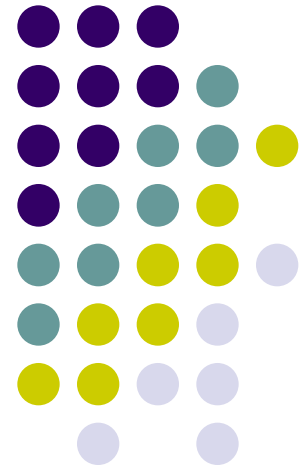
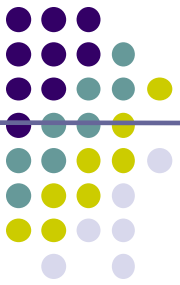




Knowledge Sharing in Hospitals: the Librarian's Role

Day Two / July 30, 2010
Providence Portland Medical Center

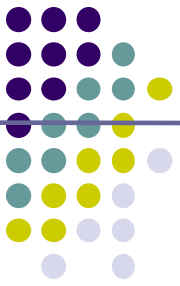




Day two agenda

July 30

- Dream phase: sharing experiences / uncovering knowledge
- Design phase
- Destiny phase: working lunch
- Sharing plans
- Wrap up & next steps
- Close: 3:15pm

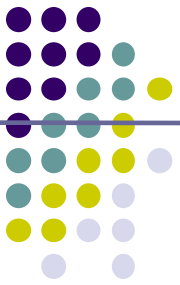


Sharing our experience - 5 minutes or less

Introduce your partner:
the Lighting Round

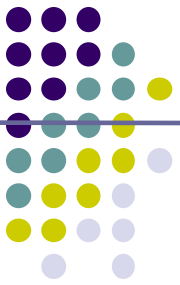
- Share their knowledge-sharing story
- Highlight perceived strengths uncovered via the conversation

Uncovering knowledge



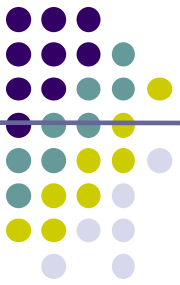
Discussion to share -

- What has been learned?
- What expertise can we offer each other?
- What expertise exists beyond traditional and established roles?



Collective themes

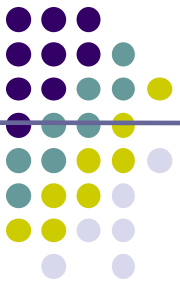
- What have we discovered?
 - Pinpoint themes for success drawn our experience
 - What elements of the healthcare environment support these strengths?
 - How can they be leveraged?



Applying our strengths to ensure success

- How do you build knowledge sharing relationships?
- Ask ourselves: what would an ideal knowledge sharing environment in health care be?

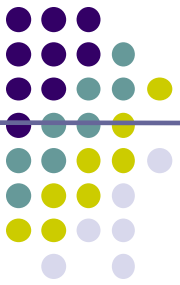
Provocative propositions



- Affirmative in nature
- Draw from interview highlights
- Build on what made the highlights possible to picture a vision of what might be ... find a desired place to go.

Samples: (from Hammond, 1996)

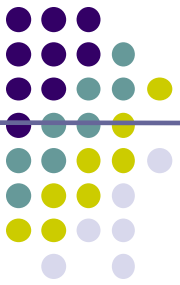
- We continually learn as we work
- We devote time to learning more so we keep our expertise current

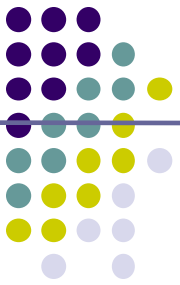


Provocative proposition

What would an ideal
knowledge sharing
environment in
health care be?

Provocative Statement



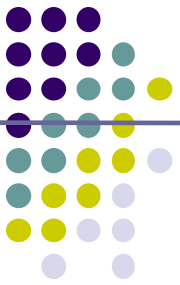


Break

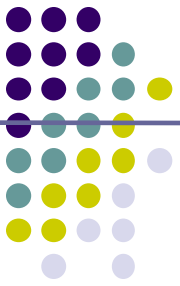
“Leaders have to believe
that solutions lie within the
people.”

Shendell-Falik N, Feinson M, Mohr BJ. Enhancing patient safety:
improving the patient handoff process through appreciative inquiry.
J Nurs Adm. 2007;37:95-104.

Opportunities = our ideas

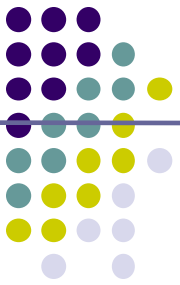


Critical thinking frames the opportunities



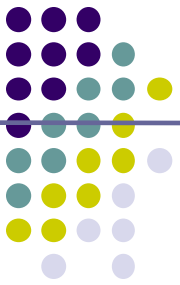
For example:

- How can the identified themes from the stories be applied to daily work to ensure they happen.
- What tool, knowledge, connection, champion, etc is needed to move forward?



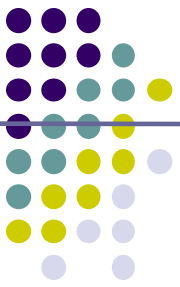
List of opportunities from day 1

- Compile and add Thursday night



Critical thinking moves us toward action

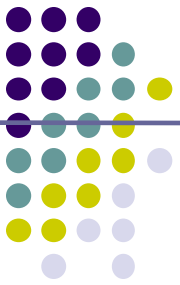
- Hazards
- Tools for our session:
Rapid Improvement Event
 - Matrix
 - PDSA



The Matrix

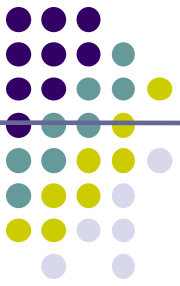
- Not about special effects but spectacular affect on organization
- Reflects aim
- Breaks down plan
 - Immediate actions for rapid improvement
 - Incremental actions with small tests of change (PDSA)

Matrix worksheet



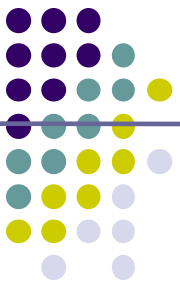
Problem	Action / test of change	Effect	Timeframe	Responsible party

Martin SC, Greenhouse PK, Kowinsky AM, McElheny RL, Petras CR, Sharbaugh DT Rapid improvement event: an alternative approach to improving care delivery and the patient experience. J Nurs Care Qual. 2009;24:17-24; quiz 25-6.



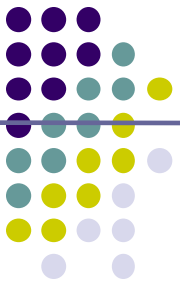
Aim: Arrive places on time and relaxed

Problem	Action / test of change	Effect	Timeframe	Responsible party
Can't find keys	Hang on hook in laundry room	Always in same place	Now	BAS
Forgot phone	Move phone and charger closer to purse	Will see phone when grabbing purse	Now	BAS
Sunglasses in wrong car	Bring from car into house on return	Always available	Tomorrow	BAS/DRS
Have to go into garage to close garage door	Replace electric eye on door	Can close door using remote control	7 - 10 days	DRS
Traffic congestion	Find new route	Arrive at work in 25 minutes	3 days	BAS



Aim: Arrive places on time and relaxed

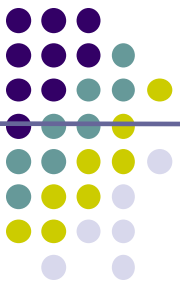
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PDSA for action

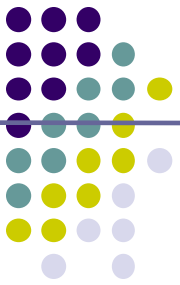
Backbone for improvement

- Plan: Your project
- Do: Your actions
- Study: Your results
- Act: Your changes based on your experiences



Plan-Do-Study-Act

- **Plan:** Analyze the problem you intend to improve and devise a plan to correct the problem.
- **Do:** Carry out the plan (preferably as a pilot project to avoid major investments of time or money in unsuccessful efforts).
- **Study:** Did the planned action succeed in solving the problem? If not, what went wrong? If partial success was achieved, how could the plan be refined?
- **Act:** Adopt the change piloted above as is, abandon it as a complete failure, or modify it and run through the cycle again.



Tool to develop PDSA

PDSA Worksheet for Testing Change

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

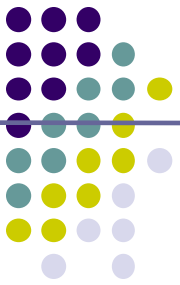
Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do Describe what actually happened when you ran the test

Study Describe the measured results and how they compared to the predictions

Act Describe what modifications to the plan will be made for the next cycle from what you learned

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PDSA Worksheet for Testing Change

Aim: Reduce time spent driving to work by 20% within 5 days

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done
Take the tollway from home to exit just past office	Becky	Tuesday	Between home and office

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done
Drive / time current route in rush hour traffic as baseline	Becky	Monday	To office via Ferry Rd
Compare distance between current route and new route (home to tollway entrance on Farnsworth, exit at Naperville Road)	Dale	Monday	Mapquest
Identify construction projects on new route		Monday	IDOT website
Confirm IPASS in car	Becky	Sunday	My car

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds
Decrease in time due to travel at faster speed	Time from leaving home to stoplight at entrance to office building

Do

Describe what actually happened when you ran the test

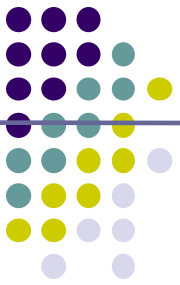
Study

Describe the measured results and how they compared to the predictions

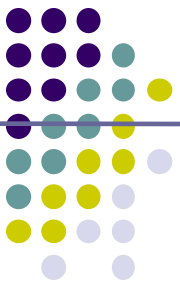
Act

Describe what modifications to the plan will be made for the next cycle from what you learned

You may not get it right the first time

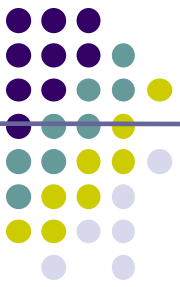


“ I thought it would take me about six months. In fact it took me 4.5 years and I built 5,127 prototypes until I got it right. That sounds tedious. In fact it was absolutely fascinating. I mean each failure, the 5,126 failures taught me so much. Successes teach you nothing. Failures teach you everything. Making mistakes is the most important thing you can do.” - James Dyson



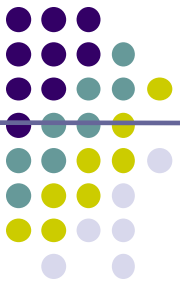
Aim: Establish monthly meeting for K-sharing among clinicians working to prevent infections by October 2010

Problem	Action / test of change	Effect	Timeframe	Responsible party
Multiple requests on same topic				
Wait list for materials				
Group not aware other groups doing or completed similar work	Post topics, identify contact for more info	Groups connect, learn from each other	Paper - Now Intranet - 7 to 10 days	LIB Webmaster



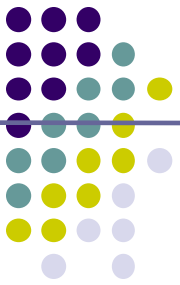
Applying what you've learned

- Divide into two groups, one partner in each group
- Select topic
- Define aim
- Use Matrix worksheet (immediate actions)
- Use PDSA to support one or more incremental actions with small tests of change
- Report to group / receive feedback



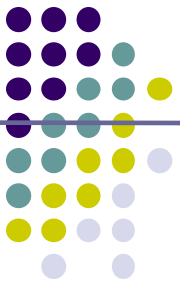
Design plan for action: step 2

- Use Matrix to frame work within Rapid Improvement Model of work
- Use PDSA tool to demonstrate one rapid cycle test
- How will we know if we are successful?
- Report out to group - receive feedback



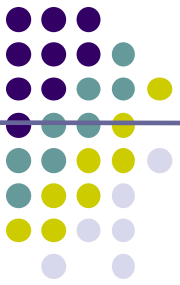
Use of planning matrix to guide work

- Specific
- Measurable
- Objective
- Target date



Breakdown of KSharing example

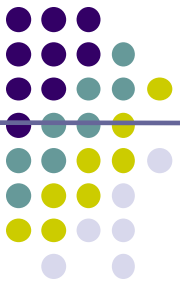
- Problem
- Action/test of change
- Effect on knowledge processes
- Timeframe
- Responsible Party



Matrix Worksheet

Problem	Action / test of change	Effect	Timeframe	Responsible party

Martin SC, Greenhouse PK, Kowinsky AM, McElheny RL, Petras CR, Sharbaugh DT Rapid improvement event: an alternative approach to improving care delivery and the patient experience. J Nurs Care Qual. 2009;24:17-24; quiz 25-6.



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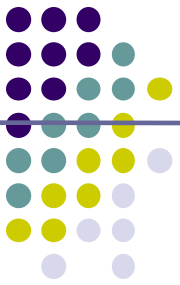
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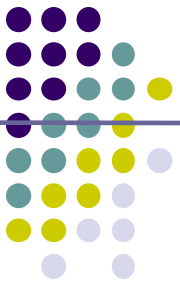
Small group report out and feedback



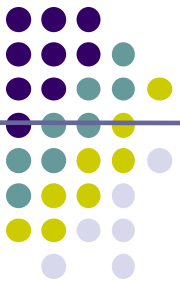
“Some is not a number, soon is not a
time.”

Don Berwick

Lunch assignment

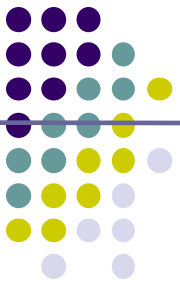


- Revisit homework statement from precall #2 re: KSharing opportunity
- Form joint statement of KSharing opportunity: validate common language
- Matrix to formalize opportunity
- As a team use three words to define what knowledge sharing in hospitals means (for presentation later)



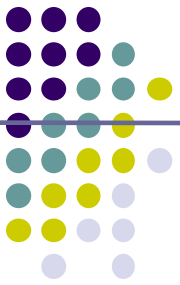
Team report out and feedback

- Reveal three words
- Present KSharing opportunity
- Present matrix and first small test of change
- Gather group feedback
- 10-minutes max per team



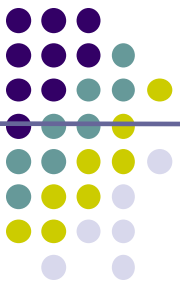
Time for a break

One small effort can have great impact.



Stoke the fire

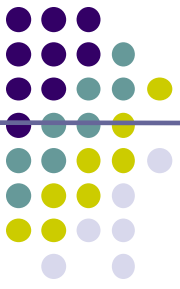
- Communicate
 - Hospital leadership needs to know ...
 - Your colleagues needs to know ...
- Communicating about KSharing to the organization
 - Nature of collaborative work and commitment
 - Keep talking and sharing experiences: model the behavior communication
 - What can we expect to be done within a week?
- Tool review
 - communications summary



Tactics ... it takes village

- Building a team¹
 - Finding a champion
 - Building on strengths of group to address culture
 - Select the right people / attitude and vision is important!
 - Cover skills required
- Remember the 6 Es!

1) from: Zipperer L. Knowledge Sharing in Hospitals. Chapter in:
MLA Guide to Hospital Library Management. In press



Next steps for workshop group

- Update others via email / informal communication
- Post-session calls
 - Select call date
 - Return communication summary on project prior to call
 - Be prepared to report out
- Evaluation



Knowledge Sharing in Hospitals: the Librarian's Role

Keep in touch!

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Becky Steward

becky.steward@comcast.net

