Respect, Reliability and Resilience: Building and Sustaining a Learning Organization

Gary S. Kaplan, MD

2015 Hospital Quality Institute Conference

November 12, 2015
“If you are dreaming about it... you can do it.”

Sensei Chihiro Nakao
Virginia Mason Medical Center

- Integrated health care system
- 501(c)3 not-for-profit
- 336-bed hospital
- Nine locations
- 500 physicians
- 6,000 employees
- Graduate Medical Education
- Research Institute
- Foundation
- Virginia Mason Institute
Time for a Change

Year 2000

Issues
  – Survival
  – Retention of the Best People
  – Loss of Vision
  – Build on a Strong Foundation

Leadership Change

A Defective Product
The Challenge of Healthcare

- Poor Quality..............................3% defect rate
- Impact on individuals.............100% defect
- Cost of poor quality...............Billions of dollars
- Cost of healthcare to those who pay..........................Unaffordable
- Access........................................Millions
- Morale of workers.......................Unreliable systems
Virginia Mason
OUR 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 Foundational Elements

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

Virginia Mason Production System

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Why is Change So Hard?

Culture

Lack of Shared Vision

Misaligned Expectations

No Urgency

Ineffective Leadership
Urgency for Change at VMMC

“We change or we die.”

— Gary Kaplan, VMMC Professional Staff Meeting, October 2000

The lead story is titled “The Biggest Mistake of Their Lives” and chronicles four survivors of medical errors.

The article goes on to say that in 2003, as many as 98,000 people in the United States will die as a result of medical errors.
November 23, 2004 – Virginia Mason Medical Center

Investigators: Medical mistake kills Everett woman

Hospital error caused death

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Clash of “Promise” and Imperatives

Traditional “Promise” Legacy Expectations

• Autonomy
• Protection
• Entitlement

Imperatives

• Improve safety/quality
• Implement EHR
• Create service experience
• Be patient-focused
• Improve access
• Improve efficiency
• Recruit/retain quality staff
Virginia Mason Medical Center
Physician Compact

Organization’s Responsibilities

Foster Excellence
- Recruit and retain superior physicians and staff
- Support career development and professional satisfaction
- Acknowledge contributions to patient care and the organization
- Create opportunities to participate in or support research

Listen and Communicate
- Share information regarding strategic intent, organizational priorities and business decisions
- Offer opportunities for constructive dialogue
- Provide regular, written evaluation and feedback

Educate
- Support and facilitate teaching, GME and CME
- Provide information and tools necessary to improve practice

Reward
- Provide clear compensation with internal and market consistency, aligned with organizational goals
- Create an environment that supports teams and individuals

Lead
- Manage and lead organization with integrity and accountability

Physician’s Responsibilities

Focus on Patients
- Practice state of the art, quality medicine
- Encourage patient involvement in care and treatment decisions
- Achieve and maintain optimal patient access
- Insist on seamless service

Collaborate on Care Delivery
- Include staff, physicians, and management on team
- Treat all members with respect
- Demonstrate the highest levels of ethical and professional conduct
- Behave in a manner consistent with group goals
- Participate in or support teaching

Listen and Communicate
- Communicate clinical information in clear, timely manner
- Request information, resources needed to provide care consistent with VM goals
- Provide and accept feedback

Take Ownership
- Implement VM-accepted clinical standards of care
- Participate in and support group decisions
- Focus on the economic aspects of our practice

Change
- Embrace innovation and continuous improvement
- Participate in necessary organizational change
### Physician Compact

**Virginia Mason Medical Center Physician Compact**

<table>
<thead>
<tr>
<th>Organization’s Responsibilities</th>
<th>Physician’s Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Foster Excellence</strong></td>
<td><strong>Focus on Patients</strong></td>
</tr>
<tr>
<td>- Ensure that patients, physicians, and staff are treated with respect and dignity.</td>
<td>- Promote the best interests of our patients.</td>
</tr>
<tr>
<td>- Support our values and mission.</td>
<td>- Ensure optimal patient care.</td>
</tr>
<tr>
<td>- Recognize the importance of education and development.</td>
<td>- Encourage patient involvement in care and treatment decisions.</td>
</tr>
<tr>
<td><strong>Provide Leadership and Professional Development</strong></td>
<td>- Achieve and maintain optimal patient care.</td>
</tr>
<tr>
<td>- Identify and support leaders in all areas.</td>
<td>- Insist on quality care.</td>
</tr>
<tr>
<td><strong>Lift and Lead</strong></td>
<td><strong>Collaborate as Care Delivery Team</strong></td>
</tr>
<tr>
<td>- Provide leadership with internal and external partners.</td>
<td>- Include staff, managers, and management on teams.</td>
</tr>
<tr>
<td>- Identify opportunities for improvement.</td>
<td>- Treat all wounds with respect.</td>
</tr>
<tr>
<td>- Build and maintain a culture of continuous improvement.</td>
<td>- Encourage the highest levels of ethical and professional standards.</td>
</tr>
<tr>
<td>- Create an environment that supports teams and individuals.</td>
<td>- Require discernment, respect, and care in all interactions.</td>
</tr>
<tr>
<td><strong>Build and Lead</strong></td>
<td><strong>Take Ownership</strong></td>
</tr>
<tr>
<td>- Manage and lead organizations with energy and accountability.</td>
<td>- Implement the best practices of health care.</td>
</tr>
<tr>
<td>- Develop leaders who lead with purpose.</td>
<td>- Participate in and support teaching.</td>
</tr>
</tbody>
</table>

### Leader Compact

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<thead>
<tr>
<th>Organization Responsibilities</th>
<th>Leader Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus on Patients</strong></td>
<td><strong>Focus on Patients</strong></td>
</tr>
<tr>
<td>- Promote a culture where physicians feel comfortable and respected.</td>
<td>- Promote the best interests of our patients.</td>
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### Board Compact

<table>
<thead>
<tr>
<th>Organization’s Responsibilities</th>
<th>Board Member’s Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus on Patients</strong></td>
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</tr>
<tr>
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The VMMC Quality Equation

\[ Q = A \times \frac{(O + S)}{W} \]

Q: Quality
A: Appropriateness
O: Outcomes
S: Service
W: Waste
You should submit wisdom to the company.

If you don’t have any wisdom to contribute, submit sweat.

If nothing else, work hard and don’t sleep.

Or resign.”
Think Different

- $\frac{1}{2}$ the human effort
- $\frac{1}{2}$ the space
- $\frac{1}{2}$ the equipment
- $\frac{1}{2}$ the inventory
- $\frac{1}{2}$ the investment
- $\frac{1}{2}$ the engineering hours
- $\frac{1}{2}$ the new product development time
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
Seeing with our Eyes
Japan 2002
Hitachi Air Conditioning

Team Leader Kaplan reviewing the flow of the process with Drs. Jacobs and Glenn
What we learned

How are air conditioners, cars, looms and airplanes like health care?

- Every manufacturing element is a production process.
- Health care is a combination of complex production processes: admitting a patient, having a clinic visit, going to surgery or a procedure and sending out a bill.
- These products involve thousands of processes—many of them very complex.
- All of these products involve the concepts of quality, safety, customer satisfaction, staff satisfaction and cost effectiveness.
- These products, if they fail, can cause fatality.
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
Visual Control for Safety

5S Anesthesia Shadow Board - Before
Visual Control for Safety

5S Anesthesia Shadow Board - After
Central Line Insertion Standard Work

Before

Dry:
30 sec scrub
30 sec dry

Wet:
2 min scrub
1 min dry

Dry: 30 sec scrub
30 sec dry

Wet: 2 min scrub
1 min dry

Maximum Barrier Protection

Thyroid

Angio Drapes

During

OR

AND

OR

Transducer Method

Manometer Method

Transducer Kit in Top Drawer of Cart

After

Approved to use
Date/Initial

Yellow – top of cart

White – in chart progress notes

Complete Paperwork

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Stopping the Line™

Virginia Mason’s Patient Safety Alert System™
Stopping the line
Patient Safety Alert Process™

Created August 2002

- Leadership from the top
- “Drop and run” commitment
- 24/7 policy, procedure, staffing
- Legal and reporting safeguards
A Turning Point for Virginia Mason

• In 2004, a medical error caused the tragic death of Mary L. McClinton, a VM patient.

• This event and the decision for full public transparency was a defining moment for the organization.
Safety Culture Question – Staff Speak Up Freely*

*Question: Staff will speak up freely if they see something that may negatively affect patient safety
60,000th PSA Reported

- 1,000th: July 2005
- 10,000th: March 2008
- 20,000th: February 2011
- 30,000th: October 2012
- 40,000th: September 2013
- 50,000th: September 2014
- 60,000th: September 2015

End of September 2015: 60,685
“Good Catch!” Safety Award
Natural Language Query Analysis

– Increase our ability to learn from PSA narratives.

• In 2013 we completed a first pilot study on response to calls for urgent care.

• We discovered patterns in the type of call that led to multiple phone-call transfers in seeking assistance.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Number of Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 : Allergic Reaction Severe</td>
<td>1 0 0 0 1 0 0 0 0</td>
</tr>
<tr>
<td>2 : Choking</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>3 : Poison or Chemical Ingestion</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>4 : Suicide</td>
<td>2 1 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>5 : Unresponsive</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>6 : Arm, back, neck, jaw, stomach discomfort</td>
<td>1 1 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>7 : Cold sweat</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>8 : Discomfort severe</td>
<td>14 4 1 0 3 0 0 0 0</td>
</tr>
<tr>
<td>9 : Lightheadedness</td>
<td>1 1 0 1 1 0 0 0 0</td>
</tr>
<tr>
<td>10 : Abdominal or Pelvic Pain</td>
<td>4 0 0 1 0 0 0 0 0</td>
</tr>
<tr>
<td>11 : Abuse or Assault</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>12 : Bleeding</td>
<td>3 0 0 4 0 0 0 0 0</td>
</tr>
<tr>
<td>13 : Breathing Difficult</td>
<td>6 8 0 3 1 0 0 0 0</td>
</tr>
<tr>
<td>14 : Burn</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>15 : Dialysis Complication</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>16 : Diarrhea</td>
<td>0 1 1 0 0 0 0 0 0</td>
</tr>
<tr>
<td>17 : Fever over 100</td>
<td>1 1 1 0 0 0 0 0 0</td>
</tr>
<tr>
<td>18 : Glycemic event in diabetic</td>
<td>1 0 2 0 0 0 0 0 0</td>
</tr>
<tr>
<td>19 : Heartbeat abnormal</td>
<td>2 0 0 0 1 0 0 1 0</td>
</tr>
<tr>
<td>20 : Hypertension</td>
<td>1 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>21 : Infection</td>
<td>4 2 2 0 1 0 1 0 0</td>
</tr>
<tr>
<td>22 : Leg swelling or DVT</td>
<td>0 0 0 1 1 0 0 0 0</td>
</tr>
<tr>
<td>23 : Needlestick or sharps</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>24 : Organ transplant complication</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>25 : Penis, testical or scrotum</td>
<td>0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>26 : Postop Complication</td>
<td>1 5 2 2 2 0 0 0 0</td>
</tr>
<tr>
<td>27 : Rash or redness</td>
<td>3 1 0 0 1 0 0 0 0</td>
</tr>
<tr>
<td>28 : Seizure or Convulsion</td>
<td>0 1 0 0 0 1 0 0 0</td>
</tr>
<tr>
<td>29 : Urinary Symptoms</td>
<td>1 0 2 0 0 0 0 0 0</td>
</tr>
<tr>
<td>30 : Vomiting</td>
<td>1 1 2 3 1 0 0 0 0</td>
</tr>
<tr>
<td>31 : Ambulation</td>
<td>0 2 2 2 0 0 0 0 0</td>
</tr>
<tr>
<td>32 : Cognition</td>
<td>2 0 3 0 1 0 0 0 0</td>
</tr>
<tr>
<td>33 : Numbness</td>
<td>3 3 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>34 : Severe headache</td>
<td>1 1 1 0 0 0 0 2 0</td>
</tr>
<tr>
<td>35 : Speech defect</td>
<td>0 1 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>36 : Visual defect</td>
<td>1 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>
Synchronized Ongoing Support (SOS): An Integrated Response to Unanticipated Outcomes

1. Major unexpected clinical need; or
2. Major immediate family need; or
3. Urgent non-clinical support need

Dial ‘0’ for Patient Safety & Patient Relations

- Identify needs, just-in-time coaching
  - Patient advocate
  - Patient safety
  - Provider
  - Clinical team
  - Peer to Peer

- Assess needs, align resources, plan next steps
  - Administrator
  - Patient advocate
  - Mgr/Primary RN
  - RN supervisor
  - Spiritual care
  - Social work
  - Patient safety

- Support immediate needs of team
  - Area leader
  - Involved team
  - Spiritual care

- Support needs of patient and family
  - Patient advocate
  - Tailored check-ins
  - Navigates needs
  - Coordinates follow up meeting

- Support needs of team member(s)
  - Team debrief
  - Tailored Check-ins
  - Spiritual care
  - EAP
  - Schwartz Rounds

- Systems review
  - Patient safety
  - PSA process
  - Care Review
  - Root Cause
  - Analysis
  - Preparation
  - Follow up family meeting

- Time zero – tailored
- Within 30 minutes
- Within 12 hours
- Tailored to needs
- Tailored to needs
- Within 8 weeks

SOS – A standard response that is transparent, individualized and phased to promote restoration and growth for all touched by the event.

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Team Support

I was pleased to see a member of Patient Relations in the hospital immediately after the incident. This was after regular business hours and I did not expect this kind of team and family support at such a late hour. I feel this was going above and beyond for our team members.

- a provider
Effectiveness of Patient Safety Program

Excludes claims without payment

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VMHS Hospital Professional/General Liability Insurance Premiums

% change from previous year, with 74% overall reduction in premium since 2004-05
“Nursing Cells” – Results > 90 days

RN time available for patient care = 90%!

Before
• RN # of steps = 5,818
• PCT # of steps = 2,664
• Time to the complete am cycle of work = 240’
• Patients dissatisfaction = 21%
• RN time spent in indirect care = 68%
• PCT time spent in indirect care = 30%
• Call light on from 7a-11a = 5.5%
• Time spent gathering supplies = 20’

After
• RN # of steps = 846
• PCT # of steps = 1256
• Time to the complete am cycle of work = 126’
• Patients dissatisfaction = 0%
• RN time spent in indirect care = 10%
• PCT time spent in indirect care = 16%
• Call light on from 7a-11a = 0%
• Time spent gathering supplies = 11’
VMPS Method: One Piece Flow
Flow Stations
Team Based Care

Medical Assistant:
- Standard rooming sequences
- Review Health Maintenance Module
- Shared documentation
- Coordinating provider “flow” through the day

RN:
- Patient assessment
- Empowerment of patient for self care
- Protocol driven-teaching and coaching for chronic conditions
- Nursing procedures

Pharmacist:
- Medication management for chronic conditions
- Advanced protocols for disease state management

Provider:
- Diagnosis and treatment of new problems
- Oversight of complicated problems
- Minor surgical and diagnostic procedures
- Mentor and coach for team based care

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Leveling the Workload

Takt Time

Minutes

Before Setup

After Setup

Setup

Setup

MA

MD

Setup

Setup

MA

MD

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VMPS Method: Mistake Proofing

The Health Maintenance Module
## Build To Order Results

<table>
<thead>
<tr>
<th>EVENT</th>
<th>OLD</th>
<th>NEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Craniotomy</td>
<td>SPD Set Up = 34:00 min</td>
<td>SPD Set Up = 18:27 min</td>
</tr>
<tr>
<td></td>
<td>OR Set Up = 24:09 min</td>
<td>OR Set Up = 2:34 min</td>
</tr>
<tr>
<td>Laminectomy</td>
<td>SPD Set Up = 34:00 min</td>
<td>SPD Set Up = 20:15 min</td>
</tr>
<tr>
<td></td>
<td>OR Set Up = 24:09 min</td>
<td>OR Set Up = 2:29 min</td>
</tr>
<tr>
<td>Minor Set</td>
<td>OR Set Up = 19:21 min</td>
<td>OR Set Up = 0:20 sec</td>
</tr>
</tbody>
</table>
Surgical Attestation Team

• **Interdisciplinary Team:** Anesthesia (Attending, Resident and Tech), Surgeons (Attending and Resident), OR Techs, ORNs, Periop Educator, Leadership

• **Aim:** Empower team members to speak up for safety

• **Vision:** To create the systematic delivery of rapid, effective and skill aligned reporting in the documentation and performance of surgical pre-incision timeout

• **Goals:**
  - 100% participation and performance of modified W.H.O. checklist
  - Increase expressions of safety during time out and during surgery
  - Improve our culture of safety
Anesthesia Provider:
- Consent is accurate & signed
- Blood products available, if ordered
- Allergies noted
- Allergy bracelet on
- Day of surgery labs drawn & results available
- Relevant documentation reviewed & matched to the patient
- Pt on Beta Blockers Pre op
- At risk for skin breakdown per pre op criteria

Circulating Nurse:
- Required implants/instruments/equipment available
- VTE Prophylaxis Ordered
- If yes, last dose (date/time) _________
- At risk for skin breakdown per pre op criteria

Surgeon:
- Consent matches plan
- Relevant images and/or diagnostic tests available & matched to patient to confirm site/sidedness
- Site/Side marked with “YES” with patient involved to the degree possible
- History & Physical updated and documented on printed H&P
- Family communication plan

Anesthesia Provider:
- Time Out performed before block
- Block site(s) marked with initials
- Anesthesia assessment & plan done
- Beta-blocker given w/in 24 hrs

Primary Surgeon/Resident/Proceduralist:
- Call for Time out

Circulating RN:
- Identify self / guest (PRN) – full name & role
- Identify patient, State Full Name & Date of Birth
- Consent signed for (state site & procedure)
- Foley - inserted/NA
- VTE Prophylaxis Initiated
- Yes
- No
- NA
- Rainbow sheet documentation accountability
- Room Status Board updated/Preliminary Count
- Solid Organ Transplant or Donation: ABO Type & Compatibility & UNOS # Verified
- NA

Surgical Scrub Tech:
- Identify self / guest (PRN) – full name & role
- Specific instrumentation available & ready
  - Specialty Implants / Equipment
  - Need for Vendor/Trainer?
- Confirms “YES” is visible in prepped field
- Drugs AND Solutions are all Labeled

Anesthesiology:
- Identify self / guest (PRN) – full name & role
- State significant Drug Allergies
- Antibiotics – given documented in Cerner/re-dosing plan
- On Beta Blocker? Received? Post-op order?
- If Diabetes & RBG =____/Insulin given/ordered?
- Normothermia measures documented
- Blood Products Ordered/Available/Amount, if applicable
- Cell Saver Plan, if applicable
- Concerns addressed? (Co-morbidities etc.), if applicable
- Plan for Post-op Pain Management

Surgeon:
- Identify self / guest (PRN) – full name & role
- State Name of Procedure, Site/s, Time Needed
- State Relevant Patient Clinical History
- Verify Imaging Matches - Patient/Site/Sidedness
- State Anticipated Difficulties / significant Co-morbidities
- State Anticipated Blood loss
- Post-op Plan – disposition/special bed?
- State Additional Information (ie. limit traffic etc.)
- Encourage Team Input or Safety Concerns

Surgeon & OR Team Confirm:
- Procedure performed, Documented
- Appropriately?
- Specimen is labeled correctly
- Special instructions communicated to the pathologist, if applicable.
- The surgeon swept the surgical site for retained items.
- Counts are correct
- Post op image reviewed, if applicable
- Family communication plan

What could have been done better
- Nothing
- Something, and a response plan formulated (who, what, when)

Equipment issues to be addressed
- No
- Yes, response plan formulated (who, what, when)

What are the key concerns for recovery and management of the patient?

PACU –
- Post Op antibiotics d/c with 24 hours
- Yes
- No, Provider Notified

Name ________________________

Date ______________________

Patient Label Here
World-Class Management

The World-Class Management System is a leadership system that provides focus, direction, alignment, and a method of management for daily work.
Set Priorities that Align with the Vision

Long Term Vision

5 year Plans

Annual Goals

KPO Priorities

Clinic Priorities

Section Priorities
Tuesday “Stand Up”

- KPO aligned with operational executive leadership
- Executive sponsorship with accountability for sustained results
- Education
- Standardization of tools, results reporting, and communication
Daily Management: Leaders Have Two Jobs

1. Run your business
2. Improve your business
Visual Controls

ED production board
Visual Controls

Patients can see status

<table>
<thead>
<tr>
<th>DATE</th>
<th>WE VALUE YOUR TIME!</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10/4/11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ON TIME</th>
<th>20 MINS LATE</th>
<th>GREATER THAN 20 MINS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Endow</td>
<td></td>
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<td>D. Cowles ARNP</td>
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Daily Accountability

Have daily huddles with your team

Example: Inpatient Orthopedics

Example: Health Information Services
Specifies the actions to be taken each day to focus on the processes in each leader’s area of responsibility.
VMPS Education

- Intro to VMPS
- VMPS General Education
- VMPS Leadership Training
- VMPS Certification
- VMPS Fellowship
Leaders Need to Be Idea Coaches

• Support staff in working on their ideas, but don’t do it for them
• Encourage root cause thinking
• Be straightforward with feedback
• Ask lots of questions to draw out creativity and critical thinking

This will be a big shift for some managers (i.e. being a coach and not the key problem-solver and rescuer!)
Everyday Lean Idea (ELI) system that puts staff in the driver seat.

The Vision

• Staff ideas with manager coaching
• all involved
• all the time
• reduce waste
• make things better
• in our work areas
• spread

“Easy Little Innovations” slogan by Jessica Noeldner, RN, Level 7
Effective Sponsorship

- Vision of success
- Set stretch goals
- Provide resources
- Remove barriers
- “Fail forward fast”
- Celebrate achievements
Genchi Genbutsu

- “It’s all lies”
- Go where the action is
- Know your people and let them know you
- Vulnerability is ok
- Connect the dots
Holding the Gains

• It takes hearts and minds
• Great people and great systems
• The gift of time is a treasure
• Accountability and audit
Our Journey

1. Institute of Medicine
2. Adverse Drug Events Prevention Team
3. Institute for Healthcare Improvement
4. Agency for Healthcare Research and Quality
5. Sociotechnical Probabilistic Risk Assessment
6. Must Do Measure Rapid Process Improvement Workshop
Respect for People refers to how we treat each other as we work together to create the perfect patient experience.
Top 10 Ways to Show Respect to People

1. **Listen to understand.** Good listening means giving the speaker your full attention. Non-verbal cues like eye contact and nodding let others know you are paying attention and are fully present for the conversation. Avoid interrupting or cutting others off when they are speaking.

2. **Keep your promises.** When you keep your word you show you are honest and you let others know you value them. Follow through on commitments and if you run into problems, let others know. Be reliable and expect reliability from others.

3. **Be encouraging.** Giving encouragement shows you care about others and their success. It is essential that everyone at VM understand their contributions have value. Encourage your co-workers to share their ideas, opinions and perspectives.

4. **Connect with others.** Notice those around you and smile. This acknowledgment, combined with a few sincere words of greeting, creates a powerful connection. Practice courtesy and kindness in all interactions.

5. **Express gratitude.** A heartfelt “thank you” can often make a person’s day and show them you notice and appreciate their work. Use the VM Applauso system, a handwritten note, verbal praise, or share a story of “going above and beyond” at your next team meeting.

6. **Share information.** When people know what is going on, they feel valued and included. Be sure everyone has the information they need to do their work and know about things that affect their work environment. Sharing information and communicating openly signals you trust and respect others.

7. **Speak up.** It is our responsibility to ensure a safe environment for everyone at VM, not just physical safety but also mental and emotional safety. Create an environment where we all feel comfortable to speak up if we see something unsafe or feel unsafe.

8. **Walk in their shoes.** Empathize with others; understand their point of view, and their contributions. Be considerate of their time, job responsibilities and workload. Ask before you assume your priorities are their priorities.

9. **Grow and develop.** Value your own potential by committing to continuous learning. Take advantage of opportunities to gain knowledge and learn new skills. Share your knowledge and expertise with others. Ask for and be open to feedback to grow both personally and professionally.

10. **Be a team player.** Great teams are great because team members support each other. Create a work environment where help is happily offered, asked for and received. Trust that teammates have good intentions. Anticipate other team members’ needs and clearly communicate priorities and expectations to be sure the work load is level loaded.
Flu Vaccination “Fitness for Duty”

- Do we put patient first?
- Compelling science
- Staff resistance
- Staying the course
- Organizational Pride
Requirements for Transformation

- Sense of Urgency
- Visible & Committed Leadership
- Shared Vision
- Aligned Expectations
- Technical & Human Dimensions of Change

Improvement Method
We are Fourteen Years into the Journey

The Kaizen Path

Point Improvements
- Eliminate waste at source - start at point closest to the customer, root out basic problems, make improvements, build a foundation

Line Improvements
- Vertical development
  - Link processes to create a cell. Flow production begins here. Flow paves the way for line improvements
  - Change production method from "Push" to "Pull"
  - Plan for Levelling
  - Develop Standard Operations
  - Quickly solve flow problems
  - Practice "Visual Control"

Spatial Improvements
- Height 3rd Dimensional
  - Link all elements from concept to customer, raise improvement to the other planes: Finance, HR, Suppliers, etc.

Plane Improvements
- Link cells to produce a product. The model line is used as a reference and replicated across the plane.

Goal: Flow vs. Batch

Goal: A Model Line

Goal: Raise to Other Planes

Goal: Spread Across Plane

2002 - 2004

2005 - 2006

2007 - present
December 2010
Chosen By Businesses:
Ongoing Challenges - Culture

- Patient First
- Belief in Zero Defects
- Professional Autonomy
- "Buy In"
- "People are Not Cars"
- Pace of Change
- Victimization
- Leadership Constancy
- Rigor, Alignment, Execution
- Drive for Results
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
“Leaders are Dealers in Hope.”

Napoleon Bonaparte
“In times of change, learners inherit the earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists.”

- Eric Hoffer