

..... W E L C O M E



The Maryland
Patient Safety Center
Perinatal Collaborative


**Who said...Change is as
Good as a Rest??**

Learning Session 1
March 15, 2007

Creating perinatal units that deliver
care safely and reliably with zero
preventable adverse outcomes

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative

Objectives

- Describe how the use of **PDSA cycles** will assist in planning engage cooperation and sustain improvement
- Apply the PDSA model when to planning to improve perinatal patient safety outcomes
- Describe key factors needed to initiate and maintain a change in culture

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative

Key Elements of Breakthrough Improvement

- **Will** to do what it takes to change to a new system
- **Ideas** on which to base the design of the new system
- **Execution** of the ideas




Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The **WILL**...

The Maryland Patient Safety Center
Perinatal Collaborative





The Maryland Patient Safety Center
Perinatal Collaborative

Factors which effect the **Will** to change

- Need and urgency for change
- Life experiences
- Positive and negative experience
- Personality
- Resources and Support

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative

Ideas: bases for design of new system

Ideas come from:

- Strong evidence
- Good knowledge (our own or others)
- Hunches
- Open, supportive and agile team-based environments

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative

Execution of the ideas

- Tap on expertise
- Multidisciplinary planning team
- Use tools and methods tested by others.
- Test, Study; Test, Study; Test, Study.
- Leadership support.
- Identify and remove barriers and *old way*.
- Illicit involvement and feedback.
- Embrace grumbling as an opportunity.
- Remember: with true change comes learning



Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative


We already are Chameleons!

Chameleons are unique creatures. Known for their ability to change color, they can be seen wearing a variety of colors, including brown, green, blue, yellow, red, black or white.

Contrary to popular belief, chameleons cannot display limitless colors and do not change colors in a camouflage response to their surroundings. Instead, their skin changes in response to their environmental temperature, light, and mood.




Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.




The Maryland Patient Safety Center
Perinatal Collaborative

...or are we??




Communication is an important reason behind these color changes. With color, chameleons can communicate with others, expressing attitudes such as their willingness to “collaborate”.

These grasping feet are ideal for tree climbing. The independently moveable eyes, which allow chameleons the ability to survey the world with nearly 360-degree vision.




Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.




The Maryland Patient Safety Center
Perinatal Collaborative

How do others perceive *you* when a change is needed?





Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.




The Maryland Patient Safety Center
Perinatal Collaborative

Stand strong...against the winds of change



The Maryland Patient Safety Center
Perinatal Collaborative


Between a rock and a hard place





The Maryland Patient Safety Center
Perinatal Collaborative

Leading and flourishing amongst dead wood




The Maryland Patient Safety Center
Perinatal Collaborative

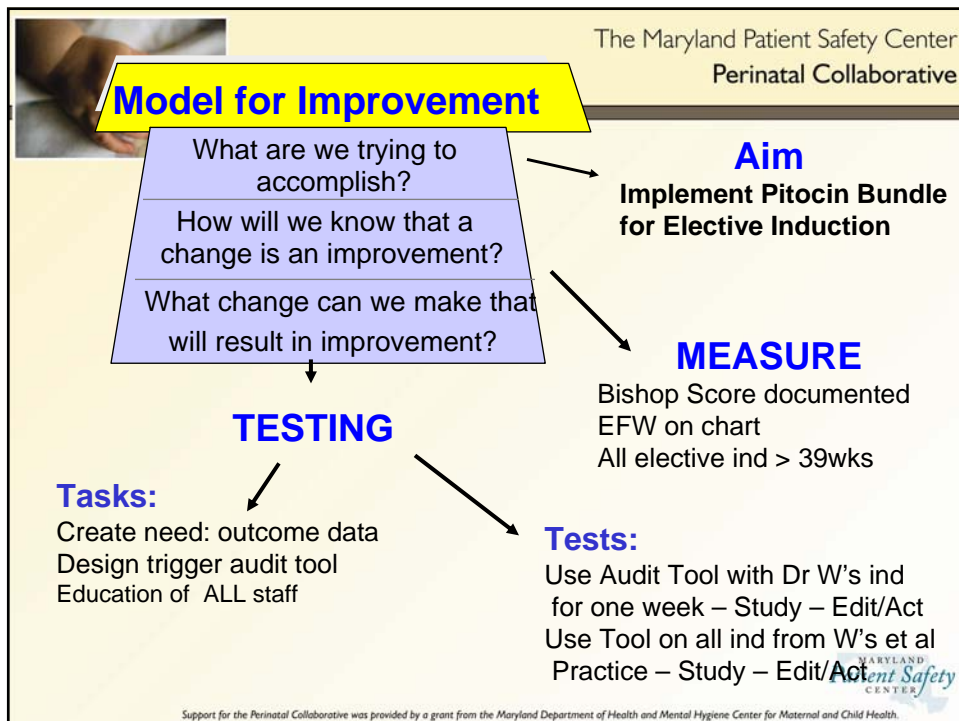
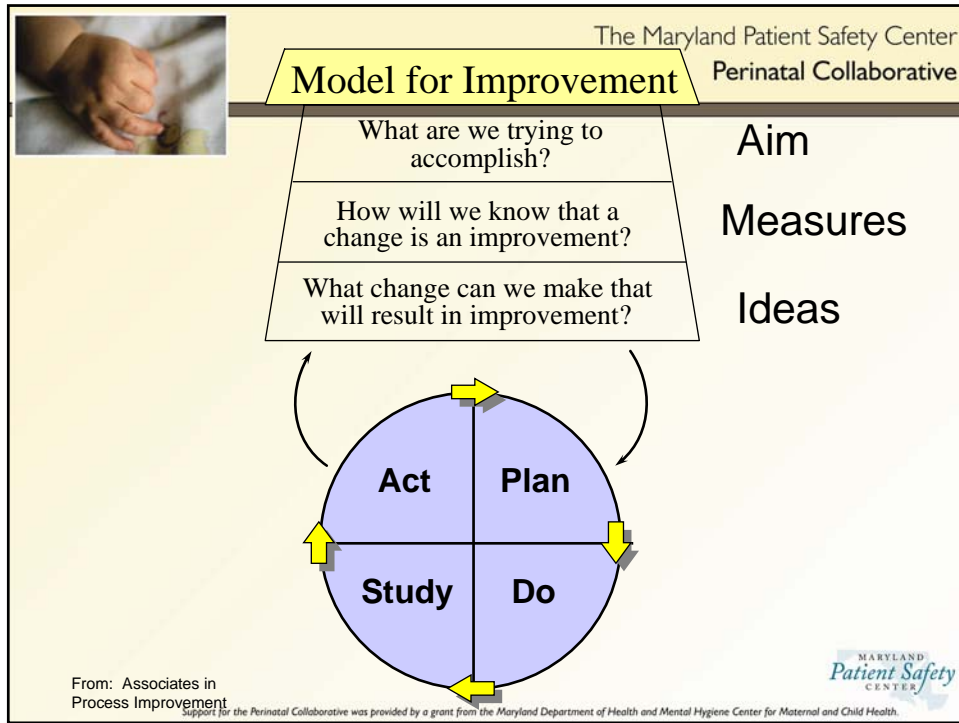
Model for Improvement


**Three Fundamental Questions
for Improvement**

- 1. What are we trying to accomplish?**
- 2. How will we know that a change is an improvement?**
- 3. What changes can we make that will result in improvement?**



Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.






The Maryland Patient Safety Center
Perinatal Collaborative

P-D-S-A Cycles

- A way to turn Ideas into Action
(P D)
- A way to connect Action to Learning
(S A)

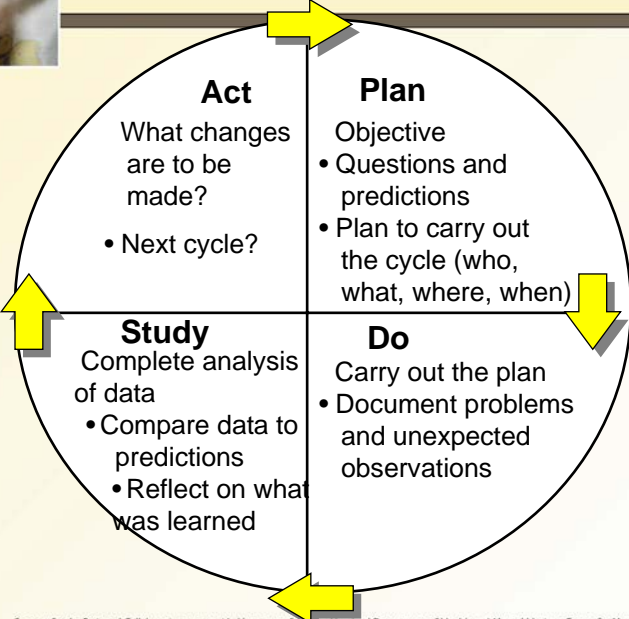
MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative

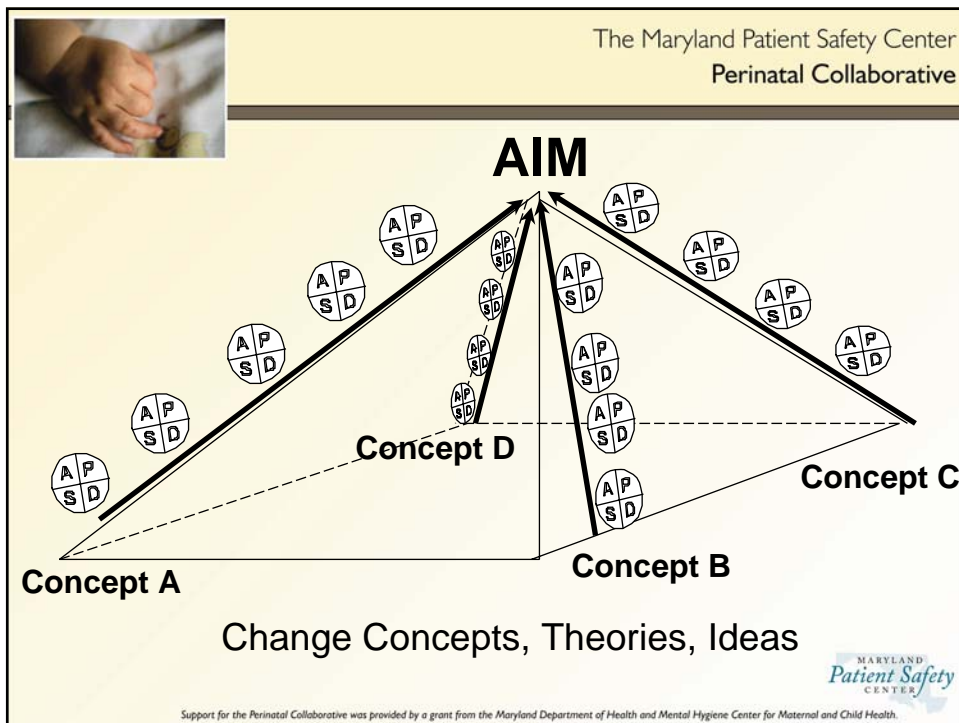
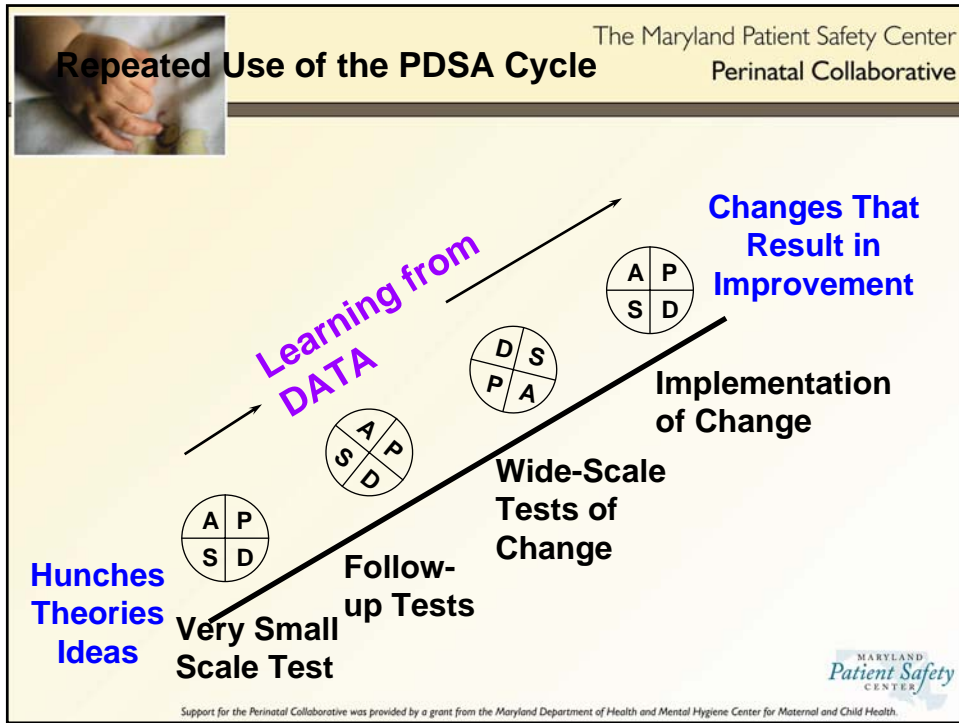
The PDSA Cycle for Learning and Improvement




Act What changes are to be made? • Next cycle?	Plan Objective • Questions and predictions • Plan to carry out the cycle (who, what, where, when)
Study Complete analysis of data • Compare data to predictions • Reflect on what was learned	Do Carry out the plan • Document problems and unexpected observations

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



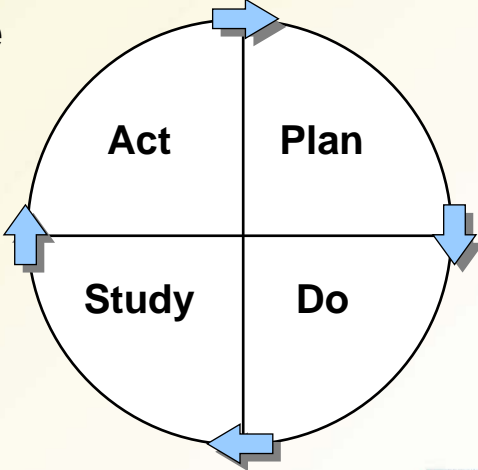


The Maryland Patient Safety Center
Perinatal Collaborative

The PDSA Cycle


Why Test?

Why Study?



MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.




The Maryland Patient Safety Center
Perinatal Collaborative

PDSAs for Testing

- Increase belief that the change will result in improvement
 - dealing with uncertainty
 - dealing with skeptics/ minimize resistance upon implementation
- Opportunity for “failures” without impacting performance
- Get idea of how much improvement can be expected from the change
- Learn how to adapt the change to conditions in the local environment
- Evaluate costs and side-effects of the change

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.




The Maryland Patient Safety Center
Perinatal Collaborative

Implementing Change - Strategies Consideration

1. The path of least resistance
 - best use of the people willing to change
2. Impact
 - biggest improvements early in implementation
3. Learning
 - the most learning as the change is implemented
4. Resources
 - best scheduling and use of available resources
5. Interdependence
 - will the change work without all its components?

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative


Implementing Change – Foolproof the New Process/procedure

Reduce likelihood of mistake/error

- Decrease the likelihood that a needed item is left off the surgery cart by prepackaging kits of instruments and other surgical items
- Make it impossible to attach the vacuum line to an oxygen outlet by installing different sizes or shapes for vacuum and oxygen connectors
- Get rid of old versions of forms!

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.




The Maryland Patient Safety Center
Perinatal Collaborative

Change the Culture – Holding the Gains

- Make reversal as difficult as possible
- Establish a standard process
- Use measurement and audits
- Pay attention to maintenance processes, especially orientation and training

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.



The Maryland Patient Safety Center
Perinatal Collaborative

Kotter's 8 Reasons Why Attempts at Change Fail

1. Not establishing a great enough sense of urgency.
2. Not creating a powerful enough guiding coalition.
3. Lacking a clear vision.
4. Under-communicating the vision by a factor of ten.
5. Not removing obstacles to the new vision.
6. Not systematically planning for and creating short-term wins.
7. Declaring victory too soon.
8. Not anchoring changes in the corporate culture.

MARYLAND
Patient Safety
CENTER

Support for the Perinatal Collaborative was provided by a grant from the Maryland Department of Health and Mental Hygiene Center for Maternal and Child Health.

