

User Experience of an Online Pocket Guide to Quality Improvement

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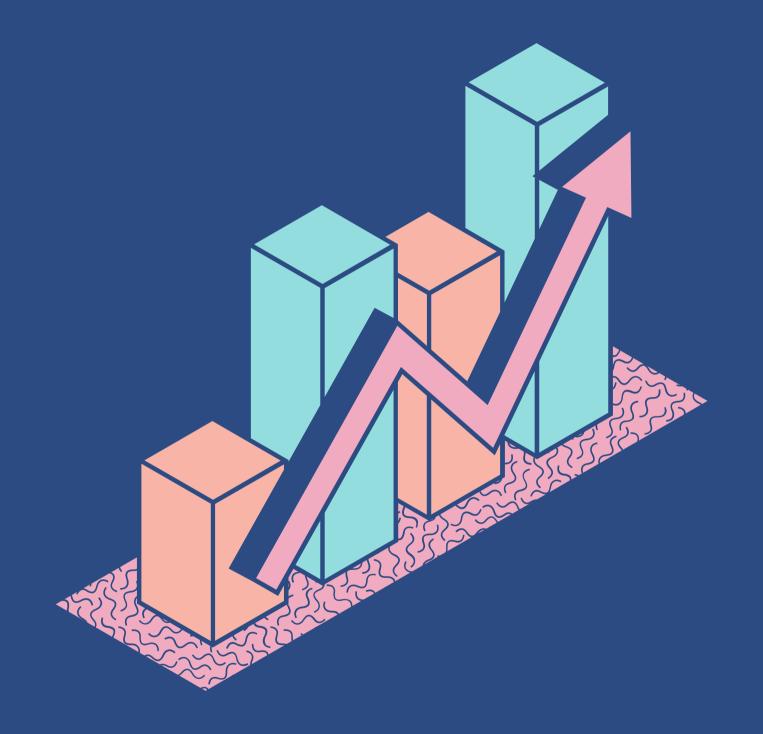
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Introduction

Continuous quality improvement empowers healthcare professionals to optimize patient safety and quality care.



A POCKET GUIDE TO

QUALITY IMPROVEMENT:

A Resource to Educate Health Profession Students and Healthcare Professionals on Quality Improvement

Pocket Guide to Quality Improvement (PGQI)

AN ONLINE INFOGRAPHIC-BASED DOCUMENT

- •Outlines key concepts in quality improvement (QI), including defining quality, identifying a quality gap, applying systems thinking and QI tools (e.g., root cause analysis, model for improvement, plan-do-study-act cycles)
- •A resource to educate healthcare professionals and students on QI

DEFINING QUALITY

HEALTH CARE SHOULD BE:

PATIENT CENTERED

Care which is respectful of and responsive to individual preferences, needs and values

SAFE

Avoiding harm or injury to patients from care which is intended to help them

EQUITABLECare which does not vary in

quality because of personal factors such as gender, ethnicity, geographic location and socio-economic status

AREAS OF
IMPROVEMENT
SHOULD LINK TO
AT LEAST ONE
OF THESE SIX
DIMENSIONS

OF QUALITY

EFFECTIVE

Providing care which is based on available evidence, avoiding underuse and overuse, and doing the right thing for the right person at the right time

TIMELY

Patients should experience seamless transitions through the healthcare system which do not ideally involve long waits in clinics, urgent care or for test results

EFFICIENT

Care which avoids waste in terms of equipment, supplies, ideas and energy

QI VS QA VS PE VS RESEARCH



QUALITY IMPROVEMENT

working to reach a level of performance that has never been achieved before



QUALITY ASSURANCE

retrospective, reactive evaluation of how well a component of a program is functioning



PROGRAM EVALUATION

examines the design,
implementation and impact of a
program and how well it's
functioning



RESEARCH

follows a scientific hypothesis, traditional methodology and biostatistics

QUALITY ASSURANCE

QUALITY IMPROVEMENT

Identify/discipline individuals responsible for outlier events

Eliminate the rare,

outlier event



Improve the system of care and its processes
Improve the average common event

Individuals: What happens relatively rarely



Sys

Meet criteria



Acł

PROGRAM EVALUATION

Understand the design, implementation, and impact of a program



QUALITY IMPROVEMENT

Improve the system of care and its processes
Improve the average common event

Programs: What actually happened (retrospectively) and how well things are working



Systems: What happens most often

Able to inform decisions or guide improvements



Achieve desirable results

RESEARCH

QUALITY IMPROVEMENT

A systematic investigation that aims to generate new knowledge



A systematic approach or review that aims to improve current practices and procedures

Requires participants outside of local sites/ departments/units for potential generalizability

Gather as much data as possible, "just

Gather as much data as possible, "just in case" One large test that requires a longer



Requires local participants in sites/
departments/units
Gather "just enough" data to learn and
complete another cycle
Small tests of change that accelerate the
rate of improvement

Results may be generalized beyond the participant/population/location/time

period of time to obtain results



Results are local to the participant/population/location/time

Generates new knowledge that may be further tested in Quality Improvement



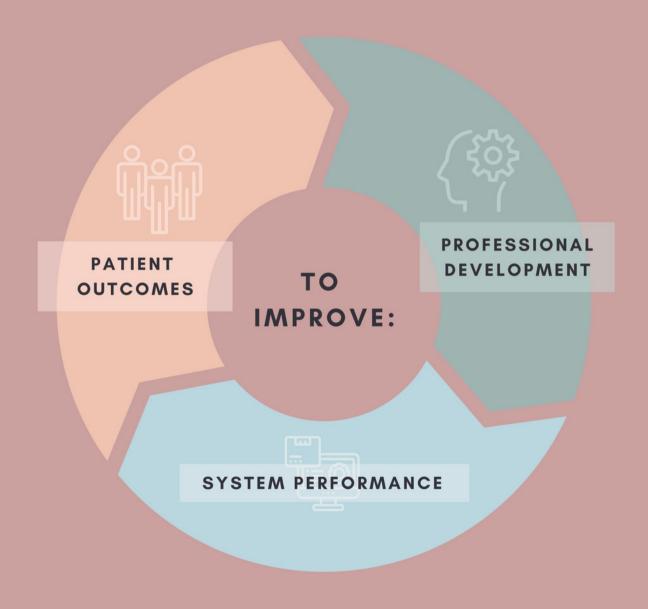
Leads to inquiry that may be further investigated in Research

Results are widely disseminated to share the new knowledge



Results are generally disseminated locally or internally

3 OBJECTIVES OF QI IN HEALTHCARE





SYSTEMS THINKING

the holistic analysis of a system; attributing errors and adverse events to the poor design of the system and not individual factors

Recognizes
systems
themselves lead
to mistakes - or
fail to prevent
them

Mistakes can
be prevented
by improving
the design of a
system at all
levels

QI TOOLS

To identify factors that contribute to an undesired outcome



NEEDS ASSESSMENTS

Used to better understand needs and perceptions as well as anticipate the needs or "wants" of stakeholders



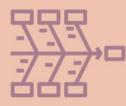
ENVIRONMENTAL SCANS

Useful to examine the current state of a system on a local and broad level



PROCESS MAPS

Used to understand processes, and the efficiencies and their deficiencies and gaps that may be impacting outcomes



FISHBONE DIAGRAMS

Helpful to identify less obvious causes of poor performance



FIVE WHY'S

Can help identify problems that would benefit from small, incremental changes so the same issue does not happen again



ROOT CAUSE ANALYSIS

Used to retrospectively analyze serious adverse events, better understand quality issues and uncover latent causes of events impacting quality

THE MODEL FOR IMPROVEMENT

1) AIM: WHAT ARE YOU TRYING TO ACCOMPLISH?

Define the problem to be fixed in clear and concise language.

Define the project's context, target population and duration.

Link activities to an outcome.

3) CHANGES:
WHAT
CHANGES CAN
YOU MAKE
THAT WILL
RESULT IN
IMPROVEMENT?

The area for improvement should be one that lends itself to small scale changes, and an intervention that can be modified and improved over time

USE
REPEATEDLY
TO TEST A
SERIES OF
CHANGES

2) MEASURES: HOW WILL YOU KNOW IF A CHANGE IS AN IMPROVEMENT?

Consider how you will measure the impact of your change.
There are 3 types of measures used to analyze the performance of a system:
outcome, process, and balancing measures.

PDSA CYCLE

rapid cycle improvements used to test changes in quality improvement to achieve process or system improvement



ACT

make changes based on what you examined



PLAN

plan changes aimed at improvement, matched to root causes

STUDY

examine the result of the change



DO

carry out the change; first on a small scale

MEASURING QUALITY IMPROVEMENT



OUTCOME MEASURES

How does your change or intervention impact outcomes?



PROCESS MEASURES

Are the steps in the system performing as planned?



BALANCING MEASURES

Are changes designed to improve one part of the system causing new problems in other parts?



Our project is aimed to collect user experience and analyze their feedback to implement targeted improvement for the PGQI.

Methodology

We administered a 14-item online survey:

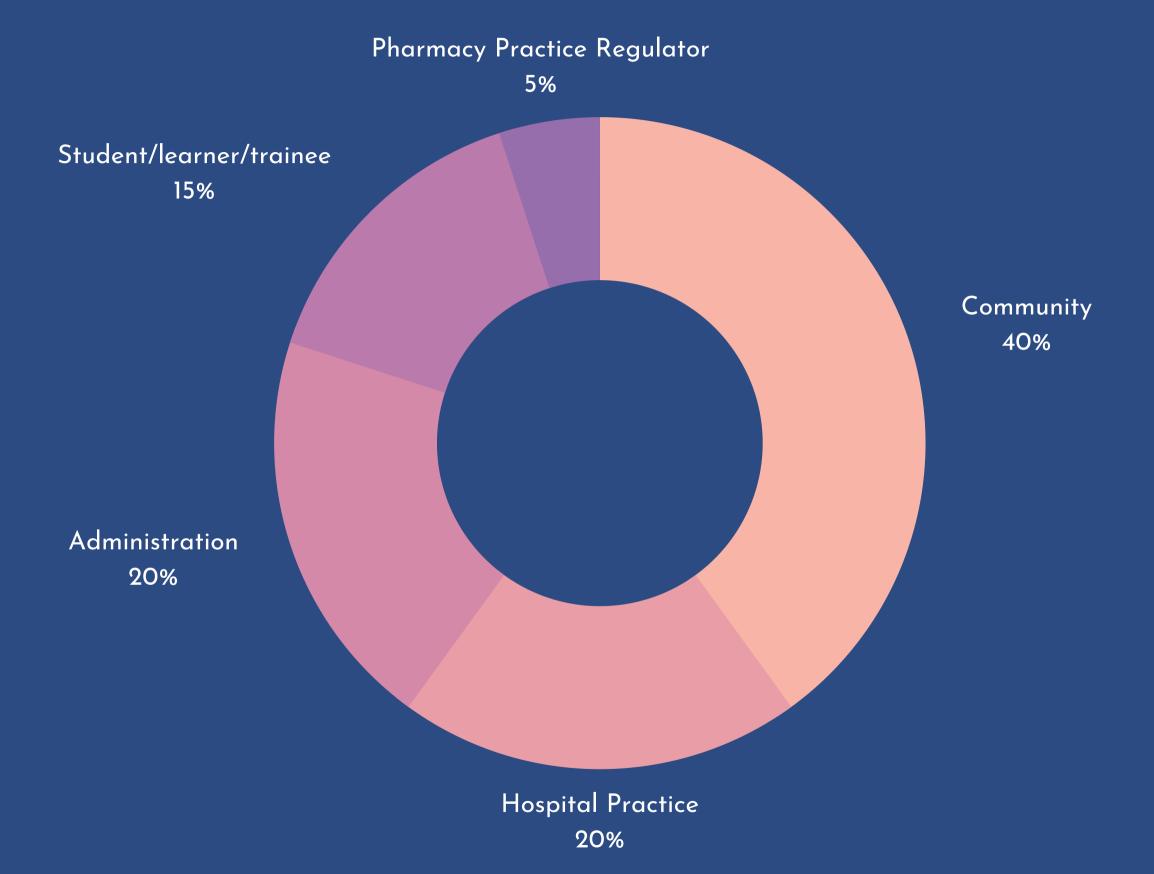
- To health care providers

 (mainly pharmacists) and
 health profession students
 (primarily pharmacy students)
- To gather their user
 experience of the PGQI
- During a four-week period in October 2021

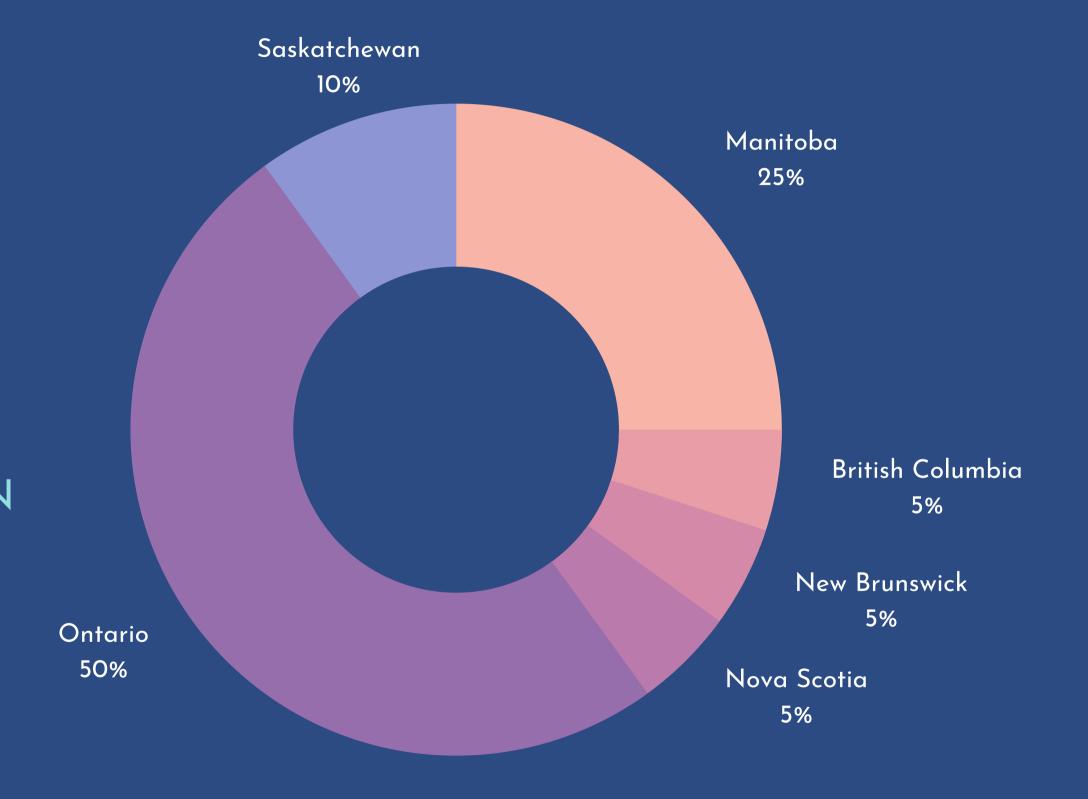
• 20 responses received

Results: Demographics

PRIMARY PRACTICE SETTING

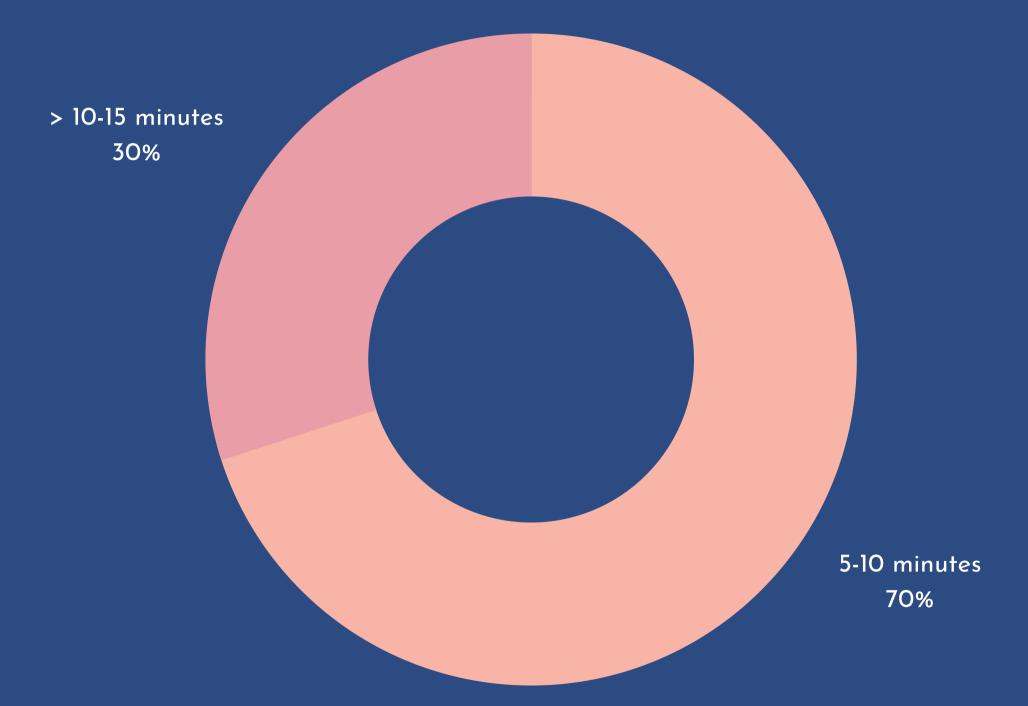


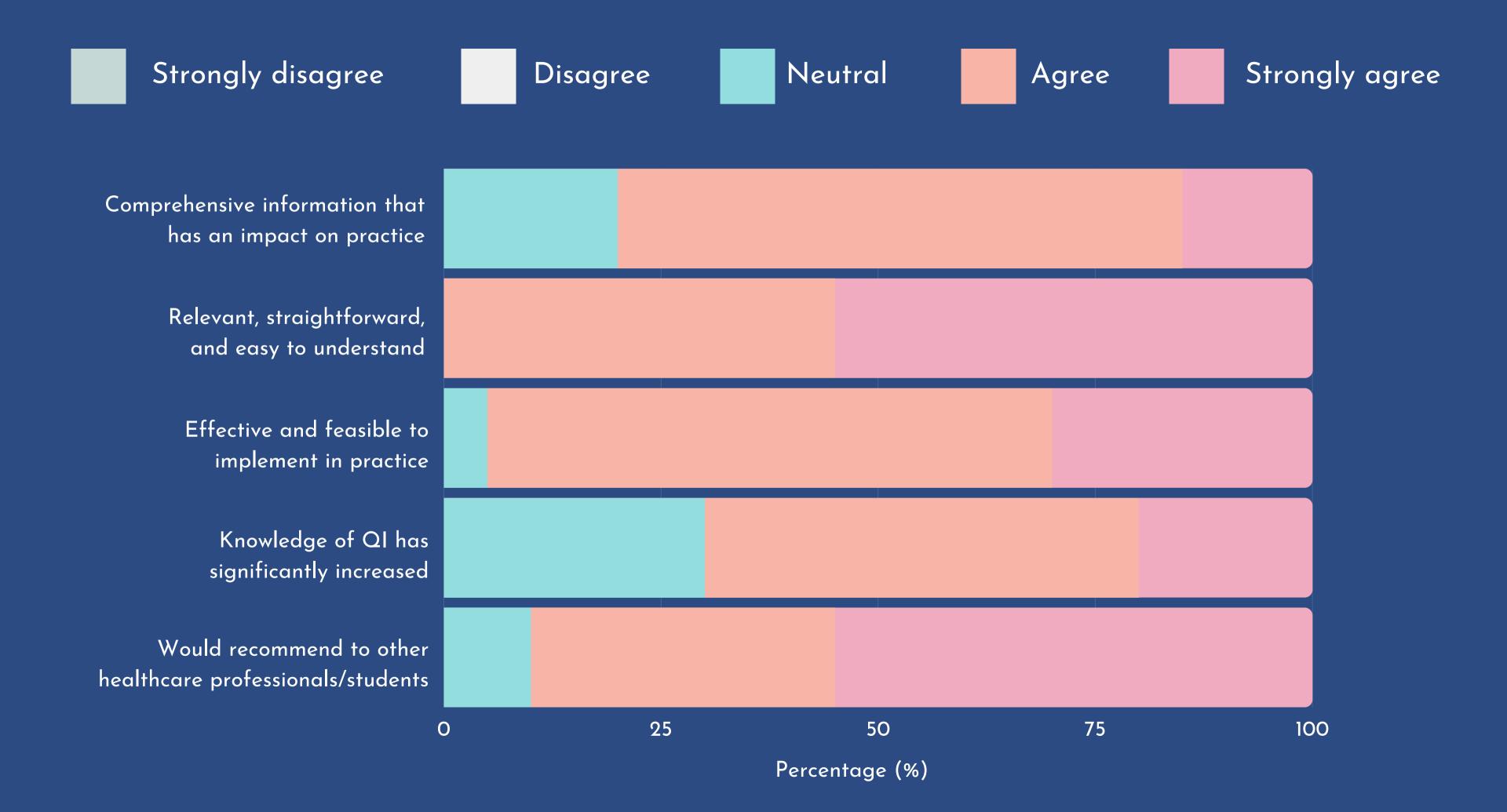
Results: Demographics GEOGRAPHICAL LOCATION



Results: Questionnaire Responses

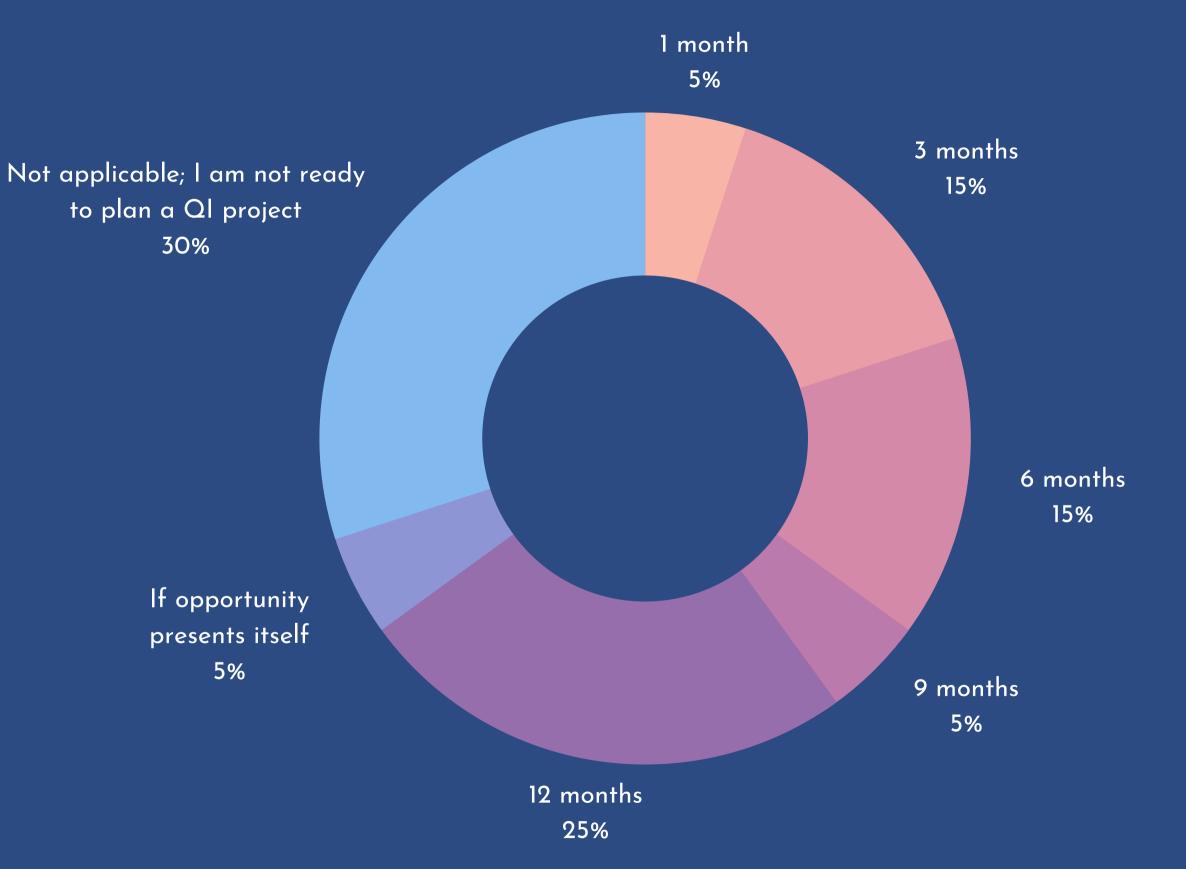
LENGTH OF TIME TO REVIEW POCKET GUIDE





Results: Questionnaire Responses

I WOULD LIKE TO
PLAN A QI PROJECT IN
THE NEXT:





- Clear and concise
- Easy to read
- Effective use of graphics/visuals
- Visually pleasing/aesthetic
- Easy to understand
- Approachable
- Accessible
- Well-summarized
- Easy to navigate/follow
- Relevant
- Good introduction to topic





Suggested improvements

- Elaborations on QI tools
- Case studies to connect definitions to practice
- Links to resources that provide more details on concepts/tools
- Improved readability on certain texts
- More explanations on defined terms
- More examples to solidify concepts
- Smaller font and more concise
- Different colour scheme, more white space, more colour contrast
- More references provided

Conclusion

The PGQI effectively presented QI concepts in an easy-to-read format. It can be easily accessible and utilized by healthcare professionals and students who wish to learn more about defining, planning, and conducting a QI project.

