The MORE^{OB} Program Overview

2011-2012

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Taking care of life

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Harm Events in the Healthcare Environment

The persistence of the problem

Harm events in the healthcare environment are serious problems that have tremendous impact on patients, healthcare providers, society, and governments. The Institute of Medicine report, published in 2000[1] was the catalyst for driving an aggressive push to improve the reliability of healthcare. In spite of all of that activity, there is a belief that the improvement has not been quick enough[2] and clinical error continues to be a serious problem.

While human beings are clearly fallible, only 2-3% of clinical errors occur as a result of incompetence, carelessness, sabotage, or gross negligence. The majority of clinical errors are due to hazards within health systems.[3] Improving the systems through which healthcare is delivered is fundamental to reducing clinical error.

Organizational and cognitive psychology models provide useful insight

Models from organizational and cognitive psychology are useful in explaining the persistence of unsafe practices in everyday work.[2] These include:

- Reason's model of Vulnerable System Syndrome which describes a cluster of "organizational pathologies" (blame, denial and the pursuit of financial**,** as opposed to safety excellence goals), interacting with one another to make some systems vulnerable to unsafe practices and harm events.[2]
- Tucker and Edmonston's concept that puts forward the "quick fix" theory of first order problem solving where healthcare providers respond with solutions that provide short term resolutions.[2]
- Amalberti's theory of migration to boundaries in which workers work outside established zones of safe practice resulting in competent, highly motivated and caring healthcare providers "working around regulations" that are in place to protect patients from harm.[2]

Managing Risks and Improving Patient Safety

In today's clinical environments, processes for identifying, analyzing and learning from serious lapses in standards of care are not widely practiced. Furthermore, there is little action taken to implement the type of "systems change" needed to prevent similar events from recurring. When things go wrong, the focus is often on the individual and the human actions immediately preceding the adverse event. Consequently, there is a failure to review the whole system's safety practices. This results in safety being treated as an isolated issue, with no effective mechanisms in place to learn from the experience. In fact, the main factor contributing to the persistence of clinical errors is the absence of learning from failure.

The key to increasing patient safety and managing adverse events is the creation of a new model of care in which patient safety is the priority. Such a model breaks down traditional hierarchy and practices, and redirects the focus toward teamwork, thereby facilitating an environment of working and learning together.

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1 *Kohn LT, Corrigan JM, Donaldson MS, editors. To err is human: building a safer health system. Washington (DC): National Academy Press; 2000.*

2 *Espin SL, Lingard L, Baker GR, Regehr G. Persistence of unsafe practice in everyday work: an exploration of organizational and psychological factors constraining safety in the operating room. Quality and Safety in Health Care 2006; 15: 165-170.*

3 *Berwick DM. President and CEO, The Institute for Healthcare Improvement. In: A statement to the committee on senate appropriations subcommittee of labor, health and human services. March 13, 2003.*

The Managing Obstetrical Risk Efficiently (MORE^{OB}) Program

The MORE^{OB} Program was created in 2001-2002 to address these serious risk and patient safety issues. The MORE^{OB} Program is a continuous patient safety improvement program for physicians, midwives, nurses, and all other stakeholders in obstetrical care units. It aims to eliminate the culture of blame, builds confidence in competency, and improves patient safety and the quality of care. It is also directed at decreasing adverse events and clinical errors by providing data to support change and encouraging collaboration among all stakeholders in obstetrical care units.

The MORE^{OB} Program Philosophy

The MORE^{OB} Program is about improving patient safety and promoting a patient safety culture in hospital obstetrical programs. It is interprofessional in purpose, format, and implementation. The program emphasizes that patient safety is everyone's responsibility, all of the time.

The MORE^{OB} Program incorporates adult education principles, reflective learning, practice modification, and evaluation as the foundation for motivating change and maintaining a current clinical knowledge base. The MORE^{OB} Program is based on the principles of High Reliability Organizations (HROs). HROs are complex, intensely interactive and technical environments in which a variety of professional disciplines with diverse roles and responsibilities work together. They carry out their demanding tasks day in and day out and seldom have a catastrophic error in their operating systems. The public has high expectations for their reliability.

A hospital's obstetrical unit has many of the characteristics that define HROs. The MORE^{OB} Program believes that the following HRO principles can be successfully adopted within the culture of obstetrical units:

- Safety is the priority and is everyone's responsibility
- Communication is highly valued
- Operations are a team effort
- Emergencies are rehearsed
- Hierarchy disappears in an emergency. Decisions on safety issues can be made at any level of the organization
- There is multidisciplinary review of events and routines

The current culture of blame in addressing patient occurrences/events is recognized as a significant barrier to improving patient safety. The MORE^{OB} Program focuses on the review of these events to find root causes and not to assign blame. The emphasis in the event review process is on understanding why the caregivers made the decisions they made within the context of the situation they were working in at the time, and how the organizational systems affected the event. The purpose of the review is to enable the caregivers to learn from the event, to share their findings with their peers, and to make recommendations to appropriate levels and departments within the organization, in order to prevent a similar event from recurring.

The Vision, Mission and Goals of the MORE^{OB} Program

Our Vision

Patient safety is the guiding principle.

Our Mission

To create a culture where patient safety is everyone's first priority by:

- Developing effective teamwork and communication.
- Eliminating the culture of blame.
- Embracing learning, knowledge sharing, and evaluation.
- Promoting interprofessional collaboration with trust and respect.

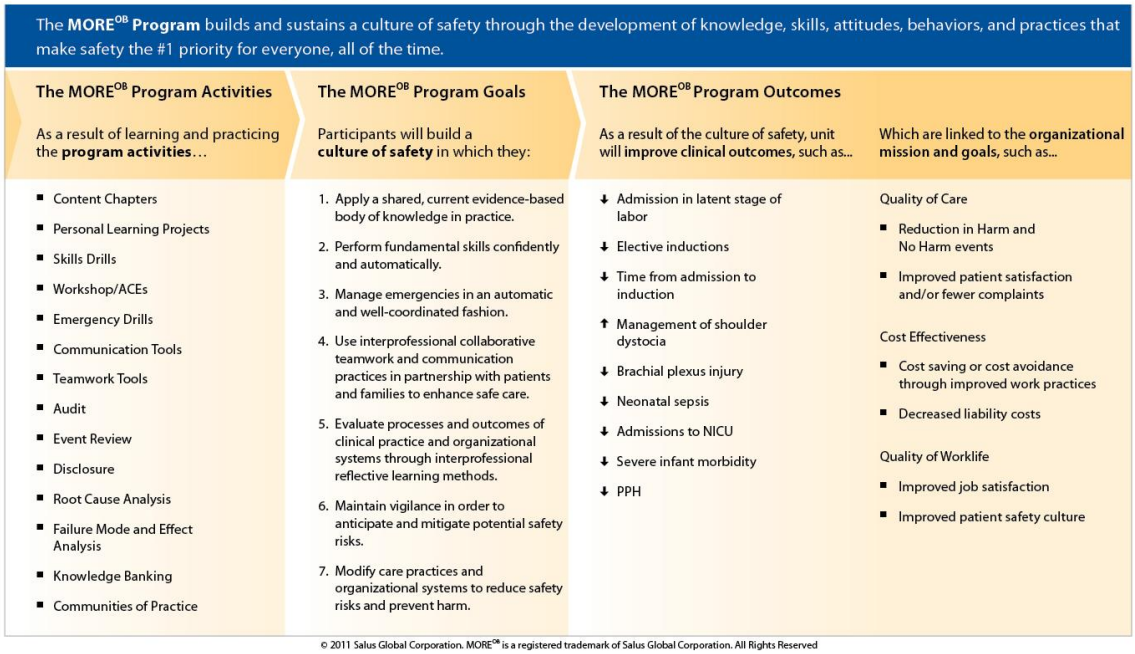
The MORE^{OB} Program Goals

The MORE^{OB} Program builds and sustains a culture of safety by developing the knowledge, skills, attitudes, behaviors, and practices that make safety the number one priority for everyone, all of the time. Upon completion of the MORE^{OB} Program, participant and their teams will be able to:

- Apply a shared, current evidence-based body of knowledge in practice.
- Perform fundamental skills confidently and automatically.
- Manage emergencies in an automatic and well-coordinated fashion.
- Use interprofessional collaborative teamwork and communication practices in partnership with patients and families to enhance safe care.
- Evaluate processes and outcomes of clinical practice and organizational systems through interprofessional reflective learning methods.
- Maintain vigilance in order to anticipate and mitigate potential safety risks.
- Modify care practices and organizational systems to reduce safety risks and prevent harm.

As a result of engaging in the MORE^{OB} Program activities, the obstetrical unit will build a patient safety culture; as a result of the improved culture, the unit may achieve improved clinical outcomes, which in turn contribute to the achievement of the organizational mission and goals related to quality of care, cost effectiveness and quality of worklife.

The MORE^{OB} Program Impact Map



Description of the MORE^{OB} Program

The MORE^{OB} Program is a collaborative relationship involving Salus Global, the participating hospital, and possible funding partners.

Structure of the MORE^{OB} Program

The MORE^{OB} Program is implemented in 3 modules over a three-year period. The healthcare organization identifies a Core Team comprised of frontline caregivers from each professional discipline providing obstetrical care, unit managers, representatives from senior administration and other key organizational stakeholders. The Core Team then rolls out the program to all participants in the unit. Each module is introduced to the Core Team by an interprofessional team of MORE^{OB} Facilitators. Subsequent to each Core Team Orientation Session, a MORE^{OB} Program Consultant provides ongoing support and guidance throughout program implementation to help Core Teams achieve the goals of each module. The modules are delivered sequentially, as building blocks and include:

- Module 1: Learning Together
- Module 2: Working Together
- Module 3: Changing the Culture

The focus of Module 1 is learning together to achieve a common, evidence-based body of knowledge across all disciplines. Improved interprofessional trust, respect, and communication resulting from shared knowledge are the first steps in an evolution toward a patient safety culture.

The focus of Modules 2 and 3 is on reflective learning, practice modification and building a patient safety culture with an emphasis on developing Communities of Practice (CoP). Communities of Practice are comprised of individuals with a common interest who share their knowledge and experience to identify and solve common problems.[4] The resultant "knowledge bank" created by the interprofessional reflective learning process can be used to develop effective strategies to solve problems and manage patient care processes. This joining together of the collective knowledge and practice experience of all involved disciplines makes CoP a very effective and efficient method to address the barriers to patient safety. The MORE^{OB} Program provides coaching and support to help Core Teams build their Communities of Practice and move toward a patient safety culture.

Each module introduces additional activities and processes so that the elements of a safety culture are gradually integrated into the unit culture in a step by step fashion over the three years of the program.

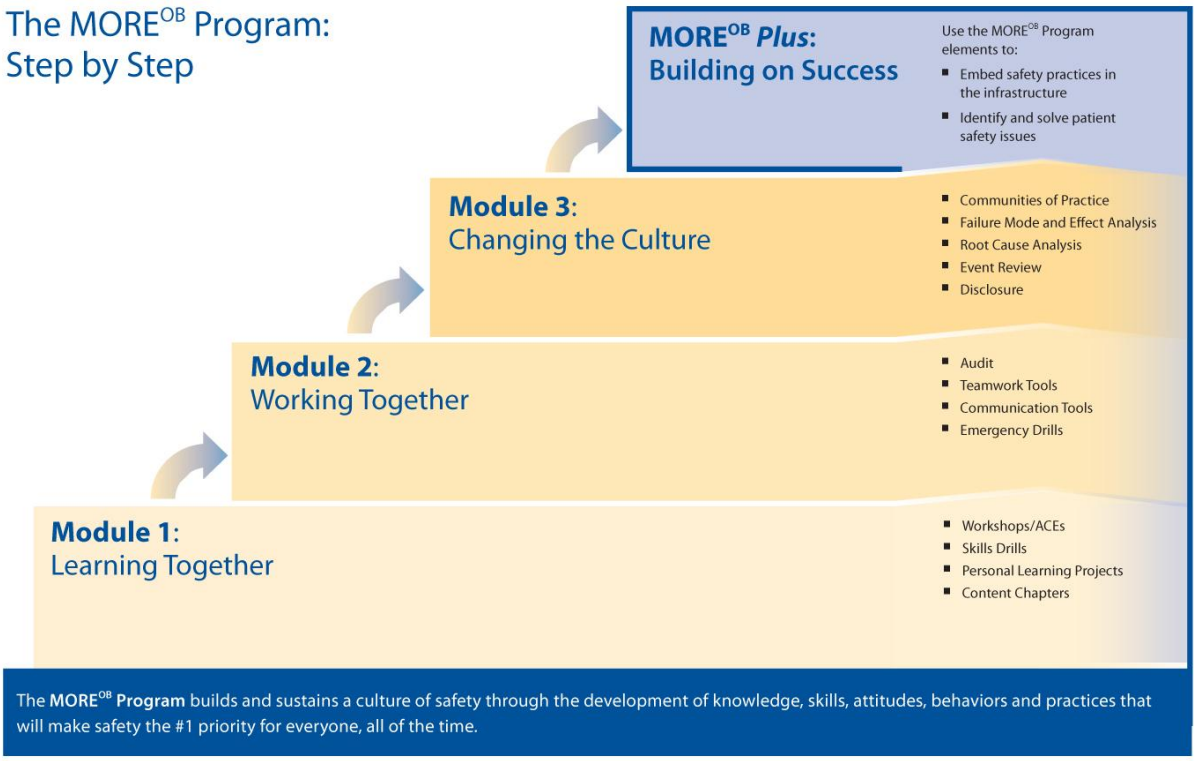
The MORE^{OB} *Plus* Program

After the completion of the MORE^{OB} Program, healthcare organizations have the opportunity to leverage their success and continue to build their patient safety capacity through engagement in the MORE^{OB} *Plus* Program. This program provides tools and strategies for sustaining and building on the results achieved in Modules 1, 2 and 3 of the MORE^{OB} Program.

The goals of the MORE^{OB} *Plus* Program are:

- Maintain competencies in the core content of the program.
- Embed safety practices into the work infrastructure.
- Build capacity to identify and solve patient safety risks with process solutions.

4 *Parboosingh IJ. Physician communities of practice: where learning and practice are inseparable. Journal Cont Educ Health Professional 2002; Vol. 22, Number 4, pp. 230-236.*



Continuing Professional Learning Principles

The MORE^{OB} Program uses the following Continuing Professional Learning (CPL) principles for:

- Evaluation
- Education
- Practice modification
- Reflective learning

Evaluation is pivotal to reflective learning for the individual participant and for the obstetrics unit as a whole. Individual evaluation is accomplished through a Self-Assessment, a Culture Assessment Survey (CAS), a Pre-test and Post-test, and repeat evaluations of each participant's knowledge base at the end of each module (annually). This evaluation is completed via *MORE^{OB} Online*, a dedicated URL website for the MORE^{OB} Program. Participant information is confidential and accessible only to the individual.

Evaluation of the obstetrical unit's progress to improved safety is accomplished through review of annual aggregate data, including unit knowledge test scores, CAS results, the Environmental Scan, Patient Satisfaction Survey results, and an impact survey for each module.

The **Educational** content is delivered in two parts. **Part 1** may be completed at home or at work, in an individual or group setting. It is provided on a Web platform to every participant registered in the program. Module 1 includes all of the clinical content chapters and introductory chapters on patient safety principles. Modules 2 and 3 contain chapters focused on patient safety concepts, processes, and methodologies. Participants are able to review all chapter content at any time. The fully referenced content is provided in an interactive format. **Part 2** of the educational content occurs in the hospital environment in an interprofessional workshop format.

The MORE^{OB} Workshop/ACE format promotes the integration of content knowledge with the HRO principles, such as patient safety, teamwork, and communication. The workshop component includes hands-on skills demonstration, interactive discussions, and interprofessional problem solving exercises. The ACE (Action to Consolidate Education) component provides an opportunity for each participant to demonstrate competency in selected topics through a peer-facilitated skills demonstration.

Practice modification involves the application of program tools and processes to modify clinical practices as required to improve patient safety performance. Program tools such as Decision Trees, Mnemonics and Skills Drills help participants to incorporate their learning into practice.

Reflective learning processes such as audit and event review provide an opportunity for individuals, the Core Team, and the obstetrical program to identify gaps and opportunities for improvement in patient safety. The audits and reviews are carried out in a non-punitive, objective, and educational environment. The purpose of the processes is to facilitate reflective learning to solve problems, identify system failures, and make recommendations to prevent and/or mitigate the impact of harm events.

Data collection from all of the above activities enables the obstetrical program to create a knowledge bank based on best practices and processes of patient care.

Salus Global is committed to ensuring that the Clinical Core Content is current, evidence-based, and updated annually. In addition, new workshops and drills are added as feedback from the participating hospitals is reviewed. Participating in Workshops and ACEs in each module helps to improve team functionality by building trust and respect.

The MORE^{OB} Program Suite of Tools

Annual Program Environmental Scan

The Environmental Scan provides a “snapshot” of the Birthing Unit’s performance according to a variety of indicators relevant to a safety culture. It consists of several sections; each section contains multiple cells of information, and associated performance markers. The Core Team enters its own unit data annually to document its performance in each category. This enables the healthcare organization to identify and benchmark its unit’s areas of strength and areas for improvement, and to compare itself to units of a similar type and size at regional, provincial/state and national levels, over time.

The Patient Satisfaction Survey

The Core Team is responsible for conducting an annual, standardized Patient Satisfaction Survey of about 30 patients in the unit. This survey allows the provided care to be assessed from a consumer’s perspective. It provides the Core Team and the administration with an objective assessment of the Birthing Unit’s facilities, programs, and staff performance with a view to celebrating strengths and correcting deficiencies.

Content Chapters

MORE^{OB} Core Content is available via *MORE^{OB} Online* and contains obstetrical clinical information structured in an interactive format, together with non-clinical sections that focus on other key aspects of the program. The clinical content is updated annually following a standardized critical appraisal of the pertinent world literature by the Obstetrical Content Review Committee (OCR) of the Society of Obstetricians and Gynaecologists of Canada. This includes systematic reviews, randomized controlled trials and controlled clinical trials, as well as policy statements, position papers and practice guidelines from major national obstetrics specialty organizations and guideline developers. Learning from the same, current core knowledge base enables all professional disciplines to communicate and work effectively together with mutual trust and respect. The chapter topics are organized by module, according to topics covered primarily in each module; however, all chapters are accessible at any time.

Knowledge Tests

At the onset of the program, and again at the end of each module, each participant completes a confidential test of 75 multiple-choice questions, which allows participants to test their current knowledge and how this knowledge changes over the course of the program. In addition, individuals can compare their results with those of their peers, at the regional, provincial/state and national levels.

Individual scores can be viewed only by the individual participant; however, the Core Team can monitor unit-level average knowledge gains over time, and can compare their unit scores with those of other units of a similar type and size at the regional, provincial/state and national level.

Annual Workshop/ACE (Action to Consolidate Education) Day

Each participant attends an annual Workshop/ACE Day, facilitated by the Core Team. This component provides participants with an opportunity to consolidate their knowledge in an environment that emphasizes team building and a “community of practice” approach.

Culture Assessment Survey (CAS)

This survey enables the Birthing Unit to identify areas of strength and any gaps which impede the building and sustaining of a patient safety culture, and to monitor progress over time. The Culture Assessment Survey is completed by each participant at the beginning of the program and at the end of each module. The scores are available via *MORE^{OB} Online,* and a detailed report is compiled and presented to the Core Team by the MORE^{OB} Program Consultant.

Skills Drills

Skills Drills enable all participants to practice common Birthing Unit procedures in a non-stressful environment. Skills Drills provide hands-on experience to assist caregivers in recognizing and anticipating problems, preparing their patients for procedures, and assisting other team members in a true interprofessional approach.

Emergency Drills

Emergency Drills are hands-on exercises that assist the interprofessional team to practice for the most common expected obstetrical emergencies. The drills are de-briefed and deficiencies, or possible problems, can be recognized in a rehearsal situation. Emergency Drills contribute to improved communication, teamwork, interprofessional trust, and respect.

Event Tracking and Review

The Event Tracking and Review Tool provides an opportunity for every participant to identify Harm and/or No Harm Events on a form that respects both patient and participant confidentiality. Interprofessional reviews of these events are led by Core Team Members following a specific set of guidelines and principles that facilitate reflective learning rather than blame. The recommendations arising from this reflective learning process will contribute to the department's knowledge base and improve patient safety by addressing the systems issues that led to the event.

Root Cause Analysis

Root Cause Analysis is a retrospective reflective learning process for identifying underlying clinical and organizational factors that influence outcomes. By focusing on system issues that led to the Harm/No Harm Event, the interprofessional team is able to identify changes that could be made in systems and procedures to reduce the risk of recurrence of the event.

Failure Mode and Effect Analysis (FMEA)

FMEA is a prospective reflective learning tool that encourages an interprofessional team approach to examining routine procedures and processes in a systematic manner. By breaking each clinical process down into its multiple steps and closely examining each step from the viewpoint of "what could possibly go wrong here?" the team can anticipate potential trouble points or deficiencies and repair them before an event occurs.

Decision Trees

A Decision Tree is provided at the end of most clinical chapters. The Decision Trees graphically represent key decision points that reflect the current evidence-based practice approaches to decision-making around common clinical situations.

Audits

A Case Audit Tool is available for most clinical chapters. These case audits may be used by individuals at the conclusion of a specific case in order to reflect on personal performance in a particular clinical area. The Case Audit Tools are also very helpful to guide caregivers in their documentation of the process and outcomes of care in the health record.

The MORE^{OB} Program also provides training and tools geared to the development of unit-specific audits to address particular areas of concern. The MORE^{OB} Group Audit process may be used to assess care practices or system processes that affect care delivery. The Core Team is responsible for selecting and assigning groups of participants to work on the audit topics, for reviewing and sharing the audit results and leading a process to learn from the audits and introduce change where indicated.

Team Fitness Test

A Team Fitness Test and associated team building exercises are available to enable the Core Team to become more effective and efficient in their implementation of the program. Areas for improvement can be identified and tools are available to use in improving teamwork within the Core Team.

Structured Communication and Teamwork Tools (CHAT/SBAR Tool)

CHAT/SBAR and a number of other structured communication and teamwork tools are provided to assist healthcare providers or disciplines to work closely together to provide safe, high-quality, coordinated care to patients.

Knowledge Management

The MORE^{OB} Program Tools help Core Teams develop and manage the knowledge that is achieved through their reflective learning. *MORE^{OB} Online* provides "knowledge bank" repositories for individual participants and for the unit as a whole to record and share their learning throughout the program.

Communities of Practice (CoP)

CoP is a network of people sharing a common interest in a defined area of knowledge or competence that are committed to working and learning together and sharing their knowledge over time. The MORE^{OB} Program promotes and fosters the growth of CoPs within obstetrical programs as a strategy to manage the program's collective knowledge and enhance a patient safety culture.

Implementation of the MORE^{OB} Program

Core Teams

The implementation process in each healthcare organization's obstetrical unit is led by an interprofessional Core Team that includes family physicians, obstetricians, midwives, nurses, risk management personnel, senior administrators, and a governing body/board member. Each member of the Core Team is required to provide a signed commitment form indicating that he/she has read the mandate and understands his/her responsibilities. A Core Team Selection Guide is provided to assist in this process.

The mandate of the Core Team is to lead the implementation of the MORE^{OB} Program within their hospital environment, monitor unit progress, and evaluate the outcome of each module. Each member of the interprofessional Core Team receives comprehensive orientation to the suite of tools contained in all of the modules of the program, and how to use these tools to transfer information to all of the other participants engaged in the program.

The leadership provided by the members of the Core Team is pivotal for the successful implementation of the MORE^{OB} Program. The members of the Core Team must be readily identified to their peers, colleagues and the public. They are selected for their exemplary leadership skills as well as for their interest in patient safety, quality of care and risk management. It is also recommended that support be provided by the hospital administration to Core Team Members' own professional development in recognition of their time commitment and leadership.

Core Team Implementation Responsibilities Include:

Module 1 Learning Together	Module 2 Working Together	Module 3 Changing the Culture
▪ Set Module 1 objectives, implementation plan and timeline ▪ Launch Module 1 ▪ Complete Environmental Scan #1 ▪ Conduct Patient Satisfaction Survey #1 ▪ Engage participants in completing Module 1 chapters ▪ Set up Skills Drills station and facilitate participant completion of Skills Drills ▪ Plan and conduct Workshop/ACE Day for all participants ▪ Monitor progress toward goals ▪ Evaluate Module 1 and share results	▪ Set Module 2 objectives, implementation plan and timeline ▪ Launch Module 2 ▪ Complete Environmental Scan #2 ▪ Conduct Patient Satisfaction Survey #2 ▪ Select Module 1 and Module 2 chapters for participants to review ▪ Continue Skills Drills ▪ Implement CHAT/SBAR and other selected communication / teamwork tools ▪ Implement Emergency Drills ▪ Implement Group Audits ▪ Plan and conduct Workshop/ACE Day ▪ Monitor progress toward goals ▪ Evaluate Module 2 and share results	▪ Set Module 3 objectives, implementation plan and timeline ▪ Launch Module 3 ▪ Complete Environmental Scan #3 ▪ Conduct Patient Satisfaction Survey #3 ▪ Select Module 1, Module 2 and Module 3 chapters for participants to review ▪ Continue Skills Drills ▪ Continue communication / teamwork tools ▪ Introduce Communication: Disclosure ▪ Continue Emergency Drills ▪ Continue Audits ▪ Implement Event Review and FMEA processes ▪ Plan and conduct Workshop/ACE Day ▪ Monitor progress toward goals ▪ Evaluate Module 3 and share results ▪ Evaluate impact of the full three-year program

Core Team Orientation

At the beginning of each module, a team of MORE^{OB} Facilitators will meet with the Core Team to present an overview of the program goals and structure, and focus on the content and performance expectations for the specific module. These sessions are interactive and will provide many opportunities for Core Team Members to work together to identify and incorporate their unit safety goals into the plans and strategies for implementing the MORE^{OB} Program in their unit. All members of the Core Team are required to attend all program orientation sessions, and must arrange to sign out of their clinical and/or administrative responsibilities during this period.

Module 1 - Learning Together

Module 1 Orientation involves a two-day (eight hours per day) session for the Core Team. It includes a general orientation to the magnitude of clinical error, safety theory, principles and practices in addition to specific information about the MORE^{OB} Program goals, tools and implementation processes.

Module 2 - Working Together

Module 2 Orientation involves a one-day (eight-hour) session for the Core Team. This session builds on the Core Team's experience in Module 1, and focuses on the objectives, tools and strategies for Module 2.

Module 3 - Changing the Culture

Module 3 Orientation involves a one-day (eight-hour) session for the Core Team, building on previous learning and focusing on the objectives, tools and strategies for Module 3.

The MORE^{OB} *Plus* Program

The MORE^{OB} *Plus* Program is available for all participating hospitals that want to continue to build on their success with the program and to sustain the development of a patient safety culture. Further information about this option will be presented by the Program Consultant during the Module 3 year.

MORE^{OB} Program Consultant

A MORE^{OB} Program Consultant is introduced during Module 1 Orientation, and continues throughout the duration of the program to provide ongoing guidance, support and assistance to the Core Team for successful program implementation and achievement of their safety goals.

Data Collection

To support the MORE^{OB} Program, a database has been developed and used as a repository for institutional, Core Team and participant activity. All information relating to the MORE^{OB} Program learning, testing, and skills assessment is maintained in this database. A third-party at a secure site holds all of the data; participant data are only available to the individual. Each healthcare organization's information is available only to that organization; organizations have access to aggregate data only for comparable organizations at a regional, provincial/state and national level.

Continuing Education Credits

The multiple components of the MORE^{OB} Program are accredited by the Royal College of Physicians and Surgeons' Maintenance of Certification program for continuing professional development and are recognized for MAINPRO® credits from the College of Family Physicians of Canada. In addition, COGNATE credits have been granted from the American College of Obstetricians and Gynecologists.

The MORE^{OB} Program enables midwives and registered nurses to provide evidence of participation in continuing education activities to meet the requirements of their provincial/state licensing bodies.

Participation in these varied continuing professional activities and the assigned CME credit hours are maintained in a personal, cumulative logbook that lists every MORE^{OB} activity logged by the participant by date, title, and time investment. This log is available via *MORE^{OB} Online* to each individual and can be downloaded in a PDF file to be used in conjunction with a downloadable participation certificate as necessary for documentation.

MORE^{OB} Program History

The Development of the MORE^{OB} Program

The MORE^{OB} Program was originally developed by the Society of Obstetricians and Gynaecologists of Canada under the leadership of Dr. J.K. Milne, the former Associate Executive Vice President of the SOGC. The SOGC collaborated with key national organizations, including the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Society of Rural Physicians of Canada, the Association of Women's Health, Obstetric and Neonatal Nurses, the Canadian Association of Midwives and Accreditation Canada.

An interprofessional working committee representing family physicians, obstetricians, midwives, nurses and hospital administrators from across the country developed the program's content. Consultation was also provided by experts in medical education, knowledge testing / examination, and delivery of training programs.

Implementation of the MORE^{OB} Program

The MORE^{OB} Pilot Program was launched in the fall of 2002, involving 21 healthcare organizations, representing 33 hospitals and 2656 participants in three provinces. Based on the success of the pilot sites, the Canadian national launch occurred in 2004, and by 2008 the program was also available in the French language. The initial two hospitals in the United States became involved in 2005, with additional hospitals joining in 2010.

Salus Global Corporation

Salus Global Corporation was formed in 2007 as the result of the common interest of the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Healthcare Insurance Reciprocal of Canada (HIROC) to continue to improve patient safety for obstetrical patients. Their support provided the necessary resources to expand the MORE^{OB} Program and begin the introduction of broader hospital patient safety programs.

Impact of the Program

The MORE^{OB} Program has expanded from the initial 33 pilot hospitals in May 2004 to over 11,000 participants in over 230 healthcare organizations in Canada and the United States. The results demonstrate the ability of the program to:

- Engage large numbers of participants in a multidisciplinary process to improve patient safety.
- Shift existing cultures to a more focused patient safety culture as measured by the CAS tool, with all elements showing improvement.
- Improve the obstetrical core knowledge of participants in all disciplines and in all environments.
- Improve maternal and fetal clinical outcomes.[5]
- Reduce incurred costs of labor and delivery claims in participating hospitals as reported by claims data provided by the Health Insurance Reciprocal of Canada.
- Support the accreditation process.
- Facilitate a process for measuring the impact on the work environment.

5 Nguyen XT, Jacobs P, Wanke MI, Hense A, Sauve R. Outcomes of the introduction of the MORE^{OB} continuing education program in Alberta. JOGC 2010; August: 749-755.

Summary

The MORE^{OB} Program is a patient safety program that facilitates a change in culture, improves quality of care, encompasses professional development, fosters communities of practices, and enhances knowledge management in obstetrical units.

The MORE^{OB} Program creates a new model of care by breaking down traditional hierarchy and practices and directing the focus on effective interprofessional communication and teamwork. It facilitates an environment of working and learning together. It is clear that the MORE^{OB} Program is consistent with the intent of the mission and vision of the Canadian Patient Safety Institute and the National Patient Safety Foundation by:

- Fostering the sharing of knowledge and information about optimal patient safety practices and models.
- Influencing change in culture and providing advice to support change in systems to improve patient safety.
- Collaborating with stakeholders in an ongoing dialogue to support patient safety improvements.

Salus Global anticipates that the MORE^{OB} Program will be adopted as a patient safety model in most obstetrical care units across Canada and the United States. Consequently, data, knowledge, and program components will support change within obstetrical care units throughout the country and can be easily shared by obstetrical healthcare providers and obstetrical departments regionally, provincially/state-wide and nationally.

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Visit the MORE^{OB} public website at www.moreob.com