MedResearchPro

Graduation Project Template

[DEGREE / PROGRAM NAME]
[TRAINING CENTER / INSTITUTION]

GRADUATION PROJECT

[PROJECT TITLE]

[Optional subtitle]

Student Name: *[STUDENT NAME]*
Student ID: *[STUDENT ID]*
Organization: *[ORGANIZATION NAME]*
Department / Unit: *[DEPARTMENT / UNIT]*
Project Subject: *[PROJECT SUBJECT]*
Supervisor: *[SUPERVISOR NAME AND TITLE]*

Academic Year *[ACADEMIC YEAR]*
Project Submission Date: *[PROJECT SUBMISSION DATE]*

About this Template

This template provides a reusable structure for an applied graduation project in any field. It follows the academic sequence of a full project (aim, context, analysis, methodology, solution, risks, implementation, conclusions, references and appendices) with ready-made tables, figures and tools, and uses placeholders and short instructions wherever your own content belongs. Complete it only with your own verified work. Delete this page before submission.

Convention	Meaning
[Teal bracketed text]	Placeholder or instruction. Replace it with your own verified content.
Shaded box with a teal bar	Guidance for completing the section. Delete it once the section is complete.
[DATA REQUIRED]	Evidence needed before a statement or figure can be reported.
[REQUIRES ON-SITE VERIFICATION]	Information that must be checked at the facility before it is stated as fact.
[ILLUSTRATIVE EXAMPLE — NOT ACTUAL PROJECT DATA]	An example showing how to complete a section. Never present it as a finding.
[INSERT VERIFIED, RELEVANT REFERENCE]	Add a real, traceable source you have consulted. Do not invent citations.

Completing the template

- Replace every cover-page placeholder, then complete each section in order.
- Keep verified findings, proposed methods, expected outcomes and recommendations clearly separate.
- When complete, update the contents and the lists of tables and figures: click inside the table and press F9, or right-click and choose Update Field.
- Check every retained reference against your program’s requirements and the current edition.

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Project Scope and Basis

[State that this graduation project was prepared as the final applied requirement of [DEGREE / PROGRAM NAME]. Explain briefly how the concepts studied (for example quality principles, indicators, analysis tools, risk management, ethics, management and standards) are applied to one real subject in one organization or setting.]

[Explain why the selected core process was chosen: which departments, people or groups it touches, why variation is likely, and why it suits a quality management project.]

Evidence statement. Before any analysis, state which evidence was actually available when the project was prepared. No percentage, rate, staff number, budget figure, audit result or other organization-specific figure may be reported unless it comes from verified, documented sources. Where a number would normally appear, propose how it will be measured or state that a baseline must be established first. The table below explains how each type of information is treated throughout the document.

Table 1: Classification of evidence used in this project

Category	Status in this project	How it is presented
Actual data	*[DATA REQUIRED: state whether organization reports or statistics were supplied]*	Reported only if verified. Otherwise written as “Baseline measurement should be established before implementation.”
Documented evidence	*[State which policies, SOPs, committee minutes and audit records were reviewed, if any]*	Where not reviewed, written as “Assessment requires on-site verification.”
Observed findings	*[State whether structured observations were carried out]*	Any practice gap that has not been observed is described as a potential gap, not a finding.
Proposed measurement	Developed in this project	Indicator cards, audit tools and a measurement plan (Sections 4 and 6, Appendices).
Expected outcome	Described as what the project aims to achieve	Worded as expected or intended results, never as achieved results.
Recommendation	Developed from the analysis	Presented in Sections 14 and 15 as proposals for organization leadership.

[Define the scope: the activities, units, services and user groups included; the support activities that make them possible; related areas discussed but not measured; and what is outside the measured scope, with the reason (for example, data that must come from the organization itself).]

1. Introduction

Most people judge an organization by what they can see: how it treats them, how long they wait and how well it appears to run. Quality management looks deeper. It asks whether products and services are safe, effective, timely, efficient, equitable and centred on the people they serve, and whether the organization has the systems to deliver them reliably every day, not only when someone is watching.

Organizations are complex. A single service can involve many staff from different professions and departments. Quality in this environment comes from well-designed processes, clear responsibilities, adequate resources and a culture where people feel able to speak up, rather than from the effort of one excellent individual. Most quality problems are therefore system problems rather than individual failures.

Risk, safety and ethics sit at the centre of any applied project. A well-designed project aims to reduce avoidable harm and unnecessary risk to people and to the organization, and it respects consent, confidentiality and fairness.

> *[Introduce the selected topic. Describe the type of problem or quality gap it addresses, why it matters for beneficiaries, staff and the organization, and why reliability (doing the right thing consistently, on every shift or occasion) is the challenge. Support statements with verified references: INSERT VERIFIED, RELEVANT REFERENCE.]*

Looking at the selected topic as a **process** rather than a list of rules changes how improvement is approached. A process has inputs (policies, trained staff, resources, equipment), activities, outputs and outcomes. When the process is mapped, it becomes easier to see where it might break down, who is responsible at each step, and where measurement should take place. A simple inputs–process–outcomes model, shown in the figure below, is a useful way to think about this link.



Figure 1: Inputs–process–outcomes model applied to [PROJECT SUBJECT]

Risk management adds another layer. Instead of waiting for an incident to reveal a weakness, a risk-based approach asks in advance what could go wrong, how likely it is and how serious the consequences would be, so that limited resources go where the risk is highest.

None of this can be managed without measurement. Quality indicators turn good intentions into something that can be tracked, discussed and acted upon, but measurement must be honest and well designed; a poorly defined indicator, or an audit that happens only before an inspection, can give a false sense of security.

Measurement then feeds continuous improvement. The Plan–Do–Study–Act (PDSA) cycle, popularized through the Model for Improvement (Langley et al., 2009), encourages teams to test changes on a small scale, learn from the results and then adopt, adapt or abandon the change.

> *[If applicable, describe the standards, regulations or accreditation framework relevant to the organization and how it addresses the selected topic. State the edition used and confirm it is current.]*
>
> *[Describe the organization context in one short paragraph using verified information. If no baseline data were available, state this plainly and explain what the project can and cannot claim.]*

1.1 Project Aim

> *[Write one overall aim in this form: "The overall aim of this project is to apply quality management principles and tools to [PROJECT SUBJECT] at [ORGANIZATION NAME] in order to propose a practical, measurable and sustainable plan for improving ..."]*

1.2 Specific Objectives

> *[Adapt each objective to the project. Where possible, write objectives in SMART form (specific, measurable, achievable, relevant, time-bound).]*

1. To describe *[PROJECT SUBJECT]* as a core process, including its inputs, activities, outputs, customers and responsible parties.
2. To apply the seven quality management principles to the process and identify potential strengths, gaps and improvement opportunities.
3. To develop *[NUMBER]* indicator cards that allow the organization to measure the process reliably.
4. To analyse potential causes of variation using process mapping, a fishbone diagram and a Five Whys analysis.
5. To design a quality improvement project using the PDSA model, with a clear measurement plan and sustainability arrangements.
6. To identify and rate the main risks in the process and propose controls through a risk register.
7. To link the project to risk, safety and ethical considerations, contemporary management concepts and *[STANDARDS / REGULATORY FRAMEWORK]* requirements.
8. To provide recommendations and an implementation plan that organization leadership can act upon.

2. Organization and Project Subject Description

2.1 Organization Profile

> *[Insert the organization profile and describe its relevant services using verified information: type of organization, population served, services relevant to the selected process, and the quality environment (committees, quality or planning department, applicable guidance). Mark anything unverified as REQUIRES ON-SITE VERIFICATION.]*

Table 2: Organization profile of [ORGANIZATION NAME]

Organization name	*[ORGANIZATION NAME]*
Organization type	*[Company / institution / public service / other]*
Sector and regulatory context	*[Public / private / other setting; guidance, standards or accreditation framework applicable]*
Beneficiary / user population	*[Describe the groups served, including groups more exposed to the risk addressed]*
Relevant services	*[List the services relevant to the selected process. REQUIRES ON-SITE VERIFICATION]*
Relevant stakeholders	*[Beneficiaries and users; operational staff; quality or planning department; support services; management; other]*
Organizational context	*[Organizational chart, committee structure and reporting lines. REQUIRES ON-SITE VERIFICATION]*
Quantitative data	*[DATA REQUIRED: staffing numbers, volume of activity, budget and outcome data, if supplied and verified. Otherwise state that they were not provided and are not reported.]*

Why the selected process was chosen

> *[Give the reasons for choosing the process. Useful prompts: Does it affect many beneficiaries? How serious are the consequences of failure? Is it visible to users? Is it emphasized in standards or regulation? Can the diploma tools (audit, indicators, PDSA) be applied directly?]*

2.2 Selected Core Process

> *[Describe the selected process, its scope, responsible departments and the user population. Define it in one paragraph, then complete the table below.]*

Table 3: Definition of [PROJECT SUBJECT]

Process name	*[PROJECT SUBJECT]*
Purpose	*[Why the process exists and what it should achieve]*
Process begins	*[Trigger or first step]*
Process ends	*[Final step or end condition]*
Inputs	*[Policies, trained staff, supplies, equipment, information, management support]*
Activities	*[Main activities, in sequence]*
Outputs	*[Products or results of the process]*

Internal customers	*[Staff groups who receive or depend on the process]*
External customers	*[Beneficiaries, families, visitors, community, regulators]*
Responsible personnel	*[Process owner and role holders]*
Participating departments	*[Departments involved. REQUIRES ON-SITE VERIFICATION]*

2.3 Process Flowchart

The figure below presents the selected process as a flowchart. The main sequence runs from identifying requirements through to monitoring. At the decision point the process splits: if the target is achieved, monitoring continues and results are fed back; if not, the gap is analysed and corrected, then re-audited. Both paths end in sustaining the improvement, and the cycle repeats. Coloured markers show where the process is most likely to fail (F), where monitoring should take place (M) and where risk to people is greatest (R).

> *[Replace the placeholder steps with the actual steps of the process, name the responsible role under each step, and move the F, M and R markers to match the process analysis. Edit the figure in a drawing tool or insert your own flowchart in its place.]*

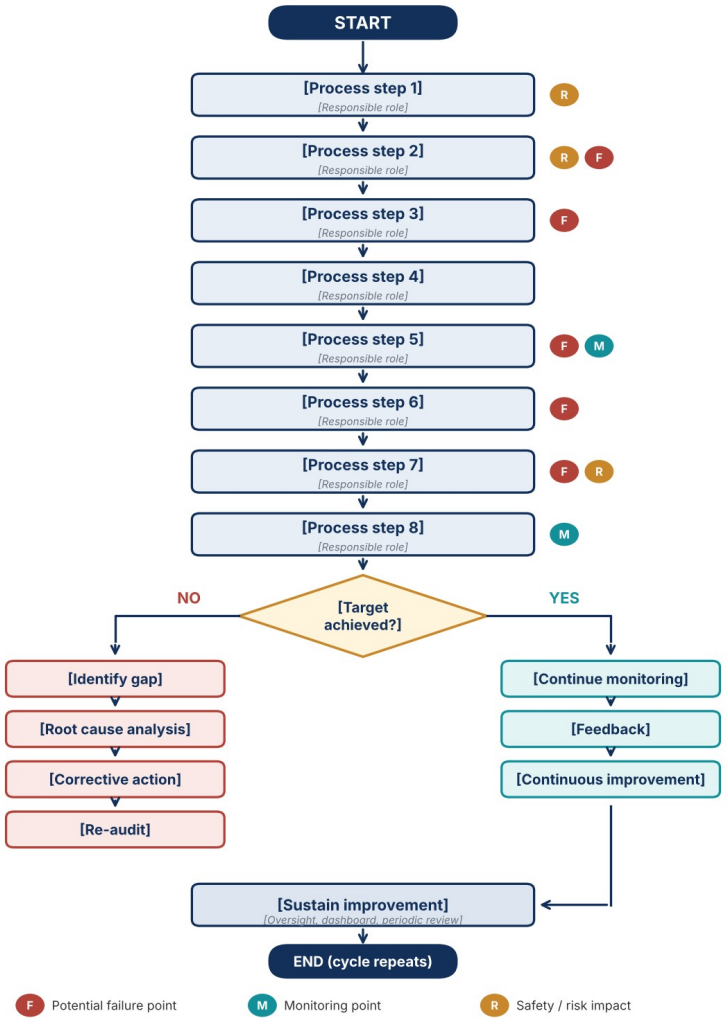


Figure 2: [PROJECT SUBJECT] flowchart at [ORGANIZATION NAME] (proposed)

The table below lists the inputs, outputs and monitoring points of the flowchart, so the reader can see what goes into each stage and what should come out of it.

Table 4: Inputs, outputs and monitoring points of the process flowchart

Process step	Main input	Main output	Monitoring point
1. *[Process step 1]*	*[Input]*	*[Output]*	*[Yes / No: type]*
2. *[Process step 2]*	*[Input]*	*[Output]*	*[Yes / No: type]*
3. *[Process step 3]*	*[Input]*	*[Output]*	*[Yes / No: type]*
4. *[Process step 4]*	*[Input]*	*[Output]*	*[Yes / No: type]*
5. *[Process step 5]*	*[Input]*	*[Output]*	*[Yes / No: type]*
6. *[Process step 6]*	*[Input]*	*[Output]*	*[Yes / No: type]*
7. *[Process step 7]*	*[Input]*	*[Output]*	*[Yes / No: type]*
8. *[Process step 8]*	*[Input]*	*[Output]*	*[Yes / No: type]*
9. Decision and follow-up	*[Results versus target]*	*[Feedback or corrective action plan]*	*[Yes: re-audit]*
10. Sustain improvement	*[Dashboard, committee review]*	*[Stable performance; updated plan]*	*[Yes: periodic review]*

2.4 Process Analysis

The flowchart shows the sequence but not where things are likely to go wrong. Each major step is therefore analysed in terms of who is responsible, what goes in and comes out, where it might fail and what that would mean for users. Unless on-site data are available, the failure points and quality gaps are **potential** ones: they must be confirmed or ruled out during baseline assessment.

> *[Add a row for each process step. After the table, summarize any pattern across the rows (for example, whether failure points relate mainly to knowledge, resources, documents, monitoring or follow-up) and state how this shaped the improvement work in Section 6.]*

Table 5: Analysis of the main process steps (potential failure points and opportunities)

Step / responsible	Activity	Potential failure point and risk	Impact on people / quality gap	Improvement opportunity
[Step 1] [Responsible role]	*[Activity]*	*[Potential failure point]*	*[Impact]*	*[Opportunity]*
[Step 2] [Responsible role]	*[Activity]*	*[Potential failure point]*	*[Impact]*	*[Opportunity]*
[Step 3] [Responsible role]	*[Activity]*	*[Potential failure point]*	*[Impact]*	*[Opportunity]*

Step / responsible	Activity	Potential failure point and risk	Impact on people / quality gap	Improvement opportunity
[Step 4] [Responsible role]	*[Activity]*	*[Potential failure point]*	*[Impact]*	*[Opportunity]*

3. Quality Principles and Customer Focus

The seven quality management principles described in ISO 9000:2015 (International Organization for Standardization, 2015) are written for any type of organization, so the real work is translating them into the language of the selected process. In this section each principle is applied to the process with a practical example. The potential strengths, gaps and opportunities for all seven are summarized in the table at the end of the section.

3.1 Customer Focus

Customer focus means understanding what customers need and expect and aiming to meet or exceed those expectations. Customers include beneficiaries and users as well as internal customers who depend on the process to do their own work.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

3.2 Leadership

Leaders at all levels establish unity of purpose and direction and create conditions in which people are engaged in achieving the organization’s quality objectives. Leadership is visible in small signals: what appears on management agendas, which budgets are protected, and how senior staff behave.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

3.3 Engagement of People

Competent, empowered and engaged people at all levels are essential to creating and delivering value. If frontline staff see the process as imposed on them, compliance tends to be fragile; if they see it as part of their own professional standard, it becomes far more stable.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

3.4 Process Approach

Consistent and predictable results are achieved more effectively when activities are understood and managed as interrelated processes. This principle is the foundation of the project: the selected topic is mapped as one process with inputs, steps, outputs and feedback loops rather than as separate rules.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

3.5 Improvement

Successful organizations have an ongoing focus on improvement. The PDSA cycle is the main improvement method in this project because it allows small tests of change before a full rollout.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

3.6 Evidence-Based Decision Making

Decisions based on the analysis and evaluation of data are more likely to produce the desired results. Where no baseline exists, the project should insist on baseline measurement first rather than assuming what the problems are.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

3.7 Relationship Management

For sustained success, organizations manage their relationships with interested parties such as suppliers, contractors, regulators and accreditation bodies.

> *[Apply this principle to the selected process with one practical example. Identify a potential strength, a potential gap that requires on-site verification, and one improvement opportunity.]*

Table 6: Summary of quality principles applied to [PROJECT SUBJECT]

Principle	Potential strength	Potential gap (to be verified)	Improvement opportunity
Customer focus	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*
Leadership	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*
Engagement of people	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*
Process approach	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*
Improvement	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*
Evidence-based decisions	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*
Relationship management	*[Strength]*	*[Gap: REQUIRES ON-SITE VERIFICATION]*	*[Opportunity]*

3.8 Internal and External Customers

A process has customers at both ends. Internal customers are people inside the organization who receive something from the process or depend on it to do their own work. External customers are people outside the organization who receive the final service. The table below explains why each group matters.

Table 7: Customers of [PROJECT SUBJECT] and why they matter

Type	Customer group	Why this group matters to the process
Internal	*[Frontline staff]*	*[What they need from the process and how they are affected]*
Internal	*[Support and environmental services]*	*[...]*
Internal	*[Quality and management staff]*	*[...]*
Internal	*[Stores / procurement and other departments]*	*[...]*
External	Beneficiaries / users	*[Main beneficiaries; what they expect from the process]*
External	Families and related third parties	*[...]*
External	Visitors and the community	*[...]*
External	Regulators and accreditation bodies	*[Requirements assessed]*

> *[Add or remove rows to reflect the real customer groups of the process.]*

3.9 Customer Satisfaction

Users cannot usually judge technical quality directly, but they form strong impressions from what they can see and hear. User perception is therefore a legitimate part of measuring the process, though it cannot replace direct observation or documented data. Complaints and feedback are also valuable: a complaint is not only a service issue, it may point to a gap in the process. Complaints related to the selected topic should be tagged in the complaint log so that the process owner can review them.

> *[State what satisfaction or complaint data were available. If none, keep the sentence "No satisfaction results or complaint data were available for this project, so the following tools are proposed rather than evaluated."]*

Table 8: Proposed tools for measuring and responding to customer satisfaction

Tool	Description	Use in the process
User satisfaction questionnaire	Short questionnaire (Appendix F) given at the end of a service or visit.	Tracks user perception over time; reviewed *[quarterly]* by *[responsible group]*.
Complaint log	Existing complaint system with a category for *[topic-related concerns]*.	Allows relevant complaints to be identified, analysed and linked to corrective action.
Feedback mechanism	*[Suggestion box, QR code or brief verbal feedback]*	Gives users an easy way to raise concerns in real time.
Service recovery process	A clear, respectful response when a user raises a concern: acknowledge, apologize where appropriate, correct the issue and inform the manager.	Protects trust and turns a complaint into an improvement opportunity.

4. Measurement and Monitoring of Quality Indicators

What gets measured gets managed, but what gets measured badly can be managed in the wrong direction. Indicators should therefore be chosen carefully, with a preference for measures that are directly observable, meaningful to frontline staff, feasible with the data systems available, and closely linked to the practices at the centre of the process.

Process indicators measure whether the right things are being done; outcome indicators measure the results for beneficiaries. Outcome indicators are important, but they need reliable definitions and data sources, enough volume to give stable rates, and they respond slowly to change. Process indicators give faster, more actionable feedback and show which behaviour needs attention.

4.1 Selection of the Key Performance Indicators

> *[Select the KPIs, one for each core practice within the scope of the project, and justify the choice in two or three sentences. This template provides four indicator cards; add or remove cards as your program requires.]*

1. KPI 1: *[KPI 1 name]*
2. KPI 2: *[KPI 2 name]*
3. KPI 3: *[KPI 3 name]*
4. KPI 4: *[KPI 4 name]*

No baseline values exist for any indicator until baseline measurement has been carried out. Targets shown in the cards are proposed targets, subject to baseline measurement, and should be reviewed by the responsible committee once the first round of data has been collected. A target far above the baseline can discourage staff, while one too close to it offers little challenge.

4.2 Indicator Cards

KPI 1: [KPI 1 name]

Table 9: Indicator card – [KPI 1 name]

Indicator name	*[KPI 1 name]*
Indicator type	*[Process / outcome / balancing indicator]*
Definition	*[Define precisely what is measured: the population, setting, time period and the standard against which performance is judged.]*
Purpose	*[State why the indicator matters and how the results will be used.]*
Numerator	*[Number of observations or events that meet the standard.]*
Denominator	*[Total number of observations or events eligible for inclusion.]*
Calculation formula	(*[Numerator]* ÷ *[Denominator]*) × 100
Unit of measurement	*[Percentage (%) / rate per 1,000 user-days / other]*
Target	*[Proposed target — subject to baseline measurement]*

Baseline	*[DATA REQUIRED: baseline to be established through initial measurement]*
Data source	*[Audit form, record or system, for example an appendix tool]*
Data collection method	*[Direct observation / record review / other; who collects; sample size; shifts covered]*
Frequency	*[Monthly per unit during the project; quarterly afterwards]*
Responsible person / department	*[Role and department]*
Reporting method	*[Report format, audience and schedule]*
Inclusion criteria	*[Which observations count]*
Exclusion criteria	*[Which observations are excluded and why]*
Interpretation	*[State whether higher or lower is better and how to read results by unit, shift and staff group.]*
Action if target is not met	*[Feedback timeline; analysis of lowest-performing areas; check of resources; targeted coaching; re-audit date.]*

KPI 2: [KPI 2 name]

Table 10: Indicator card – [KPI 2 name]

Indicator name	*[KPI 2 name]*
Indicator type	*[Process / outcome / balancing indicator]*
Definition	*[Define precisely. See KPI 1 guidance.]*
Purpose	*[Purpose]*
Numerator	*[Numerator]*
Denominator	*[Denominator]*
Calculation formula	(*[Numerator]* ÷ *[Denominator]*) × 100
Unit of measurement	*[Percentage (%) / rate per 1,000 user-days / other]*
Target	*[Proposed target — subject to baseline measurement]*
Baseline	*[DATA REQUIRED: baseline to be established through initial measurement]*
Data source	*[Data source]*
Data collection method	*[Method]*
Frequency	*[Monthly per unit during the project; quarterly afterwards]*
Responsible person / department	*[Role and department]*
Reporting method	*[Reporting]*
Inclusion criteria	*[Inclusion]*
Exclusion criteria	*[Exclusion]*
Interpretation	*[Interpretation]*
Action if target is not met	*[Follow-up action]*

KPI 3: [KPI 3 name]

Table 11: Indicator card – [KPI 3 name]

Indicator name	*[KPI 3 name]*
Indicator type	*[Process / outcome / balancing indicator]*
Definition	*[Define precisely. See KPI 1 guidance.]*
Purpose	*[Purpose]*
Numerator	*[Numerator]*
Denominator	*[Denominator]*
Calculation formula	(*[Numerator]* ÷ *[Denominator]*) × 100
Unit of measurement	*[Percentage (%) / rate per 1,000 user-days / other]*
Target	*[Proposed target — subject to baseline measurement]*
Baseline	*[DATA REQUIRED: baseline to be established through initial measurement]*
Data source	*[Data source]*
Data collection method	*[Method]*
Frequency	*[Monthly per unit during the project; quarterly afterwards]*
Responsible person / department	*[Role and department]*
Reporting method	*[Reporting]*
Inclusion criteria	*[Inclusion]*
Exclusion criteria	*[Exclusion]*
Interpretation	*[Interpretation]*
Action if target is not met	*[Follow-up action]*

KPI 4: [KPI 4 name]

Table 12: Indicator card – [KPI 4 name]

Indicator name	*[KPI 4 name]*
Indicator type	*[Process / outcome / balancing indicator]*
Definition	*[Define precisely. See KPI 1 guidance.]*
Purpose	*[Purpose]*
Numerator	*[Numerator]*
Denominator	*[Denominator]*
Calculation formula	(*[Numerator]* ÷ *[Denominator]*) × 100
Unit of measurement	*[Percentage (%) / rate per 1,000 user-days / other]*
Target	*[Proposed target — subject to baseline measurement]*
Baseline	*[DATA REQUIRED: baseline to be established through initial measurement]*
Data source	*[Data source]*

Data collection method	*[Method]*
Frequency	*[Monthly per unit during the project; quarterly afterwards]*
Responsible person / department	*[Role and department]*
Reporting method	*[Reporting]*
Inclusion criteria	*[Inclusion]*
Exclusion criteria	*[Exclusion]*
Interpretation	*[Interpretation]*
Action if target is not met	*[Follow-up action]*

4.3 Data Collection, Validation and Reporting

A good indicator can be spoiled by poor data collection. Three practical issues deserve attention. The first is **auditor training**: two auditors observing the same practice should record the same result, so auditors should practise together with the same tools and compare results until they agree. The second is the **Hawthorne effect**: staff tend to perform better when they know they are being watched. It cannot be removed completely, but it can be reduced by making observation routine and varying the times of audit. The third is **sampling**: a result based on very few observations tells little, so a minimum number of observations per unit per period should be agreed before results are reported.

Results should be reported in a simple format that frontline staff understand. A run chart for each KPI, by unit, is more useful than a single organization-wide percentage because it shows the trend and where attention is needed. A blank KPI dashboard template is provided in Appendix E. Results should be fed back to audited units within a short, agreed time, because feedback that arrives months later has little effect on behaviour.

> *[State the minimum sample size, the agreed feedback timeline, the auditors and how inter-observer agreement will be checked.]*

Table 13: Summary of the KPIs

KPI	Type	Proposed target*	Data source
1. *[KPI 1 name]*	*[Type]*	*[Target]*	*[Data source]*
2. *[KPI 2 name]*	*[Type]*	*[Target]*	*[Data source]*
3. *[KPI 3 name]*	*[Type]*	*[Target]*	*[Data source]*
4. *[KPI 4 name]*	*[Type]*	*[Target]*	*[Data source]*

**Proposed targets subject to baseline measurement. Baseline to be established through initial measurement.*

5. Performance Improvement and Quality Tools

5.1 The Quality Problem

A quality improvement project needs one clear problem to work on. Trying to fix everything at once usually means fixing nothing properly. State the problem chosen, and state clearly whether it is a confirmed finding or a potential problem that requires baseline assessment.

> *[Insert the quality problem in one sentence. If no data confirm it, write that it is presented as a potential problem requiring baseline assessment, and explain why it was chosen.]*

Problem statement

> *[Write a short problem statement: what happens, where, to whom, how consistently, and the risk it creates. Use cautious wording ("may", "potential") unless the problem has been confirmed by documented data.]*

Evidence required

To confirm, measure or rule out the problem, evidence such as the following would be needed. Each item requires on-site verification:

- Baseline measurement of the KPIs in a representative sample of units and shifts.
- Review of current policies and SOPs, including version control and accessibility on the units.
- Review of existing audit records: frequency, tools used and whether results were fed back.
- Review of training and orientation records.
- Spot checks of the availability of supplies and equipment at points of service.
- Review of incident reports and complaints related to the topic.
- Brief structured discussions with staff from different professional groups about barriers.

> *[Edit the list to match the problem. Delete items that do not apply.]*

Who may be affected and why it matters

Table 14: Potential impact of [QUALITY PROBLEM]

Beneficiary / user impact	*[...]*
Staff impact	*[...]*
Organizational impact	*[...]*
Cost and time impact	*[...]*
Quality impact	*[...]*
Safety impact	*[...]*

5.2 Selection of Quality Tools

Many quality tools were covered in the diploma, and it is tempting to use all of them. Choose the tools that fit the problem and the information available, and explain why each was chosen. Process mapping locates failure points, a fishbone diagram organizes potential causes, Five Whys follows one line of reasoning to a systemic cause, and PDSA provides the improvement model. A Pareto chart should be used only when real frequency data exist; producing one without such data would give a false impression of evidence.

> *[List the tools selected and the reason for each. State any tool deliberately not used and why.]*

5.3 Process Mapping

The process map and the step analysis in Section 2 are the first quality tool used. Mapping forces specificity about who does what, which inputs are needed at each step and where the process can fail. The map should be validated with the people who carry out the process: walk through it with a member of each main staff group and ask where the real process differs from the drawn one. The differences are often where the most important improvement opportunities lie.

> *[Summarize what the mapping revealed about where the most likely failure points sit (before, during or after the point of service).]*

5.4 Fishbone Diagram

The fishbone (Ishikawa) diagram in the figure below organizes potential causes of variation into eight categories: people, process, equipment, environment, materials, measurement, communication and management. Causes should be drawn from the process analysis, the literature and experience, and each must be treated as an area requiring verification during baseline assessment until it is confirmed.

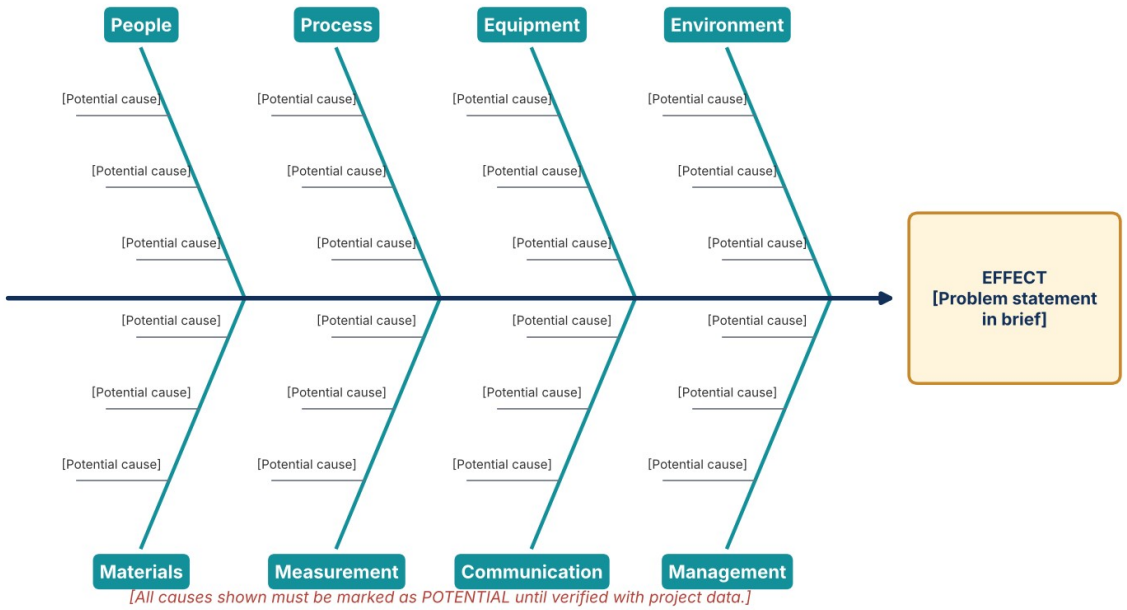


Figure 3: Fishbone diagram of potential causes of [QUALITY PROBLEM]

Some categories are closely linked. A shortage of materials may lead staff to improvise, which then appears as poor compliance in audits; if audit results are not fed back and corrective actions are not tracked, the shortage may never be addressed. The value of the fishbone lies partly in making these connections visible, so that individuals are not blamed for problems that start elsewhere in the system.

Table 15: Potential causes by category and how they could be verified

Category	Potential causes (require verification)	Verification method
People	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Process	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Equipment	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Environment	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Materials	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Measurement	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Communication	*[Potential causes]*	*[Observation / document review / records / staff discussion]*
Management	*[Potential causes]*	*[Observation / document review / records / staff discussion]*

5.5 Five Whys Analysis

The fishbone gives a wide view of possible causes. Five Whys goes in the opposite direction: it follows one line of reasoning downward until it reaches a systemic cause. The answers are potential explanations based on the process analysis and must be tested against real data before any of them is treated as confirmed.

Table 16: Five Whys analysis of [QUALITY PROBLEM]

Level	Question	Potential answer (requires verification)
Problem	What is the problem?	*[Problem statement]*
Why 1	Why might the problem occur?	*[...]*
Why 2	Why would that happen?	*[...]*
Why 3	Why might that be the case?	*[...]*
Why 4	Why might that be the case?	*[...]*
Why 5	Why might that be the case?	*[...]*
Potential root cause		*[State the systemic root cause and mark it as requiring confirmation through baseline assessment.]*

A line of reasoning that leads away from blaming individuals and toward the design of the system suggests that education alone, although necessary, is rarely enough. If staff are trained but never audited, never receive feedback and never see their managers discuss the results, performance is likely to drift.

> *[State what the Five Whys analysis suggests for the design of the improvement project in Section 6.]*

6. Quality Improvement Project

This section brings the previous analysis together into a single quality improvement (QI) project. It follows the Model for Improvement (Langley et al., 2009), which asks three questions: what are we trying to accomplish, how will we know that a change is an improvement, and what changes can we make that will result in improvement? The project should be realistic for the organization's own staff to carry out, without large capital investment.

Table 17: Quality improvement project charter

Project title	*[PROJECT TITLE]*
Organization	*[ORGANIZATION NAME]*
Process	*[PROJECT SUBJECT]*
Problem	*[Quality problem; requires baseline assessment if unconfirmed]*
Scope	*[Practices, pilot units, and intended spread]*
Proposed sponsor	*[Role]*
Proposed process owner	*[Role]*
Proposed team	*[Roles and departments represented]*
Measures	*[KPIs defined in Section 4, with process and balancing measures (Section 6.6)]*
Proposed duration	*[Number of months for the initial project, followed by routine monitoring]*

6.1 Aim Statement

> *[Write the aim statement. State what will improve, where, by how much and by when. If no baseline exists, state the aim without numbers and add that numerical targets will be set after baseline measurement. Proposed targets are subject to baseline measurement.]*

6.2 Improvement Objectives

> *[Break the aim down into SMART objectives. Because a baseline may not yet exist, leave numerical elements to be completed after the first measurement.]*

1. Establish a baseline for all KPIs in the pilot units within *[number]* months, using standardized audit tools and trained auditors.
2. Review and standardize the SOPs for the selected practices and make one-page summaries available in every pilot unit by *[month]*.
3. Ensure that relevant staff in the pilot units receive practical education and a documented competency check by *[month]*.
4. Provide written feedback of audit results to each audited unit within *[timeframe]* of every audit during the project.
5. Open a corrective action plan for every KPI result below target and track each action until closure.

6. Improve each KPI toward its proposed target, with the level of improvement defined after baseline measurement.

6.3 Interventions

The interventions below are proposals. Proposing an intervention does not mean it is currently absent: some may already exist in part, in which case the project should strengthen what is there. They are grouped according to the potential causes identified in the fishbone and Five Whys analyses, since an intervention that does not address a cause is unlikely to last.

Table 18: Proposed interventions linked to potential causes

Intervention	Description	Addresses (cause category)	KPI
Standardized SOPs	*[Review SOPs against current national and international guidance; one approved version in all units; one-page summaries]*	Process	*[1–4]*
Staff education	*[Practical, scenario-based sessions for each KPI topic; include all relevant staff groups]*	People	*[ ]*
Competency assessment	*[Observed practical checklist signed off for each staff member (Appendix H); repeated yearly]*	People, Measurement	*[ ]*
Staff orientation	*[Module for all new, rotating and temporary staff before they start work on a unit]*	People	*[ ]*
Visual reminders	*[Posters or charts at the point of service]*	Communication	*[ ]*
Point-of-service supplies	*[Supplies at the point of use; daily supply checklist; agreed par levels]*	Equipment, Materials	*[ ]*
Audit tools	*[Standardized audit tools for all KPIs (Appendices A–D); auditor training]*	Measurement	*[ ]*
Feedback mechanisms	*[Written feedback within the agreed time; unit huddles; results displayed on unit notice boards]*	Communication	*[ ]*
KPI dashboard	*[Monthly dashboard by unit (Appendix E) reviewed by the responsible committee and management]*	Management	*[ ]*
Corrective action plans	*[Standard form (Appendix G) with owner and deadline; tracked until closure]*	Management	*[ ]*
Re-audit	*[Re-audit of any unit below target within the agreed time]*	Measurement	*[ ]*

> *[Edit, delete or add interventions so that each one addresses a verified or potential cause identified in Section 5.]*

6.4 Implementation

The project is planned in phases. The detailed timeline is given in Section 15; the logic is outlined here.

> *[Describe each phase in one short paragraph: Preparation (team formation, tool finalization, auditor training, pilot unit selection); Baseline (measurement of all KPIs for at least [number] weeks across*

shifts, plus review of documents, training records and supplies); Intervention and first PDSA cycle; Study, adapt and spread. State the months for each phase. The choice of pilot units requires on-site discussion with organization management.]

6.5 PDSA Cycle



Figure 4: PDSA cycle for the [PROJECT TITLE] improvement project

Table 19: Application of the PDSA cycle

PLAN	Define the problem. Form the team, select pilot units and prepare standardized audit tools. Establish the baseline for the KPIs. Agree the intervention package and a testable prediction. Decide who will do what, when and where. *[Insert the prediction for this project in the form "If [change]*, then *[expected result]*."]
DO	Implement the interventions in the pilot units on a small scale. Carry out audits with the same tools as the baseline. Record problems and unexpected effects, and keep a simple project log.
STUDY	Analyse the KPIs and audit findings. Compare them with the baseline and the predictions using run charts, by unit, shift, staff group and type of error. Review the balancing measures to make sure the changes have not created new problems. Ask staff what helped and what got in the way.
ACT	Decide for each intervention whether to adopt it (it worked and can be spread), adapt it (it partly worked and needs modification) or abandon it (it did not work or caused problems). Update SOPs and tools, and plan the next cycle.

The PDSA cycle is not meant to be run once. After the first cycle in the pilot units, a second cycle can spread the adapted interventions to more units, and later cycles can target specific weaknesses revealed by the data. Each cycle should be short enough to keep momentum, usually one to three months, and should begin with a clear prediction that can be tested.

6.6 Measurement Plan

The measurement plan uses three types of measures, as recommended in the Model for Improvement. Outcome measures show whether the project is achieving its aim. Process

measures show whether the interventions are being carried out as planned. Balancing measures check that improvement in one area has not caused problems in another. All measures should be consistent with the selected KPIs; process and balancing measures are monitoring aids and are not additional KPIs.

Table 20: Measurement plan: outcome, process and balancing measures

Type	Measure	Link to the KPIs
Outcome	*[Change in the KPIs from baseline in the pilot units and then organization-wide]*	The KPIs themselves
Process	Proportion of pilot-unit staff who completed education and competency check	Supports all KPIs
Process	Proportion of audits whose results were fed back to the unit within the agreed time	Supports all KPIs
Process	Proportion of corrective actions closed by their due date	Supports all KPIs
Process	*[Proportion of points of service with required supplies and equipment available at spot check]*	*[Supports KPIs ...]*
Balancing	*[Possible negative side effect of an intervention, for example staff-reported irritation or overuse of supplies]*	*[Watches for side effects of KPI ...]*
Balancing	Staff time spent on audit and training, and staff perception of workload	Watches for the burden of monitoring

> *[State whether outcome data (for example incident or error rates) are used as project KPIs. If not, explain why (for example, no reliable surveillance data, or too short a project period to show change) and state that such data should be reviewed alongside the KPIs if they become available.]*

6.7 Sustainability

Many improvement projects succeed during the project period and then fade once attention moves elsewhere. Compliance often returns toward its original level unless monitoring and feedback continue. Sustainability should therefore be planned from the start rather than added at the end.

Table 21: Sustainability arrangements

Policies	*[Approved policies that define responsibilities for each step, including audit and feedback]*
SOPs	*[Standardized SOPs under document control, with a review interval]*
Orientation	*[Module included in general orientation for all new, rotating and temporary staff]*
Competency assessment	*[Frequency and recording of competency checks]*
Routine audits	*[Audits built into the annual plan with a fixed schedule]*
KPI monitoring	*[Reporting frequency once performance is stable]*
Feedback	*[Feedback timeline and forum]*
Leadership oversight	*[Standing item on the management or quality committee agenda]*
Quality dashboard	*[Integration into the organization quality dashboard]*

Periodic review	*[Annual review of the process map, risk register and targets]*
Corrective action	*[Standard process with owners, deadlines and tracking until closure]*
Continuous improvement	*[New PDSA cycles whenever a KPI falls below target or a new risk is identified]*

7. Risk Management

Risk management is about finding and dealing with threats to people, services and the organization before they cause harm. Where quality improvement asks how a process can work better, risk management asks what could go wrong and how it can be prevented or reduced. The two approaches support each other: the risk register should feed directly into the choice of interventions.

The approach follows the general steps of ISO 31000 (International Organization for Standardization, 2018): establishing the context, identifying risks, analysing and evaluating them, treating them, and monitoring and reviewing. The context is the selected process as mapped in Section 2. Risks are identified by working through each step of the process and asking what could fail, drawing on the failure points in the process analysis and the potential causes in the fishbone diagram.

7.1 Risk Assessment Method

Each risk is rated for likelihood and severity on a five-point scale, and the two ratings are multiplied to give a risk score between 1 and 25. Ratings that are not based on local incident data are **preliminary ratings**: they are a starting point for discussion and must be validated by the responsible committee using local incident reports, audit results and staff experience.

Table 22: Likelihood and severity scales used for risk rating

Score	Likelihood	Description	Severity	Description
1	Rare	May happen only in exceptional circumstances	Negligible	No harm; no impact on care
2	Unlikely	Could happen but not expected	Minor	Minor harm; first aid or short delay
3	Possible	Might happen occasionally	Moderate	Temporary harm needing extra treatment
4	Likely	Will probably happen in most circumstances	Major	Serious harm or prolonged stay
5	Almost certain	Expected to happen frequently	Catastrophic	Death, permanent harm or outbreak

Risk level = Likelihood × Severity: 1–4 Low; 5–9 Moderate; 10–16 High; 20–25 Extreme.

7.2 Risk Register

> *[Identify the main risks of the process, one row per risk. Show the potential cause, potential consequence, preliminary rating, proposed controls and suggested owner. Add rows as needed (a typical register has about ten to twelve risks).]*

Table 23: Risk register for [PROJECT SUBJECT] (preliminary ratings)

ID	Risk	Potential cause	Potential consequence	L	S	Score / level	Proposed controls	Owner
R1	*[Risk]*	*[Cause]*	*[Consequence]*	*[ ]*	*[ ]*	*[ ]*	*[Controls]*	*[Role]*
R2	*[Risk]*	*[Cause]*	*[Consequence]*	*[ ]*	*[ ]*	*[ ]*	*[Controls]*	*[Role]*

ID	Risk	Potential cause	Potential consequence	L	S	Score / level	Proposed controls	Owner
R3	*[Risk]*	*[Cause]*	*[Consequence]*	*[ ]*	*[ ]*	*[ ]*	*[Controls]*	*[Role]*
R4	*[Risk]*	*[Cause]*	*[Consequence]*	*[ ]*	*[ ]*	*[ ]*	*[Controls]*	*[Role]*
R5	*[Risk]*	*[Cause]*	*[Consequence]*	*[ ]*	*[ ]*	*[ ]*	*[Controls]*	*[Role]*
R6	*[Risk]*	*[Cause]*	*[Consequence]*	*[ ]*	*[ ]*	*[ ]*	*[Controls]*	*[Role]*

L = likelihood; S = severity. Ratings are preliminary and must be validated by the responsible committee using local data.

7.3 Risk Matrix

The figure below places the identified risks on a five-by-five matrix. Insert each risk ID in the cell that matches its likelihood and severity ratings.

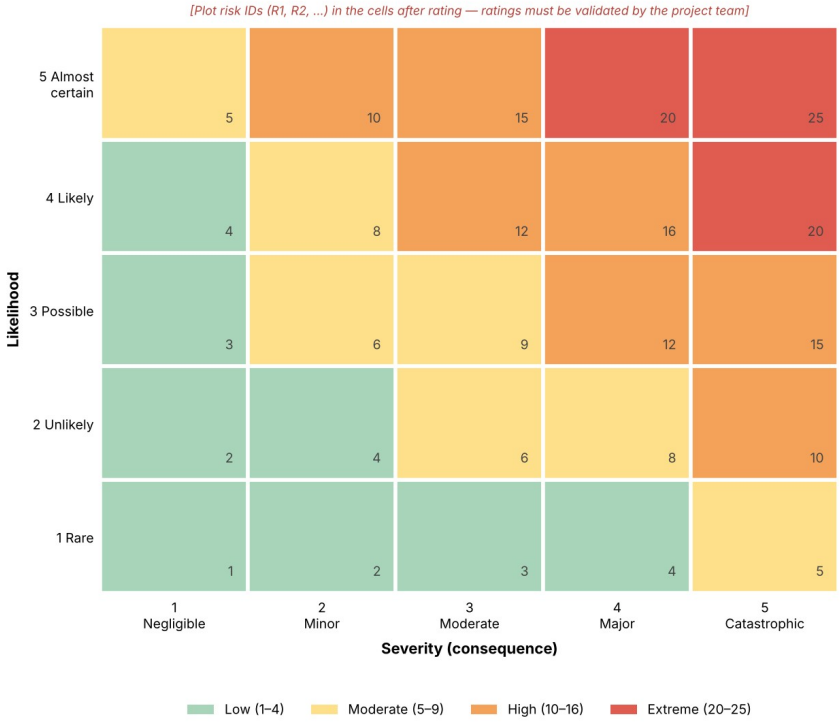


Figure 5: Risk matrix of [PROJECT SUBJECT] (preliminary ratings)

> *[Comment on where most risks fall, which have the highest scores, and which are low in likelihood but severe in consequence.]*

7.4 Risk Treatment, Monitoring and Review

Proposed controls should follow the hierarchy of controls as far as possible. Where a risk can be designed out, that is preferred, for example by placing equipment or supplies where they are needed so that correct practice becomes the easy option. Where design is not possible, administrative controls such as SOPs, training and audit are used, and personal protection is the final layer.

Several risks usually share the same controls, such as standardized audit, feedback and corrective action. The risk register should be reviewed by the responsible committee at least once a year and immediately after any serious incident, so that ratings and controls remain current. Risks with a score of 10 or more should be linked to the organization’s corporate risk register, if one exists.

Incident reporting is the main source of information for keeping the register alive. Staff should be encouraged to report incidents and near misses. A culture that treats reports as learning opportunities rather than reasons for blame will produce more reports, and more reports give a more accurate picture of risk.

8. Safety, Ethics and Stakeholder Considerations

Every applied project affects people. A well-designed project aims to reduce avoidable harm and unnecessary risk to beneficiaries, staff and the organization, and respects ethical principles such as consent, confidentiality and fairness.

> *[Explain how the project subject relates to recognized sources of avoidable harm or risk, using verified references: INSERT VERIFIED, RELEVANT REFERENCE.]*

8.1 A Systems View of Failures

James Reason's Swiss cheese model (Reason, 2000) is helpful for understanding how harm or failure can reach a person despite multiple safeguards. Each layer of defence has small holes. Most of the time the holes do not line up and people are protected; failure happens when several holes line up at once. The model explains why a project should not focus on one practice alone, and why blaming individuals is rarely effective: the person at the point of service is usually the last hole in a line that began earlier, with a supply problem, a training gap or a heavy workload.

> *[Apply the model to the project subject: name the layers of defence and the holes that could line up.]*

8.2 Safety Culture and Just Culture

A strong safety culture is one where staff feel able to report errors and hazards, speak up when they see a risk and trust that the organization will respond fairly. Speaking up can be difficult across professional or seniority gaps, and leaders set the tone. Just culture recognizes that most errors come from system problems and honest mistakes, which should be met with support and system improvement, while reckless disregard for safety rules still needs accountability. Audit and feedback should be designed in this spirit: results presented at unit level, not used to name and punish individuals, and poor results triggering a search for causes.

> *[State what is known about the safety culture of the organization. If unknown, describe it as an area requiring assessment.]*

8.3 Links with Safety and Quality Goals

The project subject may address a safety or quality goal directly and support other goals indirectly, as the table below shows.

Table 24: Links between [PROJECT SUBJECT] and safety, quality and ethics goals

Area	How the project contributes
[Primary safety or quality goal]	*[Directly addressed through ...]*
Staff safety and wellbeing	*[...]*
Safe practice and procedures	*[...]*
Effective communication	*[...]*
User and stakeholder engagement	*[...]*

Area	How the project contributes
Incident reporting and learning	*[...]*

8.4 Ethical Considerations and Data Protection

> *[State the ethical approvals, consent procedures, confidentiality and data-protection measures that apply, and how participants and data are protected. Do not claim any approval or clearance that was not actually obtained: use [REQUIRES VERIFICATION] where unsure.]*

9. Contemporary Management

Contemporary management concepts (leadership, change management, teamwork, communication, motivation and decision-making) can seem distant from the practical detail of a process, but they decide whether a quality project succeeds. Good tools and SOPs achieve little if staff are not motivated, managers are not involved, or the change is introduced in a way that creates resistance.

9.1 Leadership Style

No single leadership style fits every situation. Transformational leadership helps staff connect the work to their professional values and to the people they serve. Participative leadership involves frontline staff in designing solutions, because they often know best why a procedure is not working. Some safety rules are not open to negotiation, and here a clear, directive approach is appropriate. Role modelling deserves special mention: junior staff are influenced by what senior colleagues do.

> *[Describe the leadership approach proposed for the project and how leaders will role-model the practices.]*

9.2 Managing Change

Kurt Lewin described change in three stages: unfreezing, changing and refreezing. Unfreezing happens when baseline results are shared honestly and the reasons for change are explained in terms that matter to staff. Changing is the implementation of the interventions through PDSA cycles. Refreezing is the sustainability phase, when new practice is built into SOPs, orientation, audit schedules and the management agenda. Kotter's (1996) eight steps give more detail for larger changes, for example creating urgency, forming a guiding coalition, communicating the vision, generating short-term wins and anchoring the change in the culture. Resistance should be expected; listening, involving staff and keeping audit non-punitive are the best responses.

> *[Map the project's activities onto the stages of Lewin's model or Kotter's steps, and identify likely sources of resistance.]*

9.3 Teamwork and Communication

Quality processes depend on teamwork across professional boundaries. The project team should include the staff groups who act at each step, because a solution designed by one group alone may fail where another group needs to act. Short unit huddles are a practical way to share audit results and raise problems, and structured communication tools such as SBAR can help when escalating a concern.

> *[Describe the project team, the communication routes and any structured communication tools used.]*

9.4 Motivation and Recognition

Herzberg's two-factor theory suggests that some factors, such as working conditions and supplies, prevent dissatisfaction but do not motivate by themselves, while others, such as recognition and a sense of achievement, do motivate. Having supplies and equipment available is a hygiene factor; recognition of improvement works on the other side.

> *[Describe how the project will recognize improvement (for example, feedback to the most improved unit, certificates for local champions).]*

9.5 Lean Thinking and Resource Management

Lean thinking aims to remove waste from processes. Time lost searching for supplies is waste, and placing supplies at the point of use removes it. The 5S approach (sort, set in order, shine, standardize, sustain) can be used to standardize the layout of supplies so that correct practice becomes the easy option.

> *[Identify forms of waste in the selected process and how they will be reduced.]*

9.6 Decision-Making and Delegation

Decisions in the project should follow the evidence-based principle discussed in Section 3, with baseline and follow-up data guiding which interventions are adopted or dropped. Delegation matters too: a core team cannot audit every unit alone, so local champions are a form of structured delegation. For delegation to work, champions need clear responsibilities, training, protected time and the support of their unit managers; otherwise the role becomes one more task on a full workload and quickly lapses.

> *[State who decides what in the project, and what is delegated, to whom and with what support.]*

10. Standards, Regulation and Compliance

Standards, regulations and accreditation frameworks describe the minimum requirements an organization needs to meet in order to deliver safe, reliable work. They are more than a checklist for inspection day: they define the system that should be in place every day.

> *[Identify the standards, regulations or accreditation frameworks relevant to the project (for example ISO standards, national regulations or sector accreditation). State the edition used and confirm it is the one in force. Refer to chapters or clauses rather than copying standard wording.]*

10.1 Linking the Project to Standards

Table 25: Links between the project and relevant standards

Standard / requirement	Relevant expectation (general)	How this project contributes
[Standard or clause 1]	*[Expectation, summarized in your own words]*	*[How the project meets or supports it]*
[Standard or clause 2]	*[Expectation, summarized in your own words]*	*[How the project meets or supports it]*
[Standard or clause 3]	*[Expectation, summarized in your own words]*	*[How the project meets or supports it]*
[Standard or clause 4]	*[Expectation, summarized in your own words]*	*[How the project meets or supports it]*

> *[ILLUSTRATIVE EXAMPLE — NOT ACTUAL PROJECT DATA]* A project in a regulated sector could link each requirement to the relevant chapter or clause of the applicable standard, for example governance, quality improvement, risk management, workforce competence and environmental safety. Confirm names and numbering against the edition in force.

10.2 Compliance Readiness Self-Assessment

The table below is a proposed readiness checklist. The status column is deliberately left as “Requires on-site verification”: no actual compliance status may be reported unless it is documented, and compliance must never be assumed.

Table 26: Proposed compliance readiness checklist

Item to verify	Evidence to review	Status
An approved policy or programme and annual plan exist for the project subject	*[Policy document; annual plan]*	*[REQUIRES ON-SITE VERIFICATION]*
The responsible committee or team meets regularly and minutes are kept	*[Minutes]*	*[REQUIRES ON-SITE VERIFICATION]*
Policies and procedures are current and available to staff	*[Document control records]*	*[REQUIRES ON-SITE VERIFICATION]*
Performance is monitored and results fed back	*[Audit records; feedback reports]*	*[REQUIRES ON-SITE VERIFICATION]*
Staff receive orientation and competency assessment	*[Training and competency records]*	*[REQUIRES ON-SITE VERIFICATION]*

Item to verify	Evidence to review	Status
Indicators are reported to leadership	*[Dashboard; management minutes]*	*[REQUIRES ON-SITE VERIFICATION]*
[Add further items]	*[Evidence]*	*[REQUIRES ON-SITE VERIFICATION]*

Compliance readiness should not be approached as a short campaign before an inspection. Inspectors typically observe practice directly and talk with frontline staff. Staff who have been trained, audited and given feedback over months will answer questions and demonstrate practice with much more confidence than staff who received a briefing the week before the visit.

11. Technical Background of the Project Subject

[Replace this section with the technical content for the project subject. It should show how each component fits into the process and where the quality management tools apply. It is not intended as a full manual: refer readers to national guidelines and the organization's own approved policies for detailed procedures.]

11.1 Core Concepts

[Explain the key concept that underlies the project subject and why understanding the reason for a practice improves compliance more than a rule alone.]

11.2 Components of the Process

Table 27: Components of [PROJECT SUBJECT] and their place in the project

Component	Key practice points	Place in this project
[Component 1]	*[Key practice points drawn from verified guidance]*	*[KPI, risk register item or intervention]*
[Component 2]	*[Key practice points drawn from verified guidance]*	*[KPI, risk register item or intervention]*
[Component 3]	*[Key practice points drawn from verified guidance]*	*[KPI, risk register item or intervention]*
[Component 4]	*[Key practice points drawn from verified guidance]*	*[KPI, risk register item or intervention]*

11.3 Priority Practice in More Detail

[Describe the practice with the strongest evidence or the greatest risk in more detail. Where an evidence-based strategy exists, summarize its elements and show which of them are included in the proposed interventions. INSERT VERIFIED, RELEVANT REFERENCE.]

11.4 Supporting Practices and Enabling Conditions

[Describe supporting practices, and the resources, roles and training needed for staff to carry them out correctly. Show how they are involved in training and feedback.]

12. Integrated Analysis

Each section of the project looks at the selected process from a different angle. This section puts those views side by side to check that they are consistent and to show how they support one another. The table below follows the project logic across the core practices, from description through potential gap, impact, potential root cause, intervention and measurement to sustainability.

Table 28: Integrated analysis of the core practices

Element	[Practice 1]	[Practice 2]	[Practice 3]	[Practice 4]
Expected process	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Potential gap (to be verified)	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Impact	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Potential root cause	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Intervention	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Measurement	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Main risks	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Accreditation link	*[ ]*	*[ ]*	*[ ]*	*[ ]*
Sustainability	*[ ]*	*[ ]*	*[ ]*	*[ ]*

Three messages should come out of an integrated view. The first is **consistency**: if the same potential root cause appears under several practices and the same core intervention package addresses it, the project is one project with several measures rather than several separate projects. The second is that **the quality tools confirm each other**: the process map locates likely failure points, the fishbone organizes their possible causes, the Five Whys traces them to a systemic cause, the risk register rates them, and the KPIs test whether they are real and whether the interventions work. The third is a **limitation**: every gap and cause is a potential one, and the analysis is only as strong as the baseline that must follow it. This is the strength of the PDSA approach, which allows the plan to be corrected by real data rather than defended against it.

> *[Add two or three sentences on what the integrated analysis shows for this project, and which priorities may shift once baseline data are available.]*

13. Conclusion

13.1 Summary of the Project

> *[Summarize in one paragraph each: (1) the process and its customers; (2) the process analysis, quality principles, indicators and the root cause identified; (3) the QI project, measurement plan, risk register and links to user safety, management and accreditation. State outcomes as expected or intended, never as achieved, unless verified results exist.]*

13.2 Limitations

> *[State the limitations honestly: data that were not available, evidence that was not verified, the proposed (not measured) nature of targets, and any restrictions on scope, time or access. State that the project does not claim to describe current performance if no organization data were available.]*

13.3 Concluding Remarks

> *[Close with what the project offers and what the organization should do next (for example, establish a baseline and run the first PDSA cycle). An optional personal reflection on what the project changed in your understanding of quality management may be added here if your program permits.]*

14. Recommendations

The following recommendations are addressed to the different groups involved in the process. They are proposals based on the analysis in this project, and each should be adapted after baseline assessment.

> *[Insert recommendations supported by the documented findings. Each recommendation should be specific, actionable and linked to a finding, risk or intervention in the project. Add or remove groups as required.]*

For organization leadership

- *[Recommendation 1]*
- *[Recommendation 2]*

For the process owner and quality team

- *[Recommendation 1]*
- *[Recommendation 2]*

For operational staff

- *[Recommendation 1]*
- *[Recommendation 2]*

For support services (for example administration, procurement, maintenance)

- *[Recommendation 1]*
- *[Recommendation 2]*

For the quality department

- *[Recommendation 1]*
- *[Recommendation 2]*

For beneficiaries and users

- *[Recommendation 1]*
- *[Recommendation 2]*

15. Implementation Plan

The implementation plan translates the QI project into specific activities with responsibilities, timeframes, resources and evidence of completion. The timeline is proposed and should be confirmed with organization leadership. Month 1 begins on the date the project is formally approved.

Table 29: Implementation plan

No.	Activity	Responsible	Timeline	Resources	Evidence of completion
1	Obtain leadership approval; form project team; select pilot units	*[Role]*	*[Month 1]*	*[Resources]*	Approved charter; team list
2	Finalize audit tools; train auditors and check agreement	*[Role]*	*[Month 1]*	*[Resources]*	Training record; tools approved
3	Baseline measurement of the KPIs	*[Role]*	*[Months 1–2]*	*[Resources]*	Baseline report
4	Review documents, training records and supplies	*[Role]*	*[Months 1–2]*	*[Resources]*	Gap summary
5	Review and standardize SOPs; prepare summaries	*[Role]*	*[Month 2]*	*[Resources]*	Approved SOPs
6	Practical education and competency assessment	*[Role]*	*[Months 2–3]*	*[Resources]*	Attendance and competency records
7	Install visual reminders and point-of-service supplies; supply checklist	*[Role]*	*[Months 2–3]*	*[Resources]*	Spot-check record
8	PDSA cycle 1 in pilot units: audit, feedback, corrective action	*[Role]*	*[Months 3–4]*	*[Resources]*	Monthly reports; action tracker
9	Study results and adapt interventions	*[Role]*	*[Month 4]*	*[Resources]*	PDSA study report
10	Spread to remaining units (PDSA cycle 2)	*[Role]*	*[Months 5–6]*	*[Resources]*	Training records; audit reports
11	Re-audit and comparison with baseline	*[Role]*	*[Month 6]*	*[Resources]*	Re-audit report
12	Report to leadership; hand over to routine monitoring	*[Role]*	*[Month 6]*	*[Resources]*	Final report; management minutes

> *[Edit activities, responsible roles, timelines and resources to match the approved plan. Replace the proposed months with real dates after leadership approval.]*

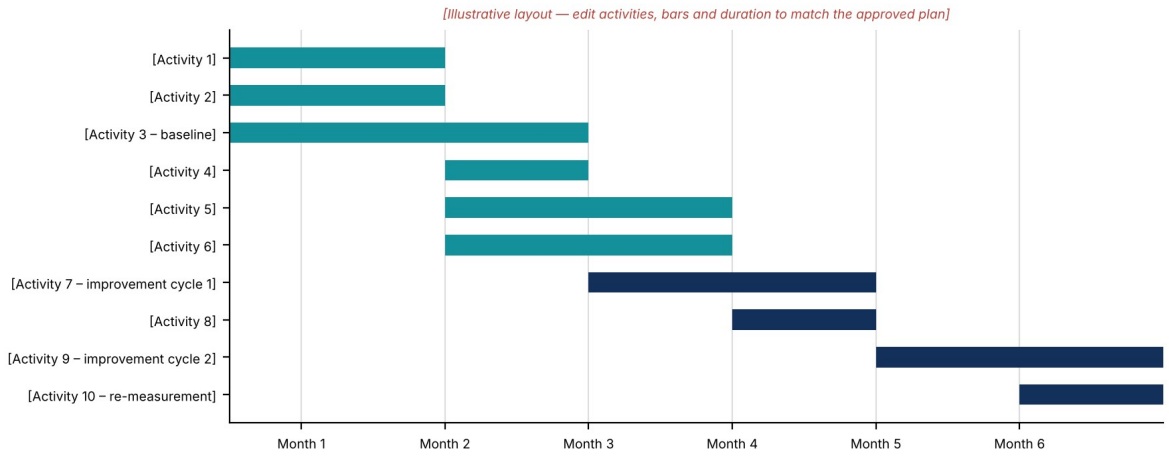


Figure 6: Proposed implementation timeline (Gantt chart)

Resources should be kept modest where possible. Most of the cost is usually staff time for training and audit, together with consumables and printed tools.

> *[Describe the main resources required and any optional enhancements if additional funding becomes available.]*

16. References

> *[Use the citation style required by your program consistently. Every in-text citation must appear in this list, and every entry must be a verified, traceable source you have actually consulted. Do not invent publications, DOIs, URLs or quotations. The references below are those cited in the reusable guidance of this template; confirm each against your program's requirements and the current edition before submission.]*

International Organization for Standardization. (2015). ISO 9000:2015 Quality management systems: Fundamentals and vocabulary. Geneva: ISO.

International Organization for Standardization. (2018). ISO 31000:2018 Risk management: Guidelines. Geneva: ISO.

Kotter, J. P. (1996). Leading change. Boston, MA: Harvard Business School Press.

Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). The improvement guide: A practical approach to enhancing organizational performance (2nd ed.). San Francisco, CA: Jossey-Bass.

Reason, J. (2000). Human error: Models and management. BMJ, 320(7237), 768–770.

[INSERT VERIFIED, RELEVANT REFERENCE]

[INSERT VERIFIED, RELEVANT REFERENCE]

[INSERT VERIFIED, RELEVANT REFERENCE]

17. Appendices

The following appendices contain blank tools proposed for use during the project. They are templates only and contain no organization data. Items shown as illustrative examples must be adapted to the project subject. Each tool should be reviewed and approved by the responsible committee or supervisor before use.

Appendix A: Direct Observation Form

Table 30: Observation form – session details

Unit / area	*[ ]*
Date	*[ ]*
Session start / end time	*[ ]*
Observer name	*[ ]*
Shift / period	*[ ]*

Table 31: Observation form – observation record

No.	Role / group observed	Activity or step observed	Result: Compliant / Not compliant / N/A	Comments
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

[Define the observation criteria and what counts as compliant before using this form.]

Appendix B: Compliance Audit Checklist

Table 32: Compliance audit checklist

No.	Criterion	Yes	No	N/A	Notes
1	*[Criterion 1]*				
2	*[Criterion 2]*				
3	*[Criterion 3]*				
4	*[Criterion 4]*				

No.	Criterion	Yes	No	N/A	Notes
5	*[Criterion 5]*				
6	*[Criterion 6]*				
7	*[Criterion 7]*				
8	*[Criterion 8]*				

[State the rule for when an activity counts as compliant, for example only if all applicable criteria are marked Yes.]

Appendix C: Document and Record Review Checklist

Table 33: Document and record review checklist

No.	Document or record	Available (Yes / No)	Current version / date	Comments
1	*[Policy or procedure]*			
2	*[Training and orientation records]*			
3	*[Previous audit reports]*			
4	*[Incident reports]*			
5	*[Complaint log]*			
6	*[Committee or meeting minutes]*			

Appendix D: Interview and Focus Group Guide

> *[ILLUSTRATIVE EXAMPLE — NOT ACTUAL PROJECT DATA]* Starter questions; adapt them to the project subject and the group interviewed.

Table 34: Interview and focus group guide

No.	Question	Notes
1	*[Opening question: role and experience]*	
2	What works well in the current process?	
3	What are the main barriers or delays?	
4	What would make the process easier or more reliable?	
5	*[Topic-specific question]*	
6	*[Closing question: anything else to add?]*	

Obtain consent before interviewing, explain how the information will be used, and protect confidentiality. Record only what the participant agrees to share.

Appendix E: KPI Dashboard Template

Table 35: KPI dashboard template (to be completed after baseline measurement)

KPI	Target*	Baseline	M1	M2	M3	M4	M5	M6	Trend
1. *[KPI 1 name]*	*[ ]*	*[ ]*							

KPI	Target*	Baseline	M1	M2	M3	M4	M5	M6	Trend
2. *[KPI 2 name]*	*[ ]*	*[ ]*							
3. *[KPI 3 name]*	*[ ]*	*[ ]*							
4. *[KPI 4 name]*	*[ ]*	*[ ]*							

**Proposed targets subject to baseline measurement.*

Appendix F: User and Stakeholder Satisfaction Questionnaire

> *[ILLUSTRATIVE EXAMPLE — NOT ACTUAL PROJECT DATA]* Starter statements; adapt them to the project subject.

Table 36: Proposed satisfaction questionnaire

No.	Statement	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	The service met my needs.					
2	Staff were helpful and respectful.					
3	I received clear information.					
4	The service was delivered on time.					
5	The environment and facilities were suitable.					
6	*[Topic-specific statement]*					
7	I would recommend the service to others.					

Open question: Do you have any comments or suggestions about [project subject]?

Appendix G: Corrective Action Plan Form

Table 37: Corrective action plan form

Unit / area	
KPI / audit concerned	
Result and target	
Gap identified	
Root cause (after analysis)	
Corrective action	
Responsible person	
Due date	
Re-audit date and result	
Status (open / closed)	
Approved by	

Appendix H: Skills and Competency Checklist

> *[ILLUSTRATIVE EXAMPLE — NOT ACTUAL PROJECT DATA]* Adapt the competencies to the practices in scope.

Table 38: Skills and competency checklist

No.	Competency	Competent	Needs practice	Assessor initials
1	*[Describes the procedure and its purpose]*			
2	*[Demonstrates the first key step correctly]*			
3	*[Demonstrates the second key step correctly]*			
4	*[Uses the required tools or equipment correctly]*			
5	*[Follows safety and confidentiality rules]*			
6	*[Records the work accurately]*			
7	*[Explains what to do if something goes wrong]*			