CAH Quality Improvement (QI) Project A3 / Storyboard Report

Project Title: [Specific QI Initiative Name]

Date: [MM/DD/YYYY] | CAH Department: [Unit/Clinic] | Team Lead: [Name/Title]

1. PLAN: Background, Problem, and Goal (The "Why" and "Target")

(Approx. 20% of the page - Upper Left)

+ **Problem Statement: (Specific, Measurable, Actionable, Relevant, Time-bound - SMART)**
  - **Example:** Within the last quarter, our average time from ED presentation to admission order for sepsis patients was 180 minutes, exceeding the state benchmark of 90 minutes.
+ **Current State Data: Use a simple chart (e.g., Run Chart or Pie Chart) to visually represent the problem's magnitude.**

  Root Cause Analysis Summary (The "How"): A brief statement summarizing the main cause(s) identified (e.g., Lack of a standardized nurse-to-physician handoff protocol for ED admissions.)

  Goal Statement: The desired measurable outcome.
  - **Example:** Reduce the average time from ED presentation to admission order for sepsis patients by 50% (to 90 minutes) within 90 days.

2. DO: Proposed Countermeasures & Implementation Plan (The "Action")

(Approx. 30% of the page - Center Right)

+ **Problem Statement: (Specific, Measurable, Actionable, Relevant, Time-bound - SMART)**

1. **[Action 1: Who, What, When]** e.g., Develop and pilot new 3-point ED handoff tool (Nurse Lead) by Week 4.
2. **[Action 2: Who, What, When]** e.g., Provide 1-hour training on the new protocol to all ED/Inpatient staff (Educator) by Week 6.
3. **[Action 3: Who, What, When]** e.g., Integrate new handoff fields into the EMR system (IT/CMO) by Week 8.

- **Resource Needs (Critical Access Focus):** Highlight necessary resources, especially staff time or minimal capital investment.
  - **Need 4 hours of Nurse Manager time per week for auditing.**
- **Risk/Barrier Mitigation: What could prevent success and how will the team respond?**
  - **Risk:** Staff resistance to a new form. Mitigation: Solicit staff input during the design phase.

3. CHECK: Results and Evaluation (The "Proof")

(Approx. 30% of the page - Center Left)

- **Results Data:** The most critical visual. Use a Control Chart or a clear Before/After Graph showing the impact of the implemented solution on the primary metric (from Section 1).
- **Goal Attainment:**
  - **Actual Result: [e.g., Achieved an average time of 85 minutes.]**

    Status: ☐ Goal Met / ☐ Goal Partially Met / ☐ Goal Not Met
- **Key Learnings:** What worked unexpectedly well, and what failed or required adjustment?
  - **Learning:** Initial training was too lecture-heavy; shifted to scenario-based role-playing, which improved adoption.
- **Patient Impact: Briefly summarize the direct benefit to patient care and/or safety.**
  - **Example:** 5 fewer patients per month experienced delays in critical antibiotic administration.

4. ACT: Standardization and Next Steps (The "Sustain")

(Approx. 20% of the page - Bottom Right)

- **Standardization** (Locking in the Gain): How will the improvement be sustained across the CAH?
  - **Update the official ED Policy and Procedure Manual (P&P).**
  - **Add the new protocol to the annual staff competency checklist.**
- **Future Plans/Horizontal Deployment:** Where else in the hospital could this solution be applied (e.g., Roll out the handoff tool to the ICU/Surgical Unit).
  - **QI Committee Approval: ☐ Yes / ☐ No**
  - **Date Approved:**

Design Tip: Use bold text and color (if possible) to separate the four PDCA sections for easy reading. The large format allows for clear labels and concise data visualizations.