



# USING DATA TO IMPROVE QUALITY: INTEGRATING LEAN TECHNIQUES INTO QI

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# LEARNING OBJECTIVES

This session should.....

- Establish a foundation for your Lean in Healthcare journey
- Encourage you to consider alternate ways of thinking
- Provide you an opportunity to learn more about Lean in Healthcare with education and discussion

This session will not.....

- Make you a master of Lean
- Be a substitute to “learn by doing” within your own organization

# WHAT IS LEAN?

- Lean is a philosophy, mindset and a set of tools focused on delivering value to customers/patients through the elimination of waste in the business process
- The two founding concepts of Lean:
  - to increase process efficiency by consistently and thoroughly eliminating waste and
  - to respect humanity by developing every worker to his or her full ability





# THE SEVEN (EIGHT) WASTES

WORMPIT

# THE SEVEN (EIGHT) WASTES - WORMPIT

- **Waiting**
- **Over-Production**
- **Rework/Defects**
- **Motion**
- **Processing (excess)**
- **Inventory**
- **Transportation**
- **Not Clear (Confusion)**





WAITING

# WAITING

## Definition:

Idle time created when people, information, equipment, or materials are not at hand

## Causes:

- Poor understanding of the time required to do a task
- Poor accountability for delivering on time
- Compounding delays
- Unresponsiveness of scheduling systems to demand of work

# WAITING

## Examples:

- Waiting for other workers at meetings, surgeries, procedures, reports
- Patients waiting for appointments, doctor visits, procedures

## Countermeasures:

- System redesigns that support workers in doing their work by clear specification of activities and outcomes, and safe environment for problem solving in the course of work
- Clear definition/understanding of what is 'defect free'





# OVER-PRODUCTION

# OVER-PRODUCTION

## Definition:

Redundant work

## Causes:

- Misinterpretation of regulations
- Poor communication between departments/offices
- No clear specification of who needs what
- Computer systems not linked

# OVER-PRODUCTION

## Examples:

- Duplicate charting
- Multiple forms with the same information
- Copies of reports sent automatically

## Countermeasures:

- Clear interpretation of regulations
- System (electronic or paper) of information traveling with patient that eliminates redundancy





# REWORK (DEFECTS)

# REWORK (DEFECTS)

## Definition:

Work that contains errors of  
lacks something of value

## Causes:

- Lack of understanding of what is 'defect free'
- Lack of specification in work processes



# REWORK (DEFECTS)

## Examples:

- Medication errors
- Variation in outcomes
- Incorrect charges/billing
- Surgical errors

## Countermeasures:

- System redesigns that support workers in doing their work by clear specification of activities and outcomes, and safe environment for problem solving in the course of work
- Clear understanding of what is 'defect free'





MOTION

# MOTION

## Definition:

Movement of people that does not add value

## Causes:

- Inconsistent information systems (includes communication)
- Materials stocking that does not match the demand
- Scheduling that creates work-arounds and re-work

# MOTION

## Examples:

- Looking for information
- Looking for materials and people
- Materials, tools located far from the work

## Countermeasures:

- IT systems that match the demand of work
- Reliable communication systems
- Fluid materials availability that meet the current demand
- Consistent scheduling that meets the demand



The background is a high-contrast, industrial scene. On the left, a large, glowing orange and yellow mass of molten metal is being poured or processed, creating a bright, hazy atmosphere. On the right, a worker in a dark, protective suit and helmet is visible, partially obscured by the bright light. The overall scene is dark, with the primary light source being the molten metal. A central white text box with a thin blue border contains the title. On either side of the text box, there are stylized, glowing blue circuit-like lines with circular nodes, extending outwards.

# PRODUCTION (EXCESS)

# PRODUCTION (EXCESS)

## Definition:

Activities that do not add value from the patient/customer perspective

## Causes:

- Work area layout that does not promote continuous flow
- Complex flow of medication delivery from pharmacy
- Multiple/complex forms

# PRODUCTION (EXCESS)

## Examples:

- Clarifying orders
- Redundant information gathering/charting
- Missing medications
- Regulatory paperwork

## Countermeasures:

- Work area re-designs to create continuous flow
- Simplified/consistent delivery systems for meds/materials/information
- Forms that document only essential information



The background of the image is a blurred photograph of a warehouse aisle. High metal shelving units are filled with numerous cardboard boxes. The perspective is looking down the aisle, with a bright light source at the far end creating a lens flare effect. In the center, a dark rectangular box with rounded corners contains the word 'INVENTORY' in white capital letters. On the left and right sides of this central box, there are stylized, light blue circuit-like lines with small circles at their endpoints, extending outwards.

# INVENTORY

# INVENTORY

## Definition:

More materials on hand than are required to do the work

## Causes:

- Supply/demand not well understood
- Outdated supplies not deleted
- Personal preferences catered, duplicated

# INVENTORY

## Examples:

- Overstocked medications on units
- Overstocked supplies on units and in central supply storeroom

## Countermeasures:

- Supply exactly what is needed; no more, no less
- Keep supply availability current
- Understand personal preferences and orchestrate “like” items





# TRANSPORTING

# TRANSPORTING

## Definition:

Required relocation/delivery of patient, materials, or supplies to complete a task

## Causes:

- Non-standardized supply location
- Supplies to complete one task located in multiple locations



# TRANSPORTING

## Examples:

- Delivery of medication from pharmacy
- Staff travel to a remote storage room to retrieve supplies
- Delivery of surgical pack to OR

## Countermeasures:

- Conduct a 5-S workplace organization to standardize location of supplies near the point of work
- Examine staff location as related to commonly used supply storage locations



The background features a dense field of interlocking gears in various shades of grey and black. Overlaid on this is a circuit board pattern with teal lines and small circles. A single square on the circuit board is highlighted in a bright orange color.

**NOT CLEAR  
(CONFUSION)**

# NOT CLEAR (CONFUSION)

## Definition:

People doing the work are not confident about the way to perform tasks

## Causes:

- Lack of standardized specification of activities of work
- Lack of common language
- Workers relying on memory or figuring things out

# NOT CLEAR (CONFUSION)

## Examples:

- Same activities being performed in different ways by different people
- Unclear physician's orders
- Unclear route for medication administration
- Unclear system for indicating charges for billing

## Countermeasures:

- All activities of work clearly specified
- Clear signals that trigger activities of work uniformly







# LEAN PROBLEM SOLVING TOOLS

# LEAN PROBLEM SOLVING TOOLS

- Observation
- 5-S
- A3 (PDCA)



A pair of binoculars with dark barrels and reddish-brown rubberized grips is lying horizontally on a blue-painted metal railing. The background is a soft-focus landscape of a beach and ocean under a clear sky. A semi-transparent dark rectangle is centered over the binoculars, containing the word "OBSERVATION" in white. Light blue circuit lines with circular nodes are overlaid on the image, extending from the left and right edges of the dark rectangle.

OBSERVATION

# OBSERVATION

## WHAT IT IS.....

- In person
- First-hand
- One at a time
- Capture what 'is'
- Recording of actual happenings

## WHAT IS IT NOT.....

- Monitoring
- Following
- Interviewing
- Watching
- Self-performed

# OBSERVATION

The only way to:

- See what is really happening vs what you believe is happening
- Experience the patient perspective
- Understand the root cause
- Ensure all on the team have knowledge of actual process
- Generate ideas to eliminate root cause vs just a quick fix



# OBSERVATION

## Go to the Gemba!!!

Japanese:

- the actual place
- the place where the work is done
- the crime scene



Observer: \_\_\_\_\_

[illegible]



# OBSERVATION FORM

Watch for:

- Lack of process in how things are done
- Inconsistent ways of completing the same tasks
- Complicated communication processes
- Equipment unavailable
- Extended travel times/distances for supplies, equipment, meds



## 5S Explanation



Sort

When in  
doubt,  
move it  
out –  
Red Tag  
technique



Set in Order

A place  
for  
everything  
and  
everything  
in its  
place



Shine

Clean and  
inspect  
or  
Inspect  
through  
cleaning



Standardize

Make up  
the rules,  
follow and  
enforce  
them



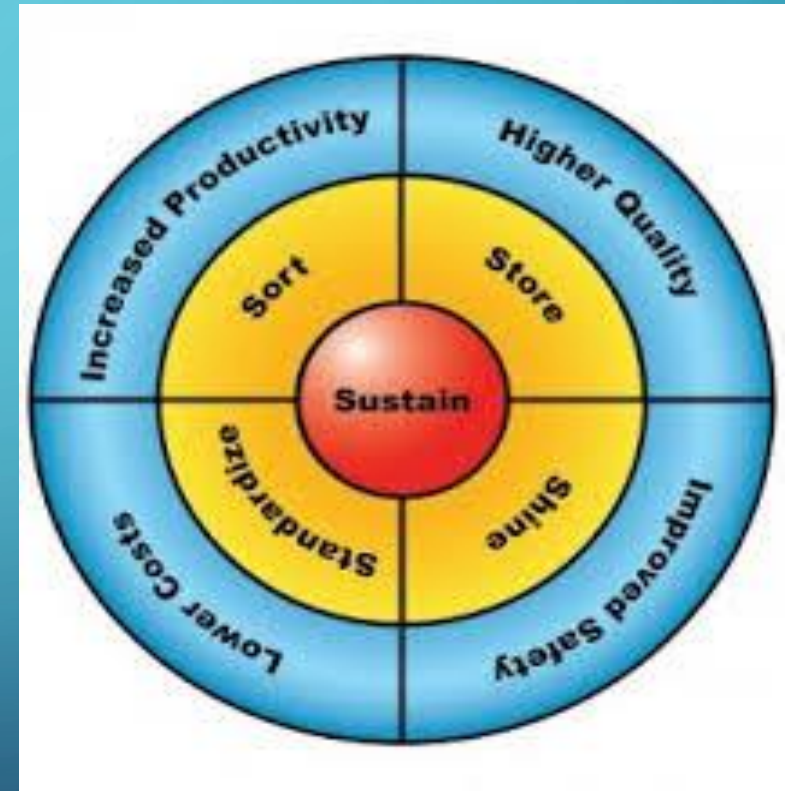
Sustain

Part of  
daily work  
and it  
becomes  
a habit

# 5S SYSTEM

# 5S SYSTEM

- Sort
  - Get rid of unneeded items
- Straighten
  - Organize and label the location for items that are needed in the area
- Shine
  - Clean the workspace
  - Equipment is clean and prepped for use
- Standardize
  - Develop cleaning methods and cleanliness standards to maintain the first 3S's
- Sustain
  - Review the workplace regularly. Make it a habit



Before 5S



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After 5S



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## How 5S is used at BIDMC

- Reduce searching
- Trigger an activity
- Define standards for consistent results
- Gain flow
- Enable communication & sharing of information
- Mistake-proof tasks



DECREASE TIME  
SEARCHING  
INCREASE STORAGE  
CAPACITY

DECREASE TIME  
SEARCHING  
INCREASE  
STORAGE  
CAPACITY



## STRAIGHTEN Strategies: Discipline Squares

Before



**Disorganized IV Stands and Cylinders**  
**No visual indication regarding location of equipment**

A PLACE FOR  
EVERYTHING

AND

EVERYTHING IN  
ITS PLACE



# STRAIGHTEN Strategies: Discipline Squares

After

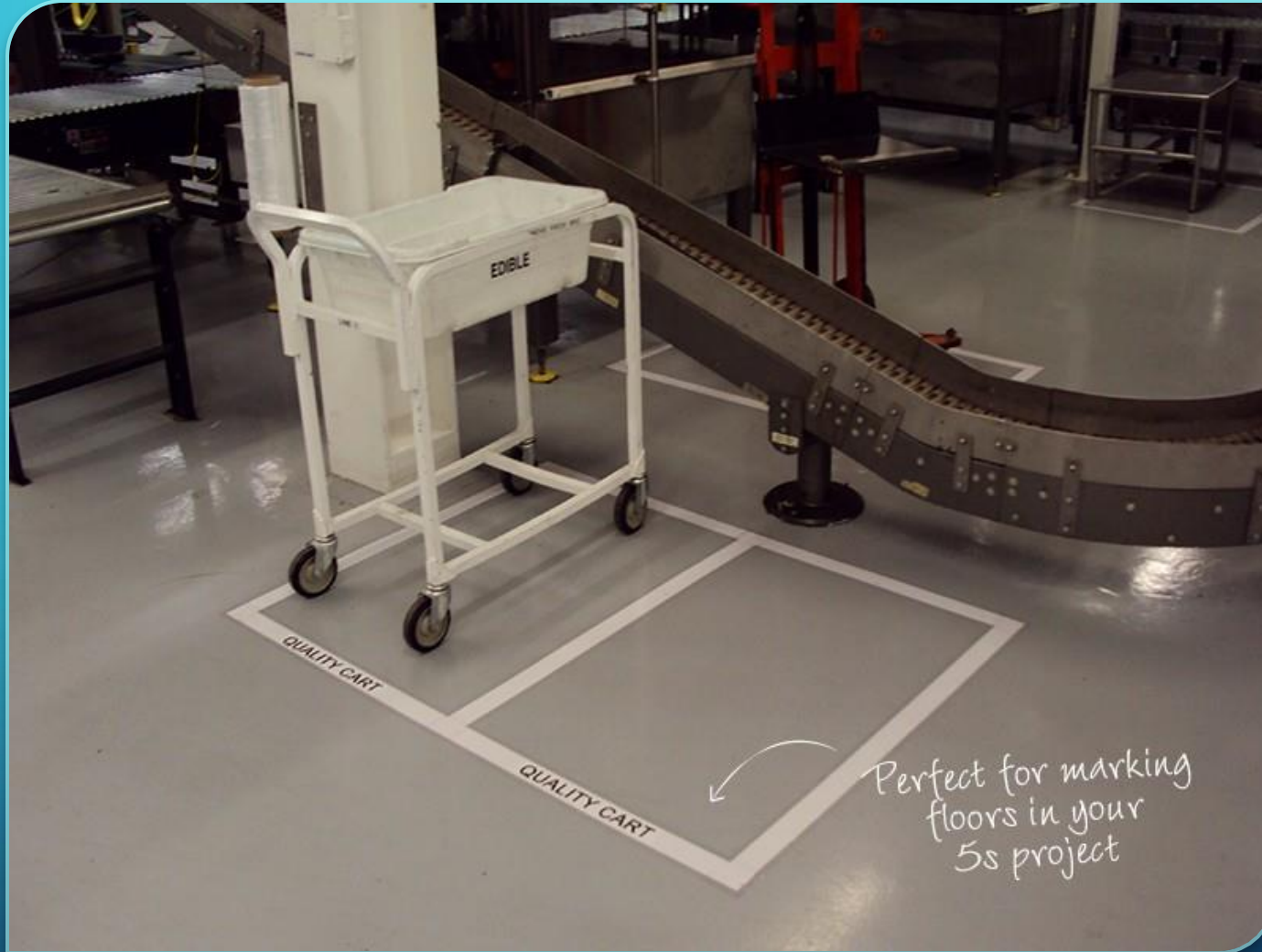


**Organized IV Stands and Cylinders**  
**Each equipment is labeled and has a home location**  
Discipline Squares and labeling as a visual management  
method

A PLACE FOR  
EVERYTHING

AND

EVERYTHING IN  
ITS PLACE



Perfect for marking  
floors in your  
5s project





# IT'S NOT THAT YOU DON'T KNOW WHAT A STAPLER IS.....





BE ABLE TO SEE  
WHAT'S  
MISSING AT A  
QUICK GLANCE









The background features a complex pattern of interlocking gears in shades of light blue and white. Several large, stylized question marks are scattered across the scene. A dark grey rectangular box with rounded corners is centered in the middle. Inside this box, a faint lightbulb icon is visible. The text 'A3 PROBLEM SOLVING' is written in white, bold, sans-serif capital letters across the center of the box. On the left and right sides of the box, there are stylized circuit board traces in a light blue color.

# A3 PROBLEM SOLVING

# A3 PROBLEM SOLVING

A3 is a template to document work and keep the team focused on solving the right problem in the right, systematic order

A3 is the size of the sheet of paper

A3 is a 'one stop' for all project information and how it is progressing

Handwritten – no extra notes or typing needed



The background of the slide is a dark, textured image featuring a circuit board pattern on the left side. The rest of the background is filled with various mathematical equations and diagrams, including a square with an arrow, a circle with a triangle inside, and several algebraic expressions like  $\sqrt{2434.96 - 0x + 0}$ ,  $\frac{24+x}{x} + \frac{2^2+3^2}{c} + \frac{1}{x^2} = 9$ , and  $\beta = 9 + x^2 + y$ .

# A3 PROBLEM SOLVING

There is no “magic” in the steps of A3 Problem Solving.

These steps are basically:

- Identify the problem or need
- Understand the current situation/state
- Develop the goal statement – develop the target state
- Perform root cause analysis (5 whys)
- Brainstorm/determine countermeasures
- Create a countermeasures implementation plan
- Study results – confirm the effect
- Update standard work

# Common Components of the A3 Report

← **Plan** →

← **Do, Check, Act** →

**Theme:** "What is our area of focus?"

## Background

- Problem statement
- Context - why is this a problem?

## Current Condition

- **Diagram** of current situation or process
- What about it is not ideal?
- Extent of the problem (metrics)

## Target Condition / Measurable Objectives

- Diagram of desired state
- Measurable targets – how will we know that the improvement has been successful?

## Root Cause & Gap Analysis

- Graphical depiction of the most likely direct (root) causes

**Owner:** Person accountable for results.

## Countermeasures / Implementation Plan

- What?
- Who?
- When?
- Where? (if relevant)

## Effect Confirmation

- What measurable results did the solution achieve (or will be measured to verify effectiveness)?
- Who's responsible for ongoing measurement?

## Follow-up Actions

- Where else in the organization can this solution be applied?
- How will the improved state be standardized and communicated?

# A3 PROBLEM SOLVING

The steps follow the Deming Plan-Do-Study-Act (PDSA) cycle:

Steps 1 through 5 being the "Plan"

Step 6 being the "Do"

Step 7 being the "Study"

Step 8 being the "Act".



Title:		Fresh Eyes: SME:		Team:		Start Date:	
Owner:						Revision Date:	
PLAN	1. Problem Statement or Need			PLAN	5. Brainstorm/Countermeasures		
	2. Current Situation/State						
	3. Goal Statement - Target State			DO	6. Countermeasures Implementation Plan (Who, What, When)		
	4. Analysis / Root Cause (5 Whys)						
STUDY				STUDY	7. Study (Planned vs. Actual Results)		
ACT/ADJUST				ACT/ADJUST	8. Update Standard Work		
Notes:							

# A3 PROBLEM SOLVING

## 1. Identify the problem or need

- Why do we need to work on this?
- What got us to believe this is an issue?
- Why this over other issues?
- Context
- Importance

# A3 PROBLEM SOLVING

## 2. Understand the current situation/state

- Problem statement/definition
- Draw
- Clear and logical
- “As Is” process map
- Scale of the problem (data)



# A3 PROBLEM SOLVING

3. Develop the goal statement –  
develop the  
target state

- Target level of performance
- Desired outcome
- Clearly and unequivocally state what the problem is

# A3 PROBLEM SOLVING

## 4. Perform root cause analysis

- All relevant factors considered
  - People, Machine, Methods, Measurement, Environment, etc
- 5 Whys

# A3 PROBLEM SOLVING

## 5. Brainstorm to determine countermeasures

- Actions being taken to address the issue
- What some term 'improvements'
- Quick fixes (containment actions)
- "To Be" Process Map



# A3 PROBLEM SOLVING

## 6. Create a countermeasures implementation plan

- Document:
  - Who is going to do
  - What are they going to do
  - Where is it going to be done
  - When will they do it
  - Why are they doing it
  - How will they do it

# A3 PROBLEM SOLVING

## 7. Study results – confirm the effect

- Results achieved
- Trend graph (before/after)
- Has actual performance moved in line with goal
- If it has not improved, then why?  
What was missed?

# A3 PROBLEM SOLVING

## 8. Update standard work

- Make process consistent
- Ensure it is exactly how process currently works
- Have someone test who is not familiar with the process and observe to ensure



Title:		Fresh Eyes: SME:		Team:		Start Date:	
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STUDY				STUDY	7. Study (Planned vs. Actual Results)		
ACT/ADJUST				ACT/ADJUST	8. Update Standard Work		
Notes:							



## REVIEW YOUR A3

- Hold it at arm's length
  - Neat, clear, uncluttered
  - Mix of text, information, and graphics
- Co-Worker Review
  - Do they understand the message
  - Can they identify the flow
  - Do they know what the goal is
- Are there mistakes



**PICK OUT CLOTHES  
THE NIGHT BEFORE**

**NO CHANGE**





READY,  
SET,  
GO

READY TO GET STARTED WITH  
YOUR LEAN JOURNEY?

# IDEAS FOR LEAN

- Care Transitions – EDTC – improved connections to patients
- Streamlining triage processes in the ED – improving OP-22
- Reduce unnecessary antibiotic prescriptions – optimizing antibiotic stewardship
- Implement fast track protocols – reduce ED Wait times and improve OP-18
- SDoH screening process – improving community connection with data
- HCAHPS question improvements – improving feedback/communication
- Revenue cycle – registration issues – paperwork reduction/pt satisfaction
- Patient discharge consistency – coordination between providers and staff

# GET OUT THERE

- Practice your 5S techniques in your workstation
  - Think of supply rooms and places that should be uniform regardless of department or area
- Talk with your front-line staff about quality projects
  - Consider Observation of a suggested improvement opportunity
- Pull out an A3 to evaluate the current state vs target state
  - Discuss countermeasures to reach the aim
  - Plan countermeasures
  - Implement countermeasures then evaluate for desired changes






QUESTIONS????

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# 2025 ORH CAH Quality Workshop

May 21-22, 2025  
Seaside, OR



**Evaluation – We Need Your Input**

