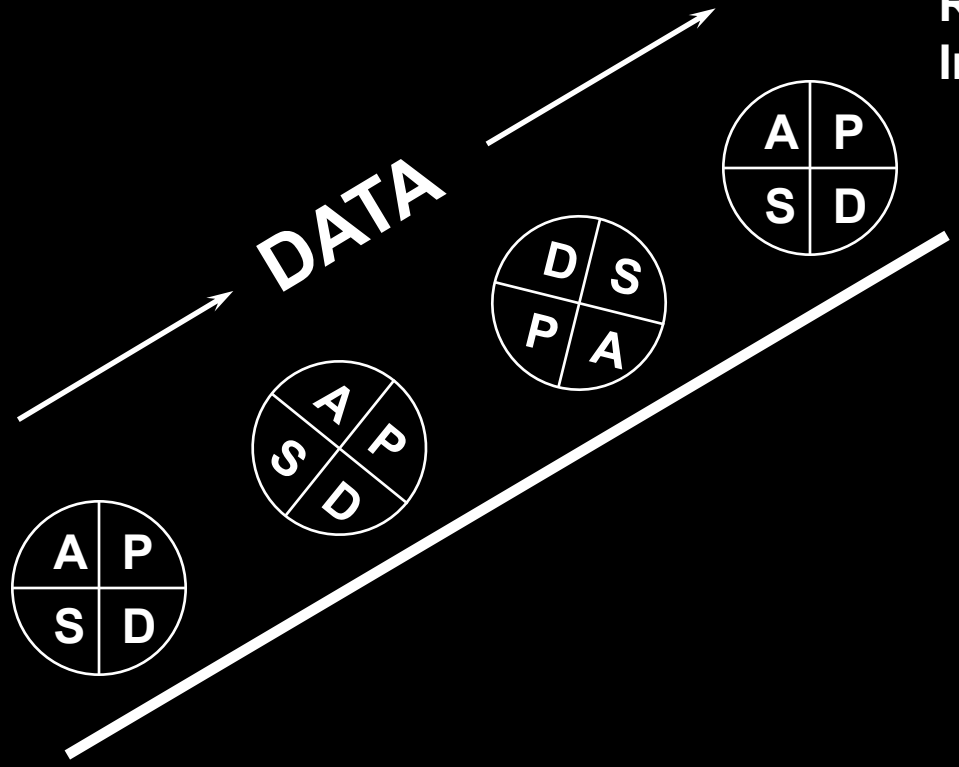
Repeated Use of the Cycle



Changes That Result in Improvement

Hunches Theories Ideas

PDSA

- Allows you to test your theory on a few patients
- It may take several PDSA cycles and several months to get your process manageable.
- That's OK!

Use the PDSA Cycle for:

1. Testing or adapting a change
2. Implementing an improvement
3. Spreading the improvements to the rest of your organization

PDSA Cycles Must Be:

- **Active**
  - Quickly plan and make process changes
- **Iterative**
  - Cycle after cycle
- **Learning**
  - Take time to study effects of your actions

Human Factors

Human Factors is about how features of our tools, tasks, and work environments continually influence what we do and how we do it.

In Other Words…

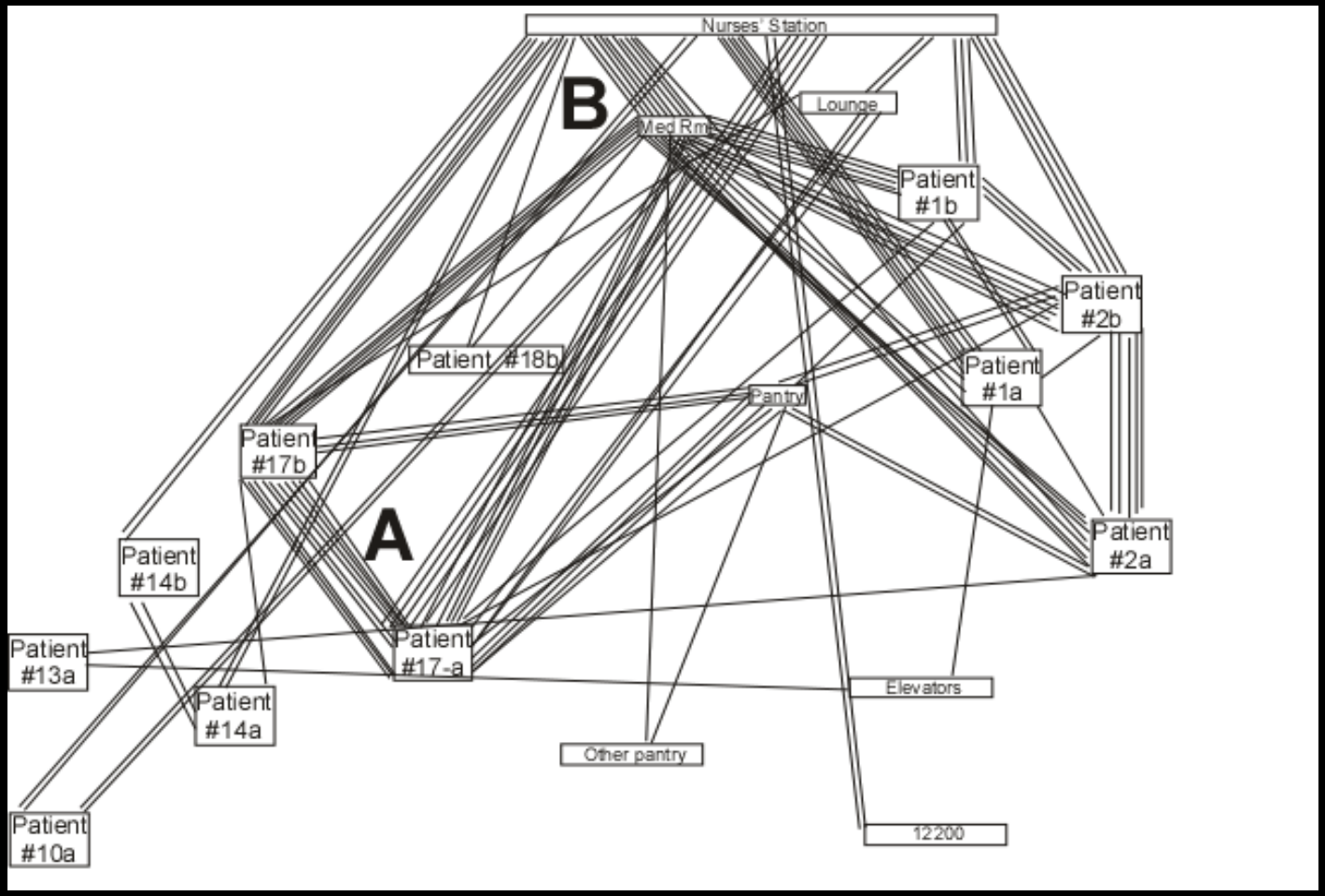
- Human Factors is about how the **design** of things impacts how well we do any task.
  - Design of our workplace
  - Design of the tools we use
  - Design of processes (how we do things around here)

Is This the Same Old Thing?

- No!
- Human Factors is **complementary** to what you are already doing to improve health care
- Human Factors will make your improvement efforts more efficient and effective
- There is a Human Factors concept behind every successful improvement effort

Talk About Human Factors!!!

Each line represents the RN's movement from one location to another.
For example, RN moves between patients 14A and 14B twice.



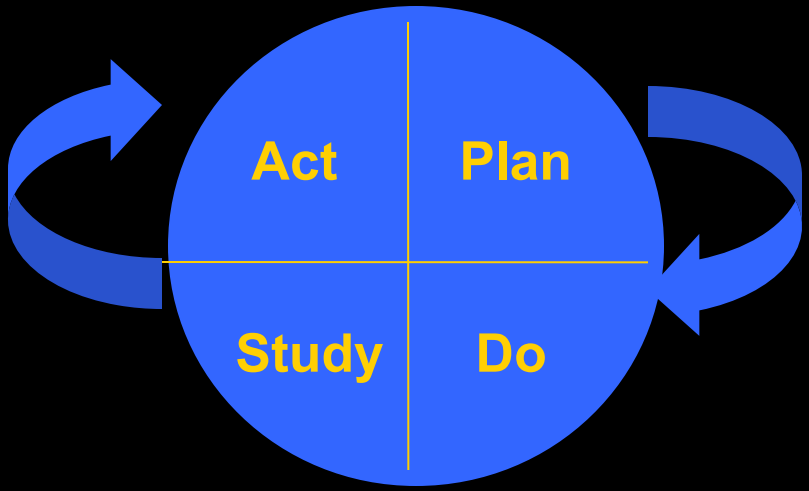
Human Factors and the Model for Improvement

What are we trying to accomplish?

How do we know that a change is an improvement?

What changes can we make that result in an improvement?

Human factors can help answer this question!



Lean Methodology

- It's all about:
  - Waste and Value
  - Always challenging processes to
    - Produce better outcomes for customers
    - Create more value with less wasted time, effort, and resources
    - Speed delivery while reducing cost
    - Lay less burden on the people doing the work.

5S

- 5S is a philosophy and a way of organizing and managing the workspace.
- The key impacts of 5S is upon workplace morale and efficiency.
  - By ensuring everything has a place and everything is in its place then time is not wasted looking for things and it can be made immediately obvious when something is missing.
- The real power of this methodology is in deciding what should be kept and where and how it should be stored

5S

整理・整頓・清掃・清潔・躾

Seiri	Seiton	Seiso	Seiketsu	Shitsuke
Sort	Set In Order	Shine	Standards	Sustain

Based on Japanese words that begin with ‘S’, the 5S Philosophy focuses on effective work place organization and standardized work procedures.

5S simplifies your work environment, reduces waste and non-value activity while improving quality efficiency
and safety.

Failure Mode Analysis

Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

Failure Mode Analysis

Continued

FMEA includes review of the following:

Steps in the process

- Failure modes (What could go wrong?)
- Failure causes (Why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

Root Cause Analysis

- A way of looking at unexpected events and outcomes to determine all of the underlying causes of the event and recommend changes that are likely to improve them.

RCA Tools

- The 5 Whys?
- Appreciation
- Drill Downs
- Cause and Effect Diagrams (Fishbone Diagrams)