An example of a completed PDSA Tool

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<tr><td>Problem statement:</td><td colspan="2">Tracking women through PMTCT care until delivery at Huduma Health Centre – women failed to continue attending to clinic appointments for PMTCT care. Women often exited PMTCT care when referred to the district hospital.</td></tr>
<tr><td>Goal statement:</td><td colspan="2">Increase 12-month retention in PMTCT care from 65% to 95% for all enrolled Pregnant women by June 2014.</td></tr>
<tr><td>Indicator description :</td><td colspan="2">Number of HIV-positive pregnant women retained in PMTCT care 12 months after enrollment.</td></tr>
<tr><td>Baseline data: (indicator performance result)</td><td colspan="2">Period under review: July 2013 to December 2013
12-month retention in PMTCT care: 65%</td></tr>
<tr><td>Plan – Describe your analysis of the process/ problem.
Attach the fish bone, flowchart, and/or any tool used for planning.</td><td colspan="2">Process flow chart done? Yes
Fish bone diagram done? Yes
The analysis highlighted that most women were lost when they were referred to the County facility for drawing of CD4 samples. The step between referral for CD4 and actual CD4 blood draw was difficult due to the long distance to the hospital and lack of direction on where to go when they reached.</td></tr>
<tr><td>Plan – Describe the change ideas/interventions you have selected to address the problem (attach a workplan for intervention).</td><td>Root cause
Lab referral – long distance to the hospital and lack of clarity

Inadequate follow-up of defaulters</td><td>Change interventions selected
Drawing blood at Huduma health center and send the specimen for CD4 analysis, rather than refer the patient to the district hospital.
Use patient diary to track missed appointments

Ensure timely home visits for women who miss appointments through mentor mothers and use of an appointment diary</td></tr>
<tr><td>Plan – Performance measurement plan Indicators (and definition), method for collection, frequency of collection.</td><td colspan="2">Indicators: Retention of PMTCT clients
Methods: File/register review
Frequency: Monthly and aggregate after 6 months.</td></tr>
<tr><td>Do – Describe implementation of the change package.</td><td colspan="2">After consulting with the district hospital to inform them of change in plan, training was done of new process flow for MCH and lab staff.
Mentor mothers were given additional training on defaulter follow-up.</td></tr>
<tr><td>Study – Describe the outcomes of the interventions (should include follow-up data using the same indicator as baseline).</td><td colspan="2">Follow-up Data (Indicator Performance Result)
Two review periods:
First period: July 2014 to September 2014
Second period: September 2014-December 2014
We conducted an in-depth analysis of the trends of process and outcomes measures- showing that 85% of pregnant women who were enrolled at Huduma health centre were retained for continuity of care until delivery between July 2014 and September 2014 and 95% between September 2014 and December 2014.</td></tr>
<tr><td>Was goal achieved?</td><td colspan="2">Yes, the goal was achieved.
If YES, continue to the Act section below.
If NO, explain below why your team thinks the intervention did not succeed (challenges faced) and next steps/way forward (e.g. beginning a new QI Project/PDSA cycle to address the problem).</td></tr>
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Act – Describe how you have institutionalized the intervention/change and how you will continue measuring the success of the institutionalized interventions over time.	If successful, sustain and upscale: • A patient diary was established at the facility to track missed appointments • A buddy system through mentor mothers was established to ensure that all women who were enrolled were supported and educated about their health care services and had follow-up home visits when they missed appointments. • Formalized the lab network referral system with the district hospital Describe any challenges faced during the process and how they were overcome: • There was need to have better coordination with the county hospital to ensure that referred women reached the county hospital