Maximizing and Sustaining Lean Improvement Efforts

Val Ferris, RN, ELMBA
Oregon Hospital Association
November 1, 2013
Objectives

• Describe the VMMC transformational journey with VMPS
• Review key learnings through application of VMPS
  ▪ Inpatient Experience
  ▪ Perioperative Experience
• Describe leadership role for sustainability
Virginia Mason Medical Center

- Integrated health care system
- 501(c)3 not-for-profit
- 336-bed hospital
- Nine locations
- 500 physicians

- 5,500 employees
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute
Virginia Mason Medical Center Strategic Plan

Patient

Vision
To be the Quality Leader and transform health care

Mission
To improve the health and well-being of the patients we serve

Values
Teamwork | Integrity | Excellence | Service

Strategies

People
We attract and develop the best team

Quality
We relentlessly pursue the highest quality outcomes of care

Service
We create an extraordinary patient experience

Innovation
We foster a culture of learning and innovation

Virginia Mason Team Medicine™ Foundational Elements

Strong Economics | Responsible Governance | Integrated Information Systems | Education | Research | Virginia Mason Foundation

Virginia Mason Production System
Visible & Committed Leadership

Dr. Kaplan reviewing the flow of the process with Drs. Jacobs and Glenn
...It will be like turning the Queen Mary

Where was Toyota in the 1950s?
Or “Made in Japan” in the 1960’s?
“If you are dreaming about it… you can do it.”

Chihiro Nakao, Chairman and CEO
Shingijutsu International

November 4, 2003
Transforming Healthcare…

FROM

• Provider First
• Waiting is Good
• Errors are to be Expected
• Diffuse Accountability
• Add Resources
• Reduce Cost
• Retrospective Quality Assurance
• Management Oversight
• We Have Time

TO

• Patient First
• Waiting is Bad
• Defect-free Medicine
• Rigorous Accountability
• No New Resources
• Reduce Waste
• Real-time Quality Assurance
• Management On Site
• We Have No Time
Requirements for Transformation

- Sense of Urgency
- Visible & Committed Leadership
- Shared Vision
- Aligned Expectations

Technical & Human Dimensions of Change
Improvement Method
The Virginia Mason Production System

We adopted the Toyota Production System key philosophies and applied them to healthcare

1. The patient is always first
2. Focus on the highest quality and safety
3. Engage all employees
4. Strive for the highest satisfaction
5. Maintain a successful economic enterprise
1. The Patient is *Always* First

- The patient is at the top of our strategic plan
- Value is defined by the patient
- Patient’s voice is embedded in our improvement activities
Virginia Mason Clinics Patient Satisfaction
Overall and Recommend Practice Mean Score Trends

- Likelihood of recommending practice
- Overall

16th Percentile
74th Percentile
71st Percentile
17th Percentile
2. Focus on Highest Quality & Safety

• Embedding mistake proofing into everything we do

• Patient Safety Alert (PSA)

• 5S across VMMC

• Standard Work
Safety Culture Question
Staff Speak Up Freely*

*Question: Staff will speak up freely if they see something that may negatively affect patient safety
Business Case for Patient Safety:
Total Number of Claims and PSAs Reported

Total number of claims excludes claims closed with no payment

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<th>Year</th>
<th>Premiums</th>
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<td>2011-12</td>
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3. Engage all Employees

- Employees trained in VMPS
- Involve employees in improving *their own* work with ELI\(^1\)
- RPIW\(^2\)/Kaizen

\(^1\)Everyday Lean Ideas (ELI)  
\(^2\)Rapid Improvement Process Work (RPIW)
4. Strive for the Highest Satisfaction Levels
VMMC Staff Partnership Results

Staff Partnership Response Rates

Staff Partnership Score

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5. Maintain a Successful Economic Enterprise

VMMC Net Margin (in Millions)

- 2000: $0.70
- 2005: $3.20
- 2006: $12.00
- 2007: $18.40
- 2008: $29.40
- 2009: $49.40
- 2010: $40.90
- 2011: $31.70
- 2012: $25.63

Shared Success Program
Our VMPS Journey

Toyota Production System introduced to VMMC

Virginia Mason Production System established

Executive visit Japan

Mary L. McClinton fatal medical error

Model line work

Monday a.m. 'Standup'

Collaboration with vendors

VMPS certify executives

Weekly RPIW report outs

VMPS certification program

Executive Office of Process Improvement, 5 FTEs

VMPS promotion office, 25 FTEs

Kaizen fellowship

Manager training

1-3 Day Kaizen events

All management leads 2-day Kaizen event annually

VMPS education cohorts

Mandatory flu shots

60 Day Updates for RPIW report outs

Quarterly 'Standup' for all staff

Training within industry

3P certification program

Jones Pavilion opened, VMPS designed

Leapfrog top Hospital of the Decade

‘Patient First’ strategic plan

Patient Safety Alerts (PSA), no layoff policy

Model line work

Primary care flow stations

Quarterly 'Standup' for all staff

Jones Pavilion opened, VMPS designed

Education

Office of Process Improvement, 5 FTEs

VMPS certification program

Executive Office of Process Improvement, 5 FTEs

Office of Process Improvement, 5 FTEs

1-3 Day Kaizen Events

All management leads 2-day Kaizen event annually

3P Certification Program

VMPS Education Cohorts

Virginia Mason Institute

Training within Industry

Moonshine prototype: Therapy car

Standard work for leaders

KPO structure

Executive visit Japan

Office of Process Improvement, 5 FTEs

VMPS certification program

Executive Office of Process Improvement, 5 FTEs

Office of Process Improvement, 5 FTEs
Priorities Align with Vision

Long Term Vision

5 Year Plans

Annual Goals

KPO Priorities

Quality and Safety
1. Ambulatory Preventive Care Bundle
2. Optimizing Care Transitions
3. Health care-acquired Infections
4. Smoothing Patient Flow
5. Preventing Hospital Induced Delirium
6. Glycemic Control

KPO Priorities

Hospital
- Reduce lead time
- Improve access and avoid the patient flow
- Eliminate fall with injury
- Medication error
- Implement Standard Work for Leaders
- Achieve margin targets

Clinic
- Reduce lead time
- Improve access and day of visit workflow
- Eliminate defects in the administration of health maintenance module
- Implement Standard Work for Leaders
- Achieve margin targets

Corporate
- Reduce lead time
- Zero defects in Hill/Platt at admission flow
- Eliminate defects in the distribution of supplies in OR instrument sets
- Implement Standard Work for Leaders
- Achieve margin targets

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We are in the Eleventh Year of our the Journey

Building the House

Point Improvements

Point Tools at point of use
Eliminate waste at source - starting at the point closest to the customer
• Non Value Added vs. Value Add tasks identified
• Work In Process (WIP) Reduction
• VMPS Leader Training
• Daily Waste Elimination of Taiichi Ohno’s 7 Wastes
• Kaizen Plan and People Link in place

Point Root out basic problems, make improvements, build a foundation

Point Improvements

Goal: Flow vs. Batch

Spatial Improvements

Jones Pavilion
Link all elements from concept to customer.
Raise improvement to the other planes: Finance, HR, Suppliers, etc.

Height
3rd Dimensional

• Feeder lines e.g., Ancillary, RX, Supply Chain, Sterile Processing are integrated
• Up & downstream value streams e.g., IT, HR, Payroll, Finance embedded

Line Improvements

Example - Sterile Processing Value Stream
Link processes to create a cell. Flow production begins here. Flow paves the way for line improvements

Line

• Change production method from “Push” to “Pull”
• Plan for Leveling
• Develop Standard Operations
• Quickly Solve Flow Problems
• Add Production Tracking Boards – practice visual control
• Standard Work for Leaders – Daily Production Visibility

Critical Transition from Point to Line

5-10 Years

Goal: A Model Line

Plane Improvements

Example - Orthopedics Model Line
Link cells to produce a product. The model line is used as a reference and replicated across the plane.

Plane

• Implement Mistake Proofing
• Balance the Line
• Heijunka – level the work
• 1 x 1 Production Flow

Other processes make point and line improvements based on the model line

10-15 Years

Goal: Raise to Other Planes

Spatial Improvements

Jones Pavilion
Link all elements from concept to customer.
Raise improvement to the other planes: Finance, HR, Suppliers, etc.

Height
3rd Dimensional

• Feeder lines e.g., Ancillary, RX, Supply Chain, Sterile Processing are integrated
• Up & downstream value streams e.g., IT, HR, Payroll, Finance embedded

Goal: Spread Across Plane

2002 - 2004

2005 - 2010

10-15 Years

2011 - today
The VMPS Structure

- Kaizen Promotion Office (KPO) is aligned with the operational executive leadership
- Executive sponsors have accountability for sustained results
Accountability: Tier Reporting

Tier 1 Reporting:
Senior Executive Leadership reports updates on key metrics to the Board of Directors

“Stand Up” Tier 2 Reporting:
Vice Presidents, KPO and Administrative Directors report updates on key metrics to the Chief Executive Officer

PeopleLink Tier 3 Reporting:
Managers report to department staff and Administrative Directors
VMPS Education

- Intro to VMPS
- VMPS General Education
- VMPS Leadership Training
- VMPS Certification
- VMPS Fellowship
Central KPO Focus: Accountability

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VMPS In Action
Hospital Nursing
Application of Virginia Mason Production System Principles

• Increase RN and PCT value added time with the patient
• Eliminate defects and improve safety
• Decrease “burden of work” for staff
• Integrate flow of patient, provider, medications, supplies, equipment and information
• Decrease lead time
Future Vision resulting from 3P’s
Whole System Redesign

Redesign of Work Spaces
- Work Cells
- Acuity Adaptable
- Safety

Redesign of Work Processes
- Remove waste
- Value added time with patients

Redesign of Care Delivery Models
- Operators needed
- Skill task alignment

Redesign of Work Culture
- Care driven by the needs of pts
- Trust
- Collaboration
“Nursing Cells” – The Idea

RAPID PROCESS IMPROVEMENT WORKSHOP IDEA FORM

<table>
<thead>
<tr>
<th>Employee / Area</th>
<th>Problems</th>
<th>Measures Taken</th>
<th>Results</th>
</tr>
</thead>
</table>
| RN / PCT assignment | • RN works in multiple PCTs & vice versa.  
  • RN assignment spread throughout entire hallway due to pt. acuities  
  • High risk patients clustered at nurse station  
  • Geographical location of RN/PCT not of highest priority | • Create/label "cells" of rooms to be assigned to RN/PCT.  
  • PCT will work only 2 RNs in adjacent cells.  
  • Cells will be rooms of close geographical proximity & RN/PCT working in more synchronized flow  
  • High risk patients evenly spread over unit - not clustered. | • With RN + PCT both working in a cell, patient surveillance increased.  
  • RN leaves cell less frequently  
  • Use call lights  
  • High risk pts spread with level loading of cells  
  • Easier for RN/PCT to locate each other for assistance |

Before Improvement

After Improvement

Remarks:  
Name: ROWENA

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Standard “Flow” Worksheet

Floor Map

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Enhancing Care Team workflows

No waiting in line for OmniCell
No missing items

Group items w/Color Codes & Map

Frequently used supplies at bedside

Linen supplied daily by Housekeeper
Foundational Elements

• Geographic assignments
• Documentation near the patient
• In room handoffs
• RN:PCT integration
• Huddles every shift
• Hourly rounds by caregivers
• Daily Leader rounds
• People Link Boards
Documentation in room or close to patients
Bedside High-Risk Med Checks
Standard Bedside Report

WHY:
- Introduction of oncoming caregivers
- Involves the patient in discussion
- Builds in safety
- Adds time with patient

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<th>Bedside Handoff Checklist</th>
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<tr>
<td><strong>1 Introduction</strong></td>
</tr>
<tr>
<td>- Name of oncoming RN and assistant</td>
</tr>
<tr>
<td>- Explains handoff process</td>
</tr>
<tr>
<td>- Inquires how patient is feeling</td>
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<tr>
<td><strong>2 Background (Basics)</strong></td>
</tr>
<tr>
<td>- Age, MD, reason for admission</td>
</tr>
<tr>
<td>- Isolation</td>
</tr>
<tr>
<td><strong>3 Current status</strong></td>
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<tr>
<td>- Brief history</td>
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<tr>
<td>- Functioning prior to admission</td>
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<td>- Key medications</td>
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<td>- Tests for the day</td>
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<td><strong>4 Assessment</strong></td>
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<tr>
<td>- Patient identification</td>
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<td>- High risk meds</td>
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<td>- IV</td>
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<tr>
<td>- Physical assessment</td>
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<tr>
<td>- Precautions/Skin/Wound</td>
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<td>- Patient input</td>
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<td><strong>5 Recommendations</strong></td>
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<tr>
<td>- Plan of the Day</td>
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<tr>
<td>- Safety concerns</td>
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<tr>
<td>- Patient issues</td>
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<tr>
<td><strong>6 Closing</strong></td>
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<tr>
<td>- &quot;Is there anything you need at this time?&quot;</td>
</tr>
<tr>
<td>- Determine when will return</td>
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RN and Patient Care Technician Integration

- Understand flow of patients
- Determined operators needed for patient care
  - 1:1 ratio RN:PCT
  - Flow of surgeries
  - Staffing ratios changed on key units
Daily Huddles
Daily Leader Rounding

- Standard process so that every patient receives a service round from unit leader during their stay:
  - Visual Control
  - Standard Work
Genchi Genbutsu

- Leader Alignment
- Defined foundational elements
- Routine genba walks with leadership and operations
- Skills maps for unit nursing leadership

### Foundational Elements Progress Report

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<tr>
<th>Units</th>
<th>Geographic Assignments</th>
<th>RN/PCT Integration</th>
<th>In Room Handoff</th>
<th>Huddles Every Shift</th>
<th>Documentation near the Patient</th>
<th>Hourly Rounds by Caregiver</th>
<th>Daily Leader Rounds</th>
<th>People Link Board (PLB) Updated</th>
<th>Monthly Staff Huddles by PLB</th>
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Criteria: Not Implemented, Implemented Plan with Progress, Fully Implemented

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Managerial Courage & Holding the Gains

- It will be worth it
- Leading change is hard work
- Accountability and follow up
- Skeptics can become champions
- Patients and staff depend on it
VMPS In Action
Perioperative Experience
Background

- Multiple events
- Great ideas
- Respect team and create alignment
- Create a common vision – Connect the Dots

Event Names:
1. PCT /Anesthesia Tech Role in Induction Kaizen Event KE
2. PCT/RN/ITT Role in Induction KE
3. Induction Room Supplies at point of use KE
4. 5S Surgery Check CSR KE
5. Planning for Surgery Guide KE
6. PeriOp Information Flow RPIW
7. Flow of Information to Families/Visitors on the Day of Surgery RPIW
8. Anesthesia Plan for Care

Dates:
1. 12/16-17 2009
2. 2/8/10 (Followup event to previous event)
3. 3/26-27/10
4. 9/16-17 2010
5. 11/10/10
6. 5/17-21 2010
7. 7/26-30/10
8. 8/9-13 2010
Start with a Vision

Surgical Services Vision Statement

To deliver a safe, timely surgical experience of the highest quality, shaped by innovation and efficiency, driven by teamwork
Move Across Traditional Silos

Clinic Experience

Periop Flow

Inpatient Care

Follow Up Care
Teamwork
# Surgical Services Priorities in 2013

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<tr>
<th><strong>We all pledge to:</strong></th>
<th><strong>Our work in 2013:</strong></th>
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<tr>
<td><strong>RESPECT.</strong></td>
<td><strong>implement TeamSTEPPS</strong> (Team Strategies and Tools to Enhance Performance and Patient Safety), a method to improve communication and teamwork skills</td>
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<tr>
<td>- Treat patients, families, and coworkers with respect</td>
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<td>- Listen to understand</td>
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<td><strong>DELiVER.</strong></td>
<td><strong>Support organizational quality and safety goals:</strong> Improve glycemic control for diabetic patients; Surgical Care Improvement Project (SCIP); and Smoothing Patient Flow</td>
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<tr>
<td>- Commit to safety and no waits</td>
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<td>- Give extraordinary service, every patient, every time</td>
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<td>- Provide a safe hand off</td>
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<tr>
<td><strong>INNOVATE.</strong></td>
<td><strong>Maintain an Integrated Kaizen Plan</strong> across the Surgical Services Value Stream</td>
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<tr>
<td>- Engage in continuous improvement</td>
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<td>****</td>
<td><strong>Involve teams in the design and process of opening new facilities</strong></td>
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</table>
# 2013 Project Plan

## Project Overview

**Date:** January 2013

**Purpose:** Review of the project plan and status update.

## Project Timeline

<table>
<thead>
<tr>
<th>Project Phase</th>
<th>Start Date</th>
<th>End Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Planning</td>
<td>January 2013</td>
<td>March 2013</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Design and Specification</td>
<td>March 2013</td>
<td>May 2013</td>
<td>Complete</td>
</tr>
<tr>
<td>Procurement</td>
<td>May 2013</td>
<td>June 2013</td>
<td>Complete</td>
</tr>
<tr>
<td>Construction</td>
<td>June 2013</td>
<td>August 2013</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Commissioning and Testing</td>
<td>August 2013</td>
<td>September 2013</td>
<td>Complete</td>
</tr>
<tr>
<td>Handover and Training</td>
<td>September 2013</td>
<td>October 2013</td>
<td>Complete</td>
</tr>
</tbody>
</table>

## Key Milestones

1. **Initial Planning**
   - 2013: Project initiation
   - 2014: Detailed planning

2. **Design and Specification**
   - 2013: Conceptual design
   - 2014: Detailed design

3. **Procurement**
   - 2013: Supplier selection
   - 2014: Contract signing

4. **Construction**
   - 2013: Site preparation
   - 2014: Construction activities

5. **Commissioning and Testing**
   - 2013: Equipment installation
   - 2014: Functional testing

6. **Handover and Training**
   - 2013: Final reviews
   - 2014: User training

## Project Budget

- **Initial Planning:** $500,000
- **Design and Specification:** $1,000,000
- **Procurement:** $2,000,000
- **Construction:** $5,000,000
- **Commissioning and Testing:** $3,500,000
- **Handover and Training:** $1,500,000

## Contact Information

- **Project Manager:** John Doe
- **Technical Support:** Jane Smith

## Project Team

- **Core Team:**
  - John Doe (Project Manager)
  - Jane Smith (Technical Support)

- **Support Team:**
  - Bob Brown
  - Alice Black
  - Sarah White

## Project Documents

- **Project Plan:**
  - 2013)
- **Design Drawings:**
  - 2013)
- **Procurement Contracts:**
  - 2013)

## Project Risk Management

- **Major Risks:**
  - Delays in construction
  - Equipment delivery delays

- **Risk Mitigation Strategies:**
  - Expedited scheduling
  - Diverse supplier selection

## Project Reporting

- **Monthly Reports:**
  - Status updates
  - Budget status
  - Risk management

## Project Closure

- **Project Closure:**
  - 2014: Project review
  - 2015: Post-project analysis

## Conclusion

The project is currently on track with all milestones completed on schedule. Further review and analysis will be conducted to ensure project closure and successful handover.

© 2013 Virginia Mason Medical Center
After 20 minutes the Charge Nurse will assess the bedside RN’s ability to take a second patient.

**ASPAN STANDARD**

- New admissions should be assigned so that the nurse can devote his/her attention to the care of that admission until critical elements are met.
- Critical Elements can be defined as:
  - Report has been received from the anesthesia care provider, questions answered, and the transfer of care has taken place.
  - Patient has a stable/secure airway
  - Initial assessment is complete.
  - Patient is hemodynamically stable
  - Patient is free from agitation, restlessness, and combative behaviors.

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Flow of PACU Patients to Support Day-of-Surgery Flow KE

Patient Discharge from PACU to Jones 11

PACU RN
- Determine patient ready to discharge (Adobe B & T8 – Final assessment charting complete)
- Signal PCT – Pt ready for Discharge
- Signal J11 w/Vocera
- Signal J11 Call Pt Transport 3 minutes prior to giving report
- Give Report to Unit RN
- Disconnect O2 Just Prior to Departure
- Final time discharge in Cerner

PCT PACU
- Receives Signal – Pt ready
- Empty Foley and Drain
- Collects Patient Belongings
- Disconnect Pt Monitor - RN Assists
- Clean wires

ITT #1
- Receives Signal – Pt ready
- Puts line thru pt name on white board
- Deps PACU
- Arrives PACU – Signal
- Pacer signal and informs PFC pt leaving

ITT #2
- Receives Vocera Signal and informs PACU of call back time
- Calls PACU RN to receive report using SBAR Format
- Deps PACU
- Arrives PACU – erases pt name and informs PFC pt leaving

UNIT RN
- Prepares the Pt Room
- Receives Vocera Signal and informs PACU of call back time
- Calls PACU RN to receive report using SBAR Format

PFC
- Call wall room – affix patient label on way unit

Outpatient Discharge Safety Checklist

DATE:
RN NAME

AFFIX PATIENT LABEL HERE

PHASE 1 - RN

PRESCRIPTIONS
- Prescriptions filled at home (via mail, etc.)
- Prescriptions given to family member prior to leaving facility
- ADDITIONAL NOTES:

FAMILY
- Family in waiting area/facility
- Family called to come to hospital for patient pick-up
- Alternate transportation called
- Other:
- ADDITIONAL NOTES

PHASE 2 - RN
- Prescriptions filled w/patient family attending
- Discharge instructions communicated to patient/family
- Voiding Criteria has been met prior to discharge
- IV Discontinued
- ADDITIONAL NOTES:

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### SBAR Tool

**Situation**
- Communicate:
  - Name and which PACU they are coming from
  - History of patient in PACU and last care only:
    - OR - treated in PACU
    - OSA - treated in PACU/ICU from home
    - HTN - treated in PACU

**Background**
- Communicate:
  - Anesthetic type
  - Surgeon's name
  - History of patient in PACU and last care only:
    - OR - treated in PACU
    - OSA - treated in PACU/ICU from home
    - HTN - treated in PACU

**Assessment**
- Communicate [ ] assessment in PACU:
  - Level of consciousness
  - Movement of extremities
  - Surgical site
  - Packing (vaginal, rectal, or any orifice)
  - POIV
  - IV access
  - Meds given by anesthesiologist (i.e. Toradol)
  - Patient Info (dentures, glasses, hearing aid)

**Recommendations**
- Communicate plan of care for:
  - Skin and Nausea
  - Diabetic management
  - Post voiding (if haven't voided or no POIV)
  - Family

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**SBAR for the RN Handoff**

**Situation**
- Name and which PACU they are coming from

**Background**
- Anesthetic type
- Surgeon's name
- History of patient in PACU and last care only:
  - OR - treated in PACU
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OR Room Turnover Time Between Cases

OR Turnover Time

- OR 1-16
- OR 17-20
- Lindeman
- Goal

Annual Trend

2013 Avg by month

Lower is better

Minutes

OR 1-16 vs OR 17-20 vs Lindeman vs Goal

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Patient Satisfaction

Surgical Services Patient Satisfaction Survey Results
2008 - 2013 June YTD

- TOTAL SCORE for OR and Recovery
- Overall rating of surgery experience
- Information to family
- Staff concern for privacy
- Comfort in recovery room
- Rating of staff
- Explanations by Anesthesiologists
- Friendliness of Anesthesiologists

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# 10 Things to Know About Periop Services!

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A New Surgical Floor is being planned on Jones Pavilion level 3. Target date for opening is <strong>late 2013</strong>.</td>
</tr>
<tr>
<td>2</td>
<td>Sterile Processing manages <strong>3,974</strong> instrument sets and will SSL <strong>482</strong> sets in preparation for their remodel on H3 which begins in September 2012.</td>
</tr>
<tr>
<td>3</td>
<td>Operating Room Turnover time has improved <strong>17%</strong> since implementing process changes from the Superflow in April. Goal is less than <strong>30 minutes</strong> from Patient-Out to Patient-In.</td>
</tr>
<tr>
<td>4</td>
<td>The Procedure Card Initiative has resulted in a <strong>20%</strong> decrease of procedure cards, and <strong>222</strong> instrument sets removed. Goal is to review 400 cards representing <strong>70%</strong> of cases.</td>
</tr>
<tr>
<td>5</td>
<td>Perioperative Services is committed to improving communication across our value stream. Strategies include: Q &amp; A * Newsletter * Work Plan * Dashboard * News Briefs</td>
</tr>
<tr>
<td>6</td>
<td><strong>Respect for People</strong> is foundational to a work environment where everyone knows their contributions matter. We will hold ourselves and others accountable to consistently demonstrate respectful behaviors.</td>
</tr>
<tr>
<td>7</td>
<td>The New Surgical Prep and Family Waiting Area opens on <strong>Sept 10</strong>. We reduced the number of touches for the patient from <strong>3 to 1</strong> with standard work and successful integration of nurse interviews.</td>
</tr>
<tr>
<td>8</td>
<td>Barcoding PACU medication administration begins <strong>Nov 15</strong>. Mistake proofing our current medication practices aligns with the organizational goal for medication safety.</td>
</tr>
<tr>
<td>9</td>
<td>Mistake proofing the <strong>flow of patient information</strong> from surgical clinics through the surgical experience remains an area of focus. Standard work for completed consents, orders, and H&amp;Ps will reduce delays on day-of-surgery.</td>
</tr>
<tr>
<td>10</td>
<td><strong>Every surgical patient</strong> now has a touch from the Pre-Anesthesia Clinic prior to surgery, either with a nurse or anesthesiologist. This provides the foundation for managing the complex patient.</td>
</tr>
</tbody>
</table>
Critical Success Factors

• Respect past efforts
• Align improvement with goals
• PDSA vs. events
• Defined scope and tight sponsorship
• Operations leading with VMPS
• Genba rounds
• Implement on Monday and debrief
• Celebrate success
Role of Leadership
Common Leadership “Mental Paradigm” Problems

**Same Old Routine**
- Manage from office
- Tell people what to do
- Blame
- Manage by numbers
- Respond to fires
- Seek confirming evidence
- Delegate
- I have the answer

**Practice New Routine**
- Go see
- Teach people
- Improve process
- Quantitative + Qualitative
- Ask why, why, why…
- Seek contrarian views
- Participate
- Let team do analysis
Leadership Requirements Needed to Sustain VMPS

- Set priorities that align with the vision
- Use VMPS tools & methods
- Lead change
- Allocate resources to VMPS
- Require accountability
- Implement standard work for leaders
Are We Ready for Change?
Nemawashi Gauge

Standard Work for Leaders

People Link / Huddle

Genba Presence

Leader Preparation

Staff Readiness / Engagement

Baseline: _____  Q1: _____  Q2: _____  Q3: _____  Q4: _____  Target: _____

5 of 10

- 0-3
- 4-6
- 7-10

Q __ ACTION
1. _____________
   _______________
2. _____________
   _______________
3. _____________
   _______________

5 of 10
Accountability: Daily Huddles

Have daily huddles with your team

Example: Inpatient Telemetry

Example: Health Information Services
Making Huddles Visual

Standing Topics for each huddle appear FIRST

New items added to reflect current issues

Wipe board pulls off of wall to use during huddle, then goes back up

Standard categories

<table>
<thead>
<tr>
<th>Topic</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| Updates | - Tony Viscom is in his week of orientation.  
- Saturday, Nurse hired to start orientation in March
- Facility updates  
  - Jones Procedural moves to May 25th; all GI recovery patients will no longer recover on H5.  
  - Will need support for training new nurses
  - H5 surgical prep and waiting room construction starts in March.  
  - Hallway by old E0 will be closed, all traffic will be routed through main hallway.  
  - Will close slot 15.
  - Implants space on H5 will be walled off.  
  - Construction in March
- Annual evaluations – Please read e-mail |

| Safety | PSA on high risk med checks
- Hand hygiene and PPE |

| VBDR | Update on Flow in IR
- Event to address admission and history the next month with goal to reduce questions on day of surgery.
- Check in ID lab draw and sending to lab if time allows.
- Standard work for all functions in IR (Playbook)
- March 19-24th event led by Bob Caplan, MD and Val Ferris to address flow of complex patients.  How do we close the gap?  More welcome!
- Other improvements
  - H5 PCT’s wearing Voicea to communicate with facilitator to pull patients
  - Training new nurse server for new surgical preparation area |

| We need your help | |

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## Accountability: Leader Rounding

### Charge Nurse Standard Work Checklist

<table>
<thead>
<tr>
<th>Time</th>
<th>Task Description</th>
</tr>
</thead>
</table>
| 7:30/8:30 AM  | - Check sick calls  
                - Check staffing (Identify on-call staff and evening closers)  
                - Make assignments (Identify float staff, preceptors, orientees)  
                - Check OR schedule and patient disposition  
                - Coordinate breaks for early morning prep staff |
| 7:45/8:45 AM  | Huddle with charge nurses – PACU 6, PACU 6, Lind, & Prep 6 (Share staffing concerns, break plans) via Vocola conference call |
| 8:00/9:00 AM  | Verify AM duties completed                                                                        |
| 9:00 AM       | Call in on-call staff (if needed)                                                                 |
| 10:00 AM      | Attend Bed-board meeting (PACU 6 Charge Nurse only)                                               |
|               | Gather Information from PACU 6 and Linderman Charge to take to bed-board meeting                 |
| 10:30 AM      | Coordinate lunch plan – huddle with floaters                                                     |
| 11:00 AM      | Ensure floaters have initiated lunch breaks                                                      |
| 1:30 PM       | Huddle with charge nurses (PACU 6, PACU 6, Linderman, Prep 6) via Vocola conference call        |
| 2:00 PM       | Assess  
                - Break status  
                - Surgery schedule/census  
                - Staffing |
| 3:00 PM       | Check surgery schedule and print staffing daily sheet for next day                              |
| 4:00 PM       | Initiate 2nd Breaks for non-Less staff  
                - Huddle with Jones and Interventional radiology (PACU 6 Charge Nurse only) via phone |
| 7:45/8:45 PM  | Handoff to evening charge (Staffing concerns, admissions)                                        |
| 5:30 PM       | Evening charge huddle: PACU 6, Lind & Prep 6 (OR add-ons, staffing concern) via Vocola          |
| 6:00 PM       | Sign-off closing duties (PACU 5 & Linderman)                                                     |
| 7:00 PM       | Evaluate Breaks and Ervow Census  
                - Sign-off closing duties (PACU 6)                                                            |

Notes: 01/2013

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### Standard Work for Leaders

<table>
<thead>
<tr>
<th>Rounding</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACU 6</td>
<td>PACU 5</td>
</tr>
<tr>
<td>OR</td>
<td>07:30-12:00</td>
</tr>
</tbody>
</table>

### RED Huddle

<table>
<thead>
<tr>
<th>Staff</th>
<th>RED</th>
<th>DC</th>
<th>Communication Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>PACU 6</td>
<td></td>
<td></td>
<td>□ Check under sinks</td>
</tr>
<tr>
<td>Level 7</td>
<td>□</td>
<td></td>
<td>□ Check Code Cart</td>
</tr>
<tr>
<td>Level 6</td>
<td>□</td>
<td></td>
<td>□ Supplies and Equipment</td>
</tr>
<tr>
<td>Level 5</td>
<td>□</td>
<td></td>
<td>□ Food and Drink</td>
</tr>
<tr>
<td>Jones 1</td>
<td>□</td>
<td></td>
<td>□ AM/PM Duty Checklist</td>
</tr>
<tr>
<td>Level 0</td>
<td>□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS</td>
<td>□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL NOTES

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Accountability: Genba Walks

1. Go to the department
2. Look at the process,
3. Talk with the staff.
Tips from the “Field”

• The truth is at the “genba”
• Root cause for “failures”
• Be present during the change
• Provide easy opportunities for feedback
• Mindful of pace of change
• “Hearts of the staff”
• Defined ownership
• Precise and focused sponsorship
• VMPS is the management method!
“Go and See”

Big Ears, Big Eyes, Small Mouth
Questions and Answers