

# € TRAINING

Lean Thinking Concept To Improve Health  
Care And Organizational Performance



# Lean Thinking Concept To Improve Health Care And Organizational Performance

## Introduction:

Health policy in much of the developed world is concerned with assessing and improving the quality of health care. But how are quality improvements to be wrought in such a complex system as health care? A recent issue of Quality in Health Care was devoted to considerations of organizational change in health care, calling it "the key to quality improvement". In discussing how such change can be managed, and articles that cultural change needs to be wrought alongside structural reorganization and systems reform to bring about "a culture in which excellence can flourish". A review of policy changes over the past two decades shows that these appeals for cultural change are not new but have appeared in various guises. However, talk of "culture" and "culture change" begs some difficult questions about the nature of the underlying substrate to which change programs are applied.

## Course Objectives:

At the end of this course the participants will be able to:

- Examine human factors and other basic safety design principles as well as commonly used unsafe practices such as workarounds and dangerous abbreviations
- Describe the benefits and limitations of selected safety-enhancing technologies such as barcodes, Computer
- Provider Order Entry, medication pumps, and automatic alerts/alarms.
- Delineate general categories of errors and hazards in care.
- Describe factors that create a culture of safety such as, open communication strategies and organizational error reporting systems.
- Describe processes used in understanding the causes of error and allocation of responsibility and accountability such as root cause analysis and failure mode effects analysis.
- Discuss the potential and actual impact of national patient safety resources, initiatives, and regulations.
- Understand what your patients value.
- Create a culture of Continuous Improvement.
- Use data to drive improvement.
- Identify and eliminate waste.

## Targeted Audience:

- Healthcare executives.
- Physicians.
- Nurses.
- Clinical staff.
- Industrial and management engineers.
- Laboratory and specialized healthcare services.
- Insurance company staff.
- Pharmaceutical staff.

## Course Outlines:

### Unit 1:

- Nursing Home Survey on Patient Safety Culture.
- Medical Office Survey on Patient Safety Culture.
- Hospital Survey on Patient Safety Culture.

## Unit 2:

- Assess their patient safety culture.
- Track changes in patient safety over time.
- Evaluate the impact of patient safety interventions.

## Unit 3:

- Demonstrate prescribing, dispensing, and medication error vulnerabilities, and ways to avoid these vulnerabilities, during pharmacology classes.
- Evaluate the research on work hours and fatigue and discuss how these affect quality of care and risk of errors.
- Use unfolding case studies incorporating multiple QSEN.

## Unit 4:

- Observe and evaluate teamwork, communication, and collaboration during interprofessional rounds discussing patients.
- Discuss near misses and adverse events with staff nurses.
- Attend a Root Cause Analysis or a Failure Mode Effects Analysis meeting.
- Develop a safety rounds checklist and make unit rounds to complete the checklist.
- Share results with staff and initiate a discussion of the findings.
- Complete an environmental safety scan of a clinical area and evaluate space and lighting adequacy, as well as accessibility for patients, families, and staff.
- Assess traffic, noise, and accessibility of supplies and equipment including space for medication preparation.
- Work in teams including nursing, medical, and pharmacy student to examine a complex patient health record and complete a medication reconciliation analysis from admission through discharge.
- Design approaches to reduce interruptions.

## Unit 5:

- Use a patient model to simulate safety breaches.
- Develop scenarios of various equipment failures and have participants detect and correct equipment problems.
- Demonstrate how a near-miss or error is documented.
- Use high fidelity clinical simulations to assess ability to deliver safe care in the clinical setting.

## Unit 6:

- Introduce the Plan-Do-Check-Act PDCA formatted problem-solving process.
- Create an understanding of the A3 thinking process and how it can be used in problem-solving.
- Practice the process in a group setting.

## Unit 7:

- Go away with a sense of how you might use the process to improve results in your organization.
- Learn how to lead efforts in which tools and methods learned can be put into practice.
- Better understand your role as a leader in Lean transformation.

#### Unit 8:

- Understand Lean implementation as a change initiative.
- Return home with a sense of direction about how to improve results in your organization.
- Explain Lean principles, systems, and tools and discuss how, when, and why they apply to healthcare environments.

#### Unit 9:

- Explain how implementing Lean thinking is intended to create sustainable organizational culture change.
- Describe the features and attributes of a Lean culture and the Lean Transformation Model.
- Apply Lean principles and methodologies to improve work processes and systems.
- Demonstrate effective coaching skills for developing problem-solving capabilities in others.

#### Unit 10:

- Examine your own role and function pertaining.
- Analyze the application of Lean principles, systems, and tools for organizational improvement.
- Identify gaps between the current state and the desired future state of your organization or unit.