Identify a clear objective.
- Develop a plan to test the change. Who? What? Where? When?
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- Make predictions. What do you think will happen?



**Do:** Put the plan into action.

- Run the test on a small scale.
- Document problems and unexpected observations.
- Keep detailed records of what happens.
- Collect the data.



**Study:** Analyze the data collected.

- Review and analyze the data.
- Compare the results to your predictions.
- Identify and summarize what was learned. What worked well? What didn't?



**Act:** Based on what you have learned, begin to make plans for the next steps.

- Adapt - make modifications and run another cycle?
- Adopt - implement and test the change on a larger scale?
- Abandon – leave this idea behind?
- This step often involves the decision to begin another PDSA cycle.

