Continuous Quality Improvement using small, low-cost, low-risk changes that add value or eliminate waste.

Kaizen asks, “how can I improve the process?”
Deming Wheel (1939)

Methodology

W. Edwards Deming

Plan
plan the change

Do
Do the change

Study
Is it working?

Act
adjust as needed to sustain

University of Wyoming (1921)
University of Colorado (1925)
Yale University (1928)
Dooming Cycle

An Occasional Satire of All Things Not Lean

Special Edition

DAILY TIMES

Today’s News

Noted Management Scholar
Dr. Dooming Identifies Corporate Cycle of Doom.

Years of research on causes of corporate errors, blunders, and failures finally pay off.

The Dooming Cycle (SRFF) is caused by batching of information. It’s amazing nobody thought of it before.

Dr. Dooming: “No shit, it came to me while I was drinking beer at the Twin Willows.”

Bob Emiliani – www.bobemiliani.com
Innovation is a high risk, high cost, seismic shift.

Kaizen involves small progressive steps aligned with a purpose.

It’s like training patiently and sensibly for one’s first marathon.

Innovation is a high risk, high cost, seismic shift.

It’s like running your first marathon with no training.
<table>
<thead>
<tr>
<th><strong>History</strong></th>
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<tr>
<th><strong>U.S. during WWII</strong></th>
<th><strong>Postwar Japan:</strong></th>
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<tbody>
<tr>
<td>Training Within Industry (TWI) program looks to improve <em>small things</em> using existing equipment. The continuous improvement philosophy focuses on <em>respect</em> for the employee.</td>
<td>Deming helps Japan rebuild using small steps that focus on <em>waste reduction</em>, respect for workers and added <em>value</em> to the customer.</td>
</tr>
</tbody>
</table>

Taiichi Ohno (Toyota): Andon Cord
Postwar U.S.

After the war, the U.S. largely forgot or ignored the concepts of Continuous Quality Improvement. Now, decades later, these are being reincorporated across multiple government and business environments and the results are shared and recognized.

Fix the problem, not the blame.
“Continuous Improvement as an Ideal in Health Care”
1989 – Donald Berwick, MD, MPP.

Theory of Bad Apples vs. Theory of Continuous Improvement

- “Quality by inspection”
- Culture of fear
- Use deterrence to improve quality

- Focus on learning, not defense
- Respect for the healthcare worker, who is assumed to be working hard, in good faith
- Systematic, open, scientific analysis of errors
“Management’s job is to create an environment where everybody may take joy in their work”
-W. Edwards Deming, Ph.D.

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Kaizen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem solving by experts and heroes</td>
<td>Scientific problem solving by everyone</td>
</tr>
<tr>
<td>Risk averse</td>
<td>Take intelligent risks</td>
</tr>
<tr>
<td>Leaders have the answers</td>
<td>Leaders have curiosity</td>
</tr>
<tr>
<td>Respect for profits</td>
<td>Respect for people</td>
</tr>
<tr>
<td>Seek out blame</td>
<td>Seek out root causes</td>
</tr>
<tr>
<td>Go see to catch and punish</td>
<td>Go see to show respect and ask why</td>
</tr>
<tr>
<td>Lead with power and authority</td>
<td>Lead by example and humility</td>
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<tr>
<td>Increase value through addition</td>
<td>Increase value by subtracting the unnecessary</td>
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</table>
People Centered *and* Scientific

…based on the idea that the people doing the work have the best ideas on how to improve it. No change is too small, participation by everyone is encouraged, and results are shared. *No kaizen is a failure.*
What Kaizen is *not*

**Kaizen is not a Suggestion Box**

Kaizen is about turning ideas into actions

My idea is....

Action
The majority of projects undertaken should be small scale, incremental changes that can be implemented in a timely manner and are driven by small defects. Larger scale projects are also undertaken, but are driven by the long term vision for the unit.
Steps to creating a Kaizen

1. Find
2. Discuss
3. Implement
4. Document
5. Share

Employee identifies idea & shares with Coach
Employee implements the changes (based on Coach’s feedback)
Written Kaizen is shared and results are monitored
Kaizen Coaches

The role of the Kaizen Coach is to approve proposed Kaizens to move them into the implementation stage while offering guidance and support and coordinating with other supervisors as needed. Great coaches always acknowledge the effort of a kaizen and share the results with others.
Visual Idea Boards are located in each unit/division and display Kaizens at three stages: Ideas, In Progress & Completed.

*Note: if a kaizen needs to be reworked, it can be moved back to “Ideas”:*
Visual Idea Boards facilitate communications within & between divisions.

Completed kaizens are entered into a database for sharing. *(Tools & web based reporting under development.)*
1. Identify the problem
2. Describe the change
3. Report on the effect

### Kaizen Report Cards

<table>
<thead>
<tr>
<th>Area/Unit</th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effect</td>
<td>Examples: Patient Safety, Quality of Care, Employee Satisfaction or Growth, Reduced Cost, Waste Reduction, Improved Efficiency / Workflow</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Dept/Unit</th>
<th>Supervisor</th>
<th>Date</th>
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<tbody>
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Kaizen

Hurdles

“How often are the following hurdles overheard?”

“I don’t have time for that.”

“I get rewarded for fighting fires”

Lack of trust in the organization

“Administration only wants cost savings”

“perceived loss of control if I let employees do Kaizen”

“People don’t think we need to change or improve”

“I have people to do that for me; I delegate it”

“Whether you think you can, or that you can’t, you are usually right” – Henry Ford

“How you think you can, or that you can’t, you are usually right” – Mark Twain
# Examples

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
<th>Effect 1</th>
<th>Effect 2</th>
<th>Date (Finalization)</th>
<th>Written by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture swabs were confusing for providers and clinic staff after changes were made by manufacturers. Swabs looked alike and it was difficult to know which to use for what purpose. Some swabs could be used for same test but on different sites. Errors resulting in patient inconvenience and clinic expense occur as a result.</td>
<td>Swabs are labeled with colored stickers which clearly indicate the type of swab and the site for which it is to be used. A poster was also created listing all swabs, tests and sites in a very clear manner with photos.</td>
<td>Quality of Care</td>
<td>Staff Efficiency</td>
<td>7/24/2015</td>
<td>Karen Beck, Kalena Kirby</td>
</tr>
<tr>
<td>CULTURE</td>
<td>SWAB CONTAINER</td>
<td>SITE</td>
<td></td>
<td></td>
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<tr>
<td>------------------</td>
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<td></td>
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<tr>
<td>Strep Culture</td>
<td></td>
<td>Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bacterial</td>
<td></td>
<td>Nose Throat</td>
<td></td>
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<td></td>
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<tr>
<td>Bacterial</td>
<td></td>
<td>Nasopharynx</td>
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<tr>
<td>Bacterial</td>
<td></td>
<td>Urogenital</td>
<td></td>
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<tr>
<td>GC/CT TRICH</td>
<td></td>
<td>Cervical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GC/CT TRICH</td>
<td></td>
<td>Male Urethra</td>
<td></td>
<td></td>
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<tr>
<td>Herpes &amp; Viral</td>
<td></td>
<td>Throat Rectal</td>
<td></td>
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<tr>
<td>Herpes &amp; Viral</td>
<td></td>
<td>Cervical Vaginal</td>
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<tr>
<td>Herpes &amp; Viral</td>
<td></td>
<td>Eye</td>
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<tr>
<td>Herpes &amp; Viral</td>
<td></td>
<td>Skin Lesions</td>
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<tr>
<td>Herpes &amp; Viral</td>
<td></td>
<td>Nasopharyngeal Urethral</td>
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<tr>
<td>PCR Pertussis</td>
<td></td>
<td>Nasopharyngeal</td>
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<tr>
<td>HPV DNA</td>
<td></td>
<td>Cervical</td>
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</table>
N=13 Kaizen reports yielding 22 improvements

Hall Health Kaizen Summary
Aug 2015
11% of employees have participated

Completed Kaizen (cumulative)
Exercise 1

What can you do today or tomorrow that is,
1. Low cost
2. Results in an Improvement
3. Sustainable
4. Straightforward to implement
Exercise 2

List drivers of employee engagement.
Survey on employee engagement

1. Opportunities to learn and develop new skills
2. Improved my skills and capabilities over the past year
3. Reputation of organization as a good employer
4. Input into decision making in my department
5. Organization focuses on customer satisfaction
6. Salary criteria are fair and consistent
7. Good collaboration across units
8. Appropriate amount of decision making authority to do my job well
9. Senior management acts to ensure organization’s long term success
10. Senior management’s interest in employee’s well-being

Towers and Perrin 2005
Next Steps

1. Incentive Program
2. Maintain Momentum
3. Practice Patience
4. Kaizen the Kaizen
5. Align with Strategy
Expectations

Three phases (Masaaki Imai)
1. Early – first 1-2 years, focus on smaller kaizen. Employee engagement
2. Growth – develop additional problem solving skills for staff, more educational resources, strategic alignment
Expectations
Kaizen is Process improvement People Centric Small, progressive steps Methodical Low Risk Evidence Based

Kaizen promotes organizational adaptability and resilience
Where can I learn more?

Resources


us.kaizen.com

www.bobemiliani.com/
The secret of getting ahead is getting started. The secret of getting started is breaking your complex overwhelming tasks into small manageable tasks, and then starting on the first one” -- Mark Twain

“It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change” -- Charles Darwin