

Change Management

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Change management is a structured process that includes the alignment of staff and resources to ensure proper implementation and long-term sustainability.¹ Successful change management requires the right approach, standardized tools and consideration of the people and culture involved in implementing and sustaining the desired change.

Facilitating and managing change initiatives that impact multiple departments and/or disciplines can present a risk and quality management challenge. When changes are made to systems, processes, policies and/or procedures, the potential for long-term success can be improved by completing an impact analysis. Also known as a proactive risk assessment, an impact analysis should identify and assess potential risks by determining how the changes might impact the work of all stakeholders and maintaining open channels of communication across the organization.



Using a structured approach and standardized tools to conduct an impact analysis can improve the outcome of change management efforts. Health care regulatory agencies and/or accreditation organizations may provide or recommend specific approaches and/or standardized tools. The following resources offer structured change management approaches and tools:

- The U.S. Department of Energy² developed a 12-Step Safety Change Checklist that can be modified and utilized by leaders and/or an oversight committee as part of a collaborative change management decision-making process (Click [HERE](#) to access the checklist).
- The failure mode and effects analysis (FMEA) approach has a 40-year history in high-risk industries (e.g., aviation and nuclear power) and has been adapted for use by health care professionals to improve processes and enhance patient safety by proactively identifying risks in systems, processes, policies and/or procedures:
 - According to the Coverys Risk Management Manual, FMEA is a team-based proactive risk analysis used to identify how and why a process or product design can fail (Click [HERE](#) to access Coverys FMEA tools, policy templates and information).
 - Health care organizations interested in high-reliability frequently use the FMEA proactive risk assessment tool from the Institute for Healthcare Improvement (IHI) to identify and analyze potential risks (Click [HERE](#) for IHI FMEA tools and information).
 - The Department of Veterans Affairs (VA) utilizes a modified FMEA approach, Healthcare Failure Mode Effect Analysis (HFMEA®), to improve patient safety throughout the VA (Click [HERE](#) for information on the Veterans Health Administration FMEA tool).

Most change management approaches include the following:

- Identifying a multidisciplinary team that includes frontline staff.
- Identifying an oversight committee and senior leader champion.

- Completing each step in the chosen process.
- Documenting each step.
- Testing the newly designed or redesigned process.
- Establishing and implementing measures of success to monitor the effectiveness of the process over time (Click [HERE](#) to learn more about measures of success).

However, the use of a standardized approach and tools may not guarantee success if change leaders fail to consider the involved people and the organizational safety culture. This consideration requires a basic understanding of safety culture³, human factors⁴ and the psychology of change.⁵

James Reason⁶ taught us that a safety culture (Click [HERE](#) for a safety culture primer) is the product of five interdependent components/subcultures:

- Just Culture
- Reporting Culture
- Informed Culture
- Flexible Culture
- Learning Culture

Defined as “the relationship between human beings and the systems with which they interact”, human factors play a major role in patient safety and risk reduction activities.⁷ The World Health Organization⁸ (WHO) recognizes that human factors (e.g., fatigue, stress, poor communication and inadequate knowledge and skills) affect the ability of health professionals to safely carry out their work. In addition, leadership awareness of human factors can lead to the development of systems and processes that make it easy to do the right thing and hard to do the wrong thing (Click [HERE](#) to learn more about the role of human factors in health care).

Improvement thought leader W. Edwards Deming considered psychology as the adaptive, human side of change.⁹ According to the Institute for Healthcare Improvement (IHI), consideration of the human side of change enables leaders to provide staff the ability and resources to act (Click [HERE](#) to access the IHI Psychology of Change Framework).

The use of a structured approach and standardized tools paired with consideration of the people and culture involved in the desired change can significantly increase successful implementation and long-term sustainability of new or modified systems, processes, policies and/or procedures.

¹ <https://safetyrisk.net/?s=change+management+checklist>

² US Department of Energy Human Performance Improvement Handbook, Volume 1, DOE-HDBK-1028-2009 Roughton, James, Nathan Crutchfield.

³ <https://psnet.ahrq.gov/primer/culture-safety>

⁴ https://www.hopkinsmedicine.org/armstrong_institute/centers/human_factors_engineering/

⁵ <https://www.mckinsey.com/business-functions/organization/our-insights/the-psychology-of-change-management#>

⁶ Reason (1999). Safety Paradoxes and Safety Culture. Retrieved from:
<https://safetyhub.co.nz/wp-content/uploads/2013/09/Safety-Paradoxes.pdf>

⁷ Kohn LT, Corrigan JM, Donaldson MS, eds. To Err is Human - Building a Safer Health System. Washington, DC, Committee on Quality of Health Care in America, Institute of Medicine, National Academies Press, 1999.

⁸ https://www.who.int/patientsafety/education/curriculum/who_mc_topic-2.pdf

⁹ Deming WE. The New Economics for Industry, Government, Education. 3rd edition. The MIT Press; 2018.