Engaging Frontline Staff in Quality and Safety

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October 3, 2013
Objectives

• Discuss current Perinatal priorities
• Discuss change management concepts
• Describe strategies designed to engage staff in quality and safety initiatives
Perinatal Care Priorities

• 2020 Vision For a High-Quality, High-Value Maternity Care System
• TJC Perinatal Core Measures
  • PC-01 Elective Delivery
  • PC-02 Cesarean Section
  • PC-03 Antenatal Steroids
  • PC-04 Health-Care Associated Blood Stream Infections in Newborns
  • PC-05 Exclusive Breast Milk Feedings
2020 Vision

Childbirth Connection convened a “Vision Team” of innovators from diverse backgrounds “to develop framework of fundamental values, principles, and goals for a high-quality, high-value maternity care system that could serve as a focal point to inspire improvement strategies.”

www.childbirthconnection.org
2020 Vision

Foundational Aims based on IOM

- **Woman centered**
  - Care respects values, culture, choices

- **Safe**
  - Care is reliable, coordinated, provided in a culture of safety and teamwork

- **Effective**
  - Care based on best evidence

- **Timely**
  - Care delivered when needed

- **Efficient**
  - Best possible care and outcomes utilizing most appropriate resources

- **Equitable**
  - All women and families have access to and receive same quality care
Why Change?

• Quality and Safety
  • IOM reports
• Value over volume
• Mandatory external reporting linked to payment
• Health care delivery model changes
• Population health initiatives
• Overwhelming health care spending
• Patient experience/satisfaction tied to compensation
Patient-centered Care

Attributes

- Access
- Continuity
- Comprehensiveness
- Coordination and communication
- Cultural competency
- Family and person-focus
- Payment alignment

Health Care Manage Rev 2012, 38(2), 166-175
Where do you begin?

• Define vision, mission and organizational priorities
• Assessment of current state
• Understand resistance—stakeholder analysis
• Build case for change
• Data
• Conceptual model
• Strategy
Organization or System Needs

- Mission, vision and strategies
- Culture that reflects values and norms
- Operational functions and processes that support work needed to provide patient care
- Infrastructure
- Staff and physician engagement
Common Vision---Common Goal

- Transformational Leadership
- Common vision
  - Silo approach is limiting
- Data driven and evidence based
- Need for organized, aligned and structured project work
- Prioritization
- Resources
Conceptual Models

• Visual map of organizational structure
• Guide strategy and alignment
• Define the organization or system
• Communicate message
A framework for patient-centered innovation in health care

**Environmental Context**

**Strong Motivators for Change**

**Effective Organizational Leadership**

**Organizational Mission & Culture**
- Clear mission
- Aligned beliefs, values, norms
- Proactively initiate change
- Willing to experiment & take risks

**Organizational Strategy**
- Clarity of Purpose
- Specific change objectives
- Coherence of strategic & operational plans

**Organizational Capability**
- Structure
- Design & coordination mechanisms
- Task Design
- Human resource processes
- Size
- Technological

**Patient-Centered Innovation**

Health Care Manage Rev. 2013, 38(2)
Key Drivers

- **Impetus to transform**
- **Leadership commitment to quality**
- **Improvement initiatives** that actively involve staff in *meaningful* problem solving
- **Alignment** to achieve consistency of organizational goals
- **Integration** to bridge traditional intra-organizational boundaries

*Health Care Manage Rev, 2007, 32(4), 309-320*
“It must be considered that there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things.”

*The Prince*

Kotter, JP., Schlesinger, LA, HBR July Aug 2008
Change Management Strategies

- Numerous approaches to organizational change
  - High Reliability
  - Lean
  - Lean Six Sigma
  - Toyota
  - Model for Improvement
Continuous Improvement

Safety

Learning

RCA

DMAIC

MFI

PDSA

Outcomes

Resistance

Vision

Transformational Culture

Overwhelming

Collaborative

Opportunity

Lean cycle

Toyota

Rapid

TC

NICHQ

Teamwork

Empowerment

Sigma Six

Capacity

Innovation

Model

IHI

Sigma Quality

FMEA

AHRQ

Change

Leadership

Lean

Families

Core

Kaizen
Change Management Process

- Establish sense of urgency
- Guiding coalition
- Create vision
- Communicate vision
- Empower teams
- Short term wins
- Continuous improvement cycles
- Sustain gains

Kotter, JP., Schlesinger, LA, HBR July Aug 2008
Now what do I do?!
Adoption and Resistance

Many resources to guide

• Rogers Diffusion of Innovation
• Adaptive versus Technical change concept

Understand organizational tolerance for change

• Assessment

Define motivating factors

• Why?
Adopter Categories

- Innovators: 2.5%
- Early Adopters: 13.5%
- Early Majority: 34%
- Late Majority: 34%
- Laggards: 16%

Adaptive Change

“There is a myth that drives many change initiatives into the ground: that the organization needs to change because it is broken. The reality is that any social system (including an organization or a country or a family) is the way it is because the people in that system (at least those individuals and factions with the most leverage) want it that way.”

Heifetz, R., Grashow, A, Linsky, M; The Practice of Adaptive Leadership: Tools and Tactics
Adaptive versus Technical Change

**Adaptive**
A challenge that requires changes in the system. People may not face an adaptive challenge while keeping their old priorities or habits.

**Technical**
is one for which a solution already exists even if not everyone knows the solution and even if the problem is particularly complex.

ihi.org
## Approaches to Adaptive Challenges

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be unwavering in your goal and invite everyone to participate</td>
<td>Choose an achievable goal that requires a team approach</td>
</tr>
<tr>
<td>Surface the real and perceived losses</td>
<td>People resist change most often from a perceived versus actual loss</td>
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<tr>
<td>Communicate the need for change</td>
<td>Take out the guesswork—clearly explain need for change</td>
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<tr>
<td>Understand the need for “What’s in it for me”</td>
<td>Maximize benefits, minimize losses</td>
</tr>
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<td>“Seek to understand rather than judge”</td>
<td>Make an effort to understand the perspective of the dissenters</td>
</tr>
<tr>
<td>Monitor organizational capacity</td>
<td>Assess improvement capability</td>
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Culture Change: It’s Different Work

From *The Dilemma of Foundation Leadership*, by Ronald Heifetz
Managing Resistance

• Understand expected resistance
• Determine optimal speed of change
• Provide support through education, opportunity to participate, skills, training
• Engage physicians and frontline staff prior to planning phase
• Transparency
• Communication
### Exhibit 1

**Methods for dealing with resistance to change**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Commonly used in situations</th>
<th>Advantages</th>
<th>Drawbacks</th>
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</thead>
<tbody>
<tr>
<td>Education + communication</td>
<td>Where there is a lack of information or inaccurate information and analysis.</td>
<td>Once persuaded, people will often help with the implementation of the change.</td>
<td>Can be very time consuming if lots of people are involved.</td>
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<tr>
<td>Participation + involvement</td>
<td>Where the initiators do not have all the information they need to design the change, and where others have considerable power to resist.</td>
<td>People who participate will be committed to implementing change, and any relevant information they have will be integrated into the change plan.</td>
<td>Can be very time consuming if participators design an inappropriate change.</td>
</tr>
<tr>
<td>Facilitation + support</td>
<td>Where people are resisting because of adjustment problems.</td>
<td>No other approach works as well with adjustment problems.</td>
<td>Can be time consuming, expensive, and still fail.</td>
</tr>
<tr>
<td>Negotiation + agreement</td>
<td>Where someone or some group will clearly lose out in a change, and where that group has considerable power to resist.</td>
<td>Sometimes it is a relatively easy way to avoid major resistance.</td>
<td>Can be too expensive in many cases if it alerts others to negotiate for compliance.</td>
</tr>
<tr>
<td>Manipulation + co-optation</td>
<td>Where other tactics will not work or are too expensive.</td>
<td>It can be a relatively quick and inexpensive solution to resistance problems.</td>
<td>Can lead to future problems if people feel manipulated.</td>
</tr>
<tr>
<td>Explicit + implicit coercion</td>
<td>Where speed is essential, and the change initiators possess considerable power.</td>
<td>It is speedy and can overcome any kind of resistance.</td>
<td>Can be risky if it leaves people mad at the initiators.</td>
</tr>
</tbody>
</table>
The Power of Positive Deviants

“This is a major project of utmost importance, but it has no budget, no guidelines, no support staff, and it’s due in 15 minutes. At last, here’s your chance to really impress everyone!”
Choose Methodology

- Lean
- Six Sigma
- Model for Improvement
- Robust Process Improvement

*Usually a combination of multiple strategies*
Alignment

• Align with organizational strategy
• Utilize available evidence
• Develop improvement portfolio based on data and safety
• Communicate vision
• Charter teams for key initiatives
• Empower frontline staff to identify needed change
• Start working on small things which will lead to large scale change over time
• Leadership role to facilitate, guide and mentor---not control
Where do you start?

- Project idea
- Establish project team
- Charter
- Stakeholder analysis
- Fishbone
- Process mapping

- Determine scope
- Literature review
- Driver diagrams
- Prioritization
- Develop aim statement
- Design tests of change

*Continuous Improvement and Testing!*
Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

From: Associates in Process Improvement
Project Charter

Overview /Problem Statement

Customer(s):

Aim Statement

IOM – Aim
X Safe  X Effective  X Patient Centered
X Timely  X Efficient  X Equitable

Business Case
## Mobilizing Commitment

### Resistance Analysis

<table>
<thead>
<tr>
<th>Key Stakeholder (Individual or Group)</th>
<th>What’s Important</th>
<th>Reasons for Resisting Change</th>
<th>Level of Resistance (High, Med, Low)</th>
<th>Strategy for Dealing with Resistance</th>
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</table>
# Road Map

## Leadership Safety Forums

<table>
<thead>
<tr>
<th>Aim Statement</th>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>PDSA Cycles</th>
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</thead>
<tbody>
<tr>
<td><strong>Global aim:</strong> Increase frontline staff and physician safety survey scores from a baseline of &lt; 70% to &gt; 80% on results related to recognition and escalation of safety concerns by October 2013.</td>
<td><strong>Communication, Collaboration and Teamwork</strong></td>
<td><strong>Interdisciplinary team communication strategies</strong></td>
<td><strong>Morning interdisciplinary team huddles</strong></td>
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<tr>
<td><strong>Specific aim:</strong> Implement a standardized process for frontline staff and physicians to meet with the executive team to discuss and resolve existing and potential patient safety concerns by April 1, 2013.</td>
<td><strong>Culture of Quality and Safety</strong></td>
<td><strong>Improve safety and quality culture</strong></td>
<td><strong>RN shift huddles</strong></td>
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<tr>
<td></td>
<td><strong>Leadership</strong></td>
<td></td>
<td><strong>OR to unit handoff</strong></td>
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<tr>
<td></td>
<td><strong>Education and Training</strong></td>
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<tr>
<td></td>
<td><strong>Physician and nursing administration support and resource allocation</strong></td>
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<td><strong>Facilitate staff and physician participation in huddles and handoff initiatives</strong></td>
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<tr>
<td></td>
<td><strong>Communication techniques</strong></td>
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<td></td>
<td><strong>Quality and safety training</strong></td>
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<td><strong>Unit communication strategy</strong></td>
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<td></td>
<td><strong>Quality and Safety workshops</strong></td>
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<td></td>
<td><strong>Standardized bulletin boards</strong></td>
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<td></td>
<td><strong>Shift huddle education</strong></td>
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<td></td>
<td><strong>Faculty and staff conferences</strong></td>
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Perinatal Community: Reducing Harm, Improving Care, Supporting Healing

- **Perinatal Leadership**
  - Align Unit Measures Strategies Projects with Org. Strategy and Goals (Clinical, Patient, Exp. Financial and Workforce)
  - Channel Senior Leadership Attention and Develop Unit Leadership
  - Engage Physicians
  - **Build Improvement Capacity and Provide Resources for Improvement**
    - Establish a Just Culture
    - Develop a Competent Trained and Available Workforce
    - Establish Credentialing of Core Competency and Training for all Providers
    - Use ACOG/AWHONN Guidelines for Documentation and Staffing
    - Develop a Consumer Advisory Board
  - Execute care that meets national standards (Implement Bundles, Perinatal Core Processes)
  - Develop standard processes and protocols for response to obstetrical emergency
  - Design care process improvement based on trigger tool analysis, event detection, sentinel event
  - Standardize administration of high alert medications – oxytocin, magnesium sulfate, epidurals
  - **Create an environment that Supports Care and Healing**
  - Consider segments of population and design reliable and appropriate processes for specific needs and characteristics of this segment of the population

- **Reliable Design / Reduce Variation**
  - Adopt common language and interpretation of EFM with multi-disciplinary training i.e. NICHD criteria
  - Implement techniques for effective communication i.e. SBAR
  - Establish reliable techniques for handoffs
  - Establish Team Response Protocols
  - **Implement Huddles**
  - Design Simulations

- **Effective Peer Teamwork**
  - Design processes to support partnership in care between provider and patient and family
  - Develop with patient a customized interdisciplinary shared care plan
  - Design care process improvement based on information obtained about patient experience (interviews, assessments, focus groups, surveys)
  - Include patients and families on design and improvement teams
  - Communicate openly and honestly with family and patients at regular intervals
  - Do what you say, mean what you do

- **Respectful Patient Partnership**
  - Reduce harm to 5 or less per 100 live births
  - Zero incidence of elective deliveries prior to confirmation of fetal maturity
  - Augmentation Bundle(s) Composite or Compliance greater than 90%
  - Improve organizational culture of safety survey scores in Perinatal units by 25%
  - 100% of participating teams will have documentation of Patient & Family Centered Care
  - Reduce harm to 5 or less per 100 live births
  - Zero incidence of elective deliveries prior to confirmation of fetal maturity
  - Augmentation Bundle(s) Composite or Compliance greater than 90%
  - Improve organizational culture of safety survey scores in Perinatal units by 25%
  - 100% of participating teams will have documentation of Patient & Family Centered Care
## Determining Scope for Testing

<table>
<thead>
<tr>
<th>Current Situation</th>
<th>Resistant</th>
<th>Indifferent</th>
<th>Ready</th>
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<tbody>
<tr>
<td><strong>Low Confidence that current change idea will lead to Improvement</strong></td>
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<tr>
<td>Cost of failure large</td>
<td>Very Small Scale Test</td>
<td>Very Small Scale Test</td>
<td>Very Small Scale Test</td>
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<tr>
<td>Cost of failure small</td>
<td>Very Small Scale Test</td>
<td>Very Small Scale Test</td>
<td>Small Scale Test</td>
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<tr>
<td><strong>High Confidence that current change idea will lead to Improvement</strong></td>
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<td>Cost of failure large</td>
<td>Very Small Scale Test</td>
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<td>Large Scale Test</td>
</tr>
<tr>
<td>Cost of failure small</td>
<td>Small Scale Test</td>
<td>Large Scale Test</td>
<td>Implement</td>
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</tbody>
</table>
## Tests of Change

### PDSA: Data Collected Routinely

<table>
<thead>
<tr>
<th>Objective for this series of tests</th>
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<tbody>
<tr>
<td>Overall Population</td>
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</table>

### TEST CYCLE 1

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
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<table>
<thead>
<tr>
<th>Test Population</th>
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#### Plan

- **Tasks:**

#### Prediction

1. 
2. 
3. 

#### Do


#### Study


#### Act


Kaizen

A Japanese word meaning incremental continuous improvement which involves cross-functional teams working together.

- “Kai” means “Change”
- “Zen” means “Good”
Kaizen

• Good change
  • “Kai” means “change”
  • “Zen” means “good”

• Methodology and philosophy utilized to engage frontline teams

• Work is executed through empowering frontline staff to improve their daily work
Kaizen

• Map things “as they are” using Value Stream Mapping
• Measure current performance
• Eliminate what does not add value
• Flow Value-Added activities
• Brainstorm and implement improvements
• Train employees in new process
• Test changes
• Measure again
• Put in controls to sustain gains
• Present and celebrate the accomplishments!
What Are The 6s’s?

- Safety
- Sort
- Scrub (Shine)
- Straighten (Set in Order)
- Standardize
- Sustain
Kaizen Events And Workplace Organization

Event Elements

Document Reality

Start Here

Do It Again!

Celebrate

Make This The New Standard

In a Week!

Identify Waste

Normal vs. Abnormal

VA NVA

NECESSARY REDUCE

UNNECESSARY

Plan Countermeasures

Target Matrix

Reality Check

Lean?

Make Change

Verify Change

Quantify Results

Make This The New Standard

In a Week!

Topics:

TPM Supplier Improvement

Mixed Model

Flow

TAKT Time

Std.

Work

Visual Control

5's

Current Results

Weigh

100 Pts.

High Impact

Some Impact

Support

11

Other

LOB:

Specific Targets:

Goal

Results

0 to 4

$58K

3 2

1200 sq ft to 600 sq ft

4000 ft to 2000 ft

Bushing/Plug Production

141 sec

Ken Bigg

Close delivery perf.

gap by 50% (Cust.
\%
Svc. 98%)}

92%

98%

Improve Asset Turns

Turns 15% (WIP Inv. Red. 75 %)

1% Impr. In Gr. Mar gin (Productivity 33 %)
Engage teams through the use of simple visual tools
Monitor and Sustain

• System dashboards
• Data tools
• Audits
• Ongoing communication and updates
Spread to Other Medical-Surgical Units

<table>
<thead>
<tr>
<th>TCAB Changes</th>
<th>6E</th>
<th>6N</th>
<th>7E</th>
<th>7N</th>
<th>7S</th>
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<td>Rapid Response Teams</td>
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<td>Medication Reconciliation</td>
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<td>SBAR</td>
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<td>Multi-disciplinary Rounds</td>
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<td>Daily Goals</td>
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<td>Discharge Preparation</td>
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<td>5S Unit Supplies</td>
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100% Coverage

http://www.ihi.org
“Keep your hand on the thermostat. If the heat’s too low, people won’t make difficult decisions. If it’s too high, they might panic.”
Challenges

• Improvement fatigue
• Multiple competing priorities
• Lack of quality and safety education
• Leadership
• Other thoughts?
Questions?
“The world is not a dangerous place because of those who do harm, but because of those who look on and do nothing.”

Albert Einstein