

LEADING THROUGH INFLUENCE

Dane Falkner, MBA, LSSBB

DANE FALKNER

Dane Falkner is a Lean Six Sigma Black Belt (LSSBB) with a BS in Finance from the University of Utah and an MBA from Westminster College. Dane has been with the University of Utah Health for over 7 years and his current role is the Manager of System Quality. Dane has also held improvement roles in non-healthcare industries including Visa and Caesars Entertainment.

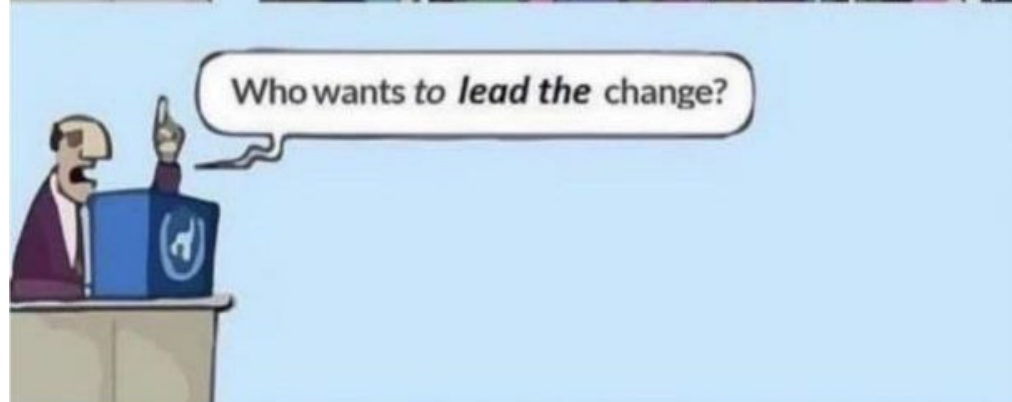




LEADING THROUGH INFLUENCE

DANE FALKNER, MBA, LSSBB

MANAGER, QUALITY AND OPERATIONAL EXCELLENCE



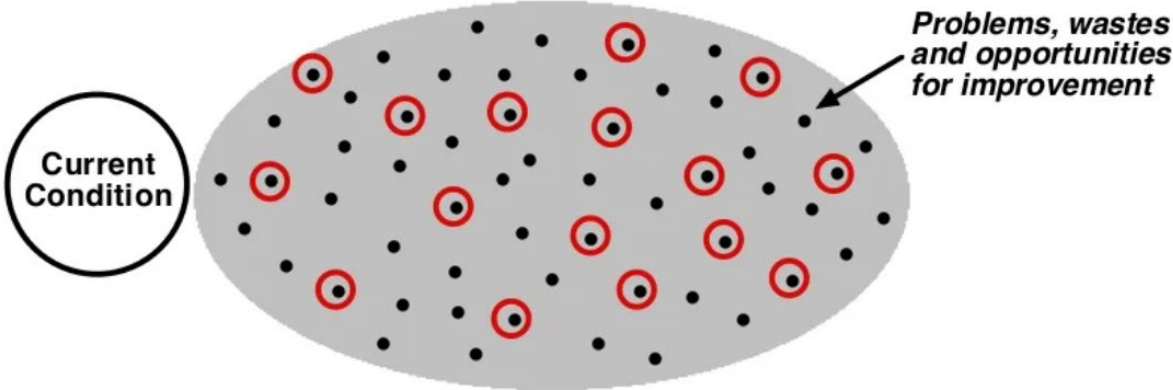
Does this resonate?



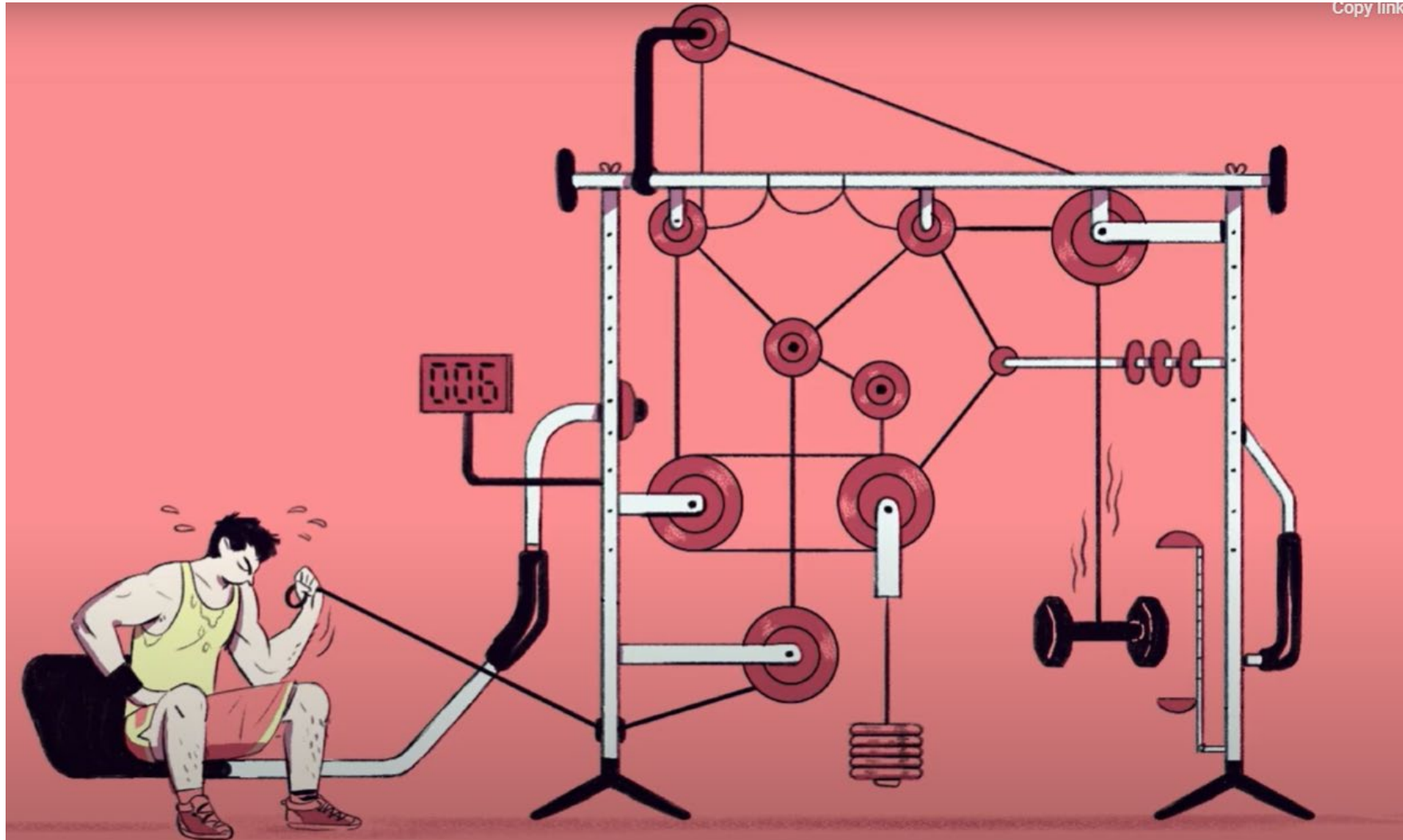
DOCTORS, NURSES, AND STAFF ALL HAVE JOBS TO DO...



FIREFIGHTING CAN RESULT IN THIS...



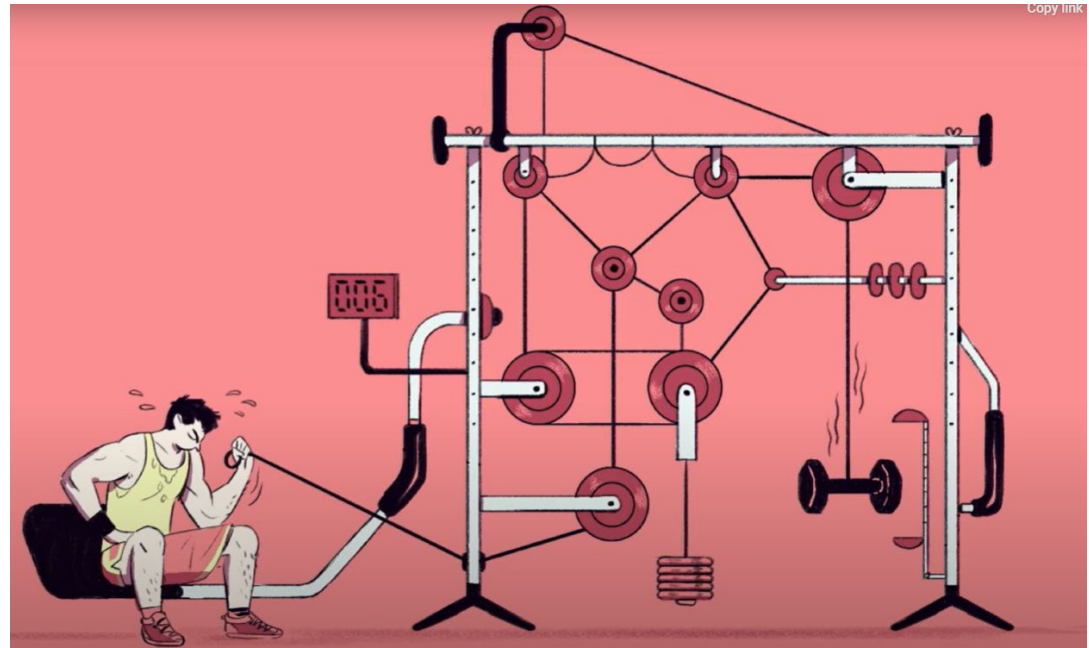
OR LOOK LIKE THIS...



OR THIS...



WE NEED TO BEGIN REMOVING OBSTACLES AND SIMPLIFYING PROCESSES...BUT HOW?



We Need A System...



Systems Start With Principles



PILLARS OF IMPROVEMENT

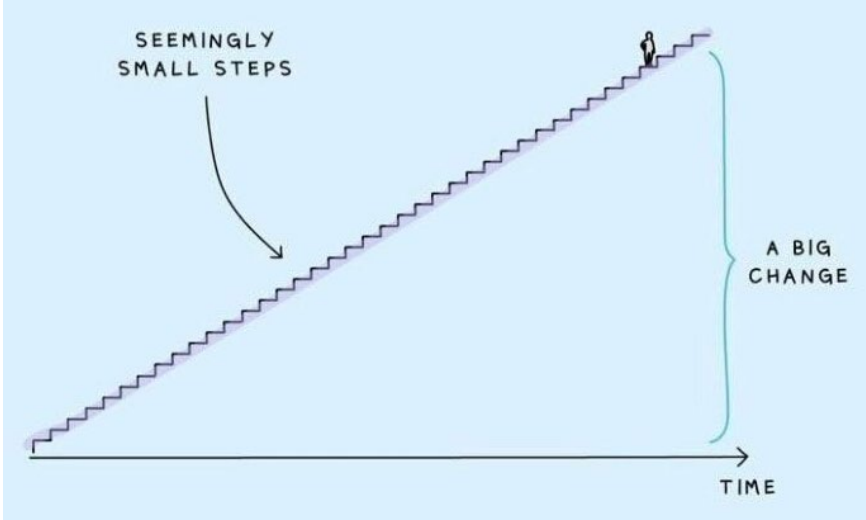
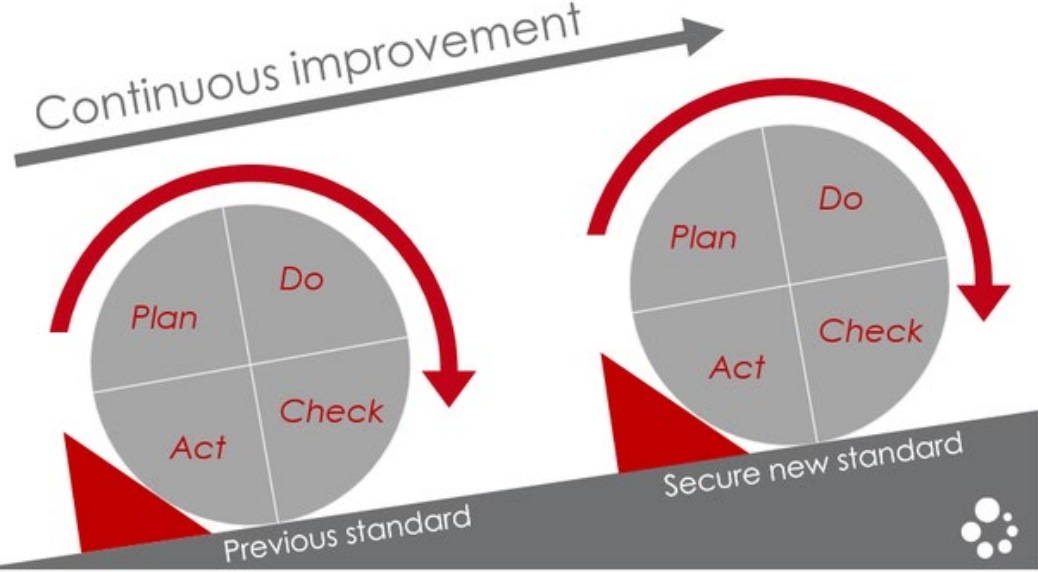


Continuous Improvement

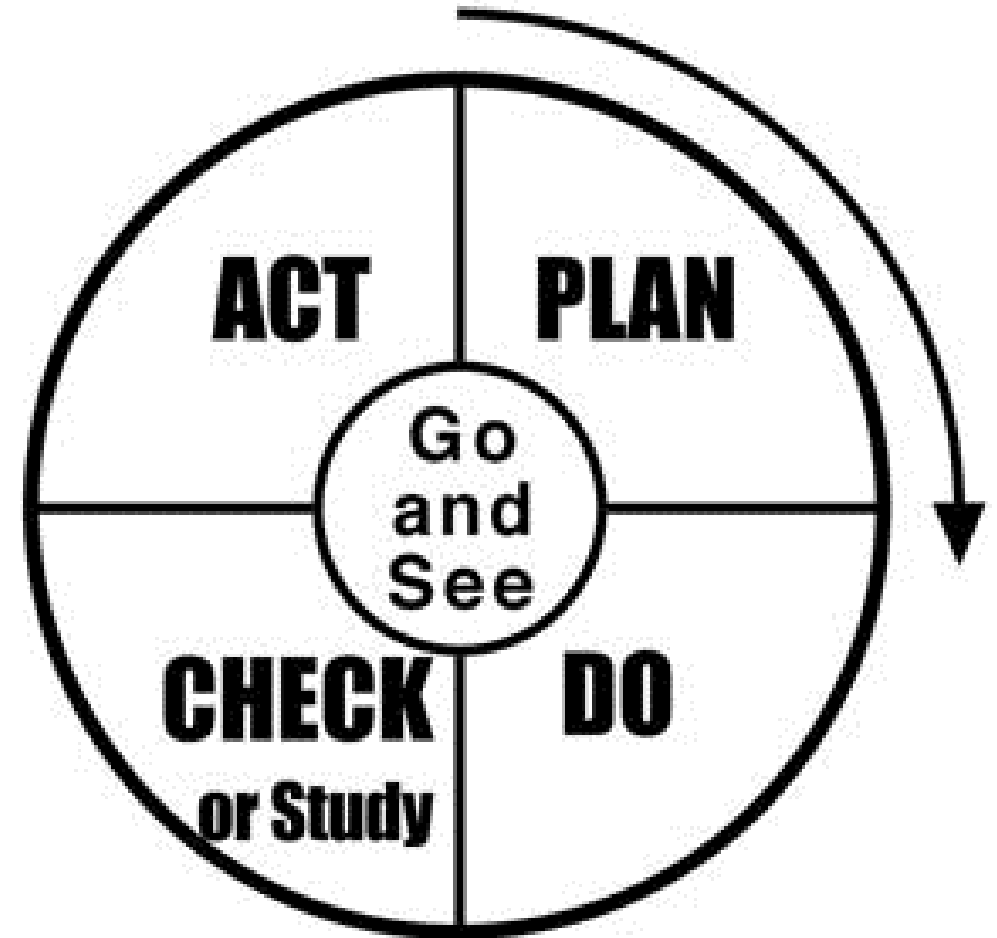


Systemic Respect

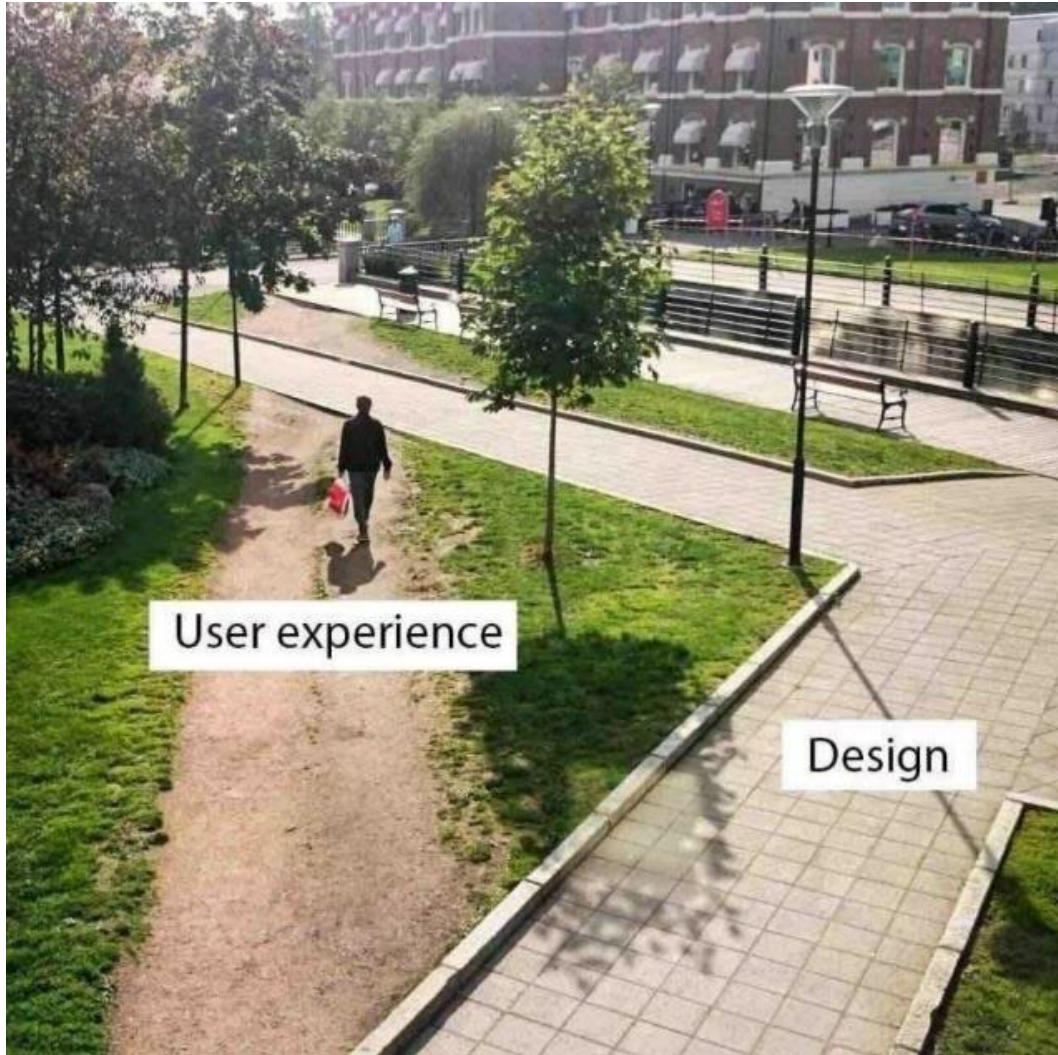
CONTINUOUS IMPROVEMENT



CONTINUOUS IMPROVEMENT



SYSTEMIC RESPECT



SYSTEMIC RESPECT



EXAMPLES OF SYSTEMIC DISRESPECT

- Processes change but procedural instructions aren't updated
- Clinic regularly runs behind
- Staff are expected to be in two places at once
- Duties are added but workloads aren't rebalanced
- Metrics are reported but not discussed
- Suffering with worn-out equipment
- Entering duplicate information in multiple systems
- Collecting 80 lines of clinical info when only 8 are needed
- Staff are expected to memorize multiple provider methods
- Performing processes that are no longer needed

PILLARS OF IMPROVEMENT

Continuous Improvement



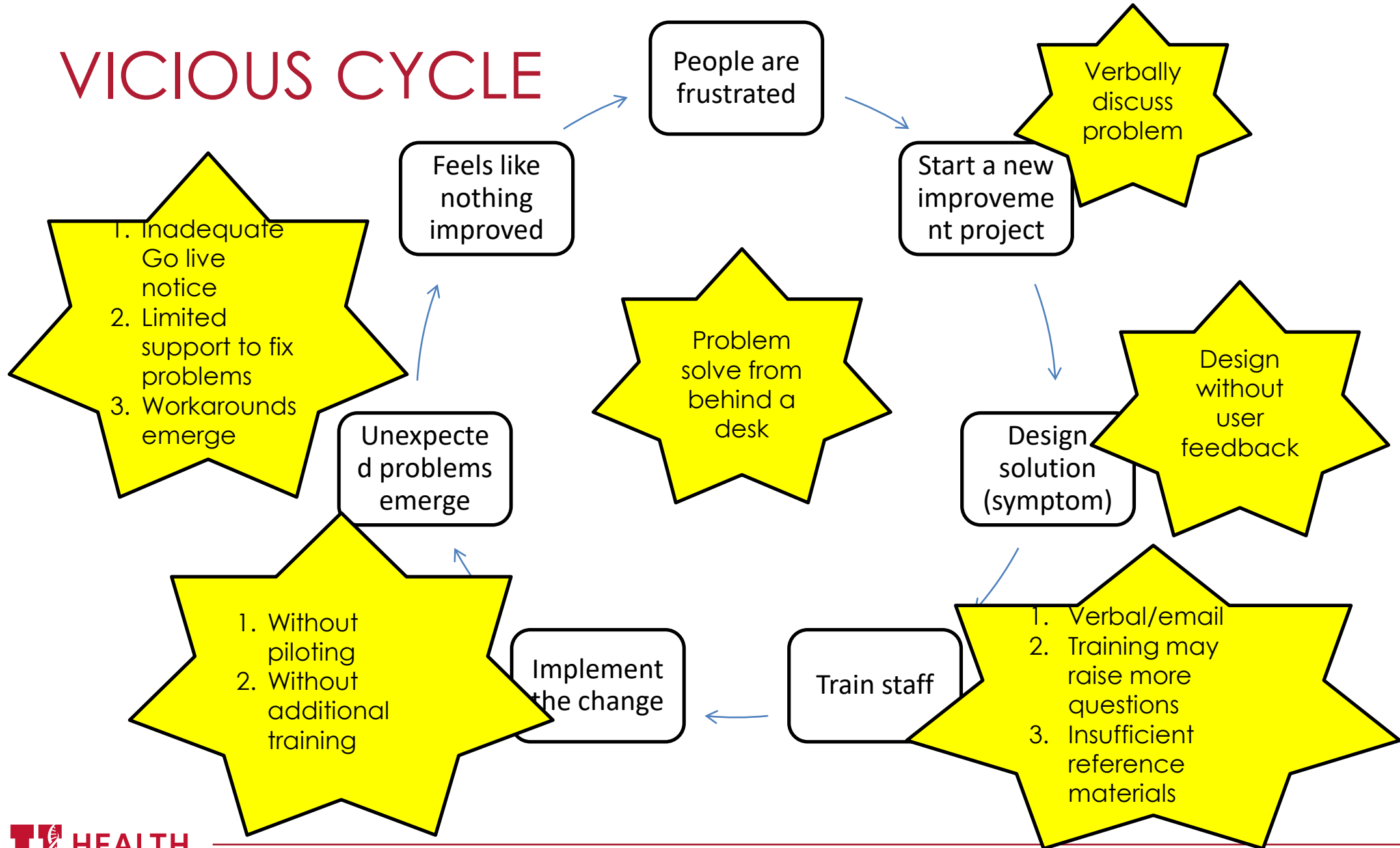
Everybody, everyday
experimenting with small
tests of change

Systemic Respect



When the system performs in a
way that makes it easy to deliver
AND receive quality care correctly
the first time

VICIOUS CYCLE



VIC

Tie up loose ends
(sutures not band aids)

STOP
and
reflect

People are
frustrated

Prioritize
next
problem

Make
problems
visible

Start a new
improvement
project

Feels like
nothing
improved

Go see.
Ask why.
Show
respect.

Experiment
and design
with user
feedback

Design
solution
(symptom)

Unexpected
problems
emerge

1. Go lives are
scheduled with
a "go/no go"
meeting before
launch
2. Full support
available to fix
problems

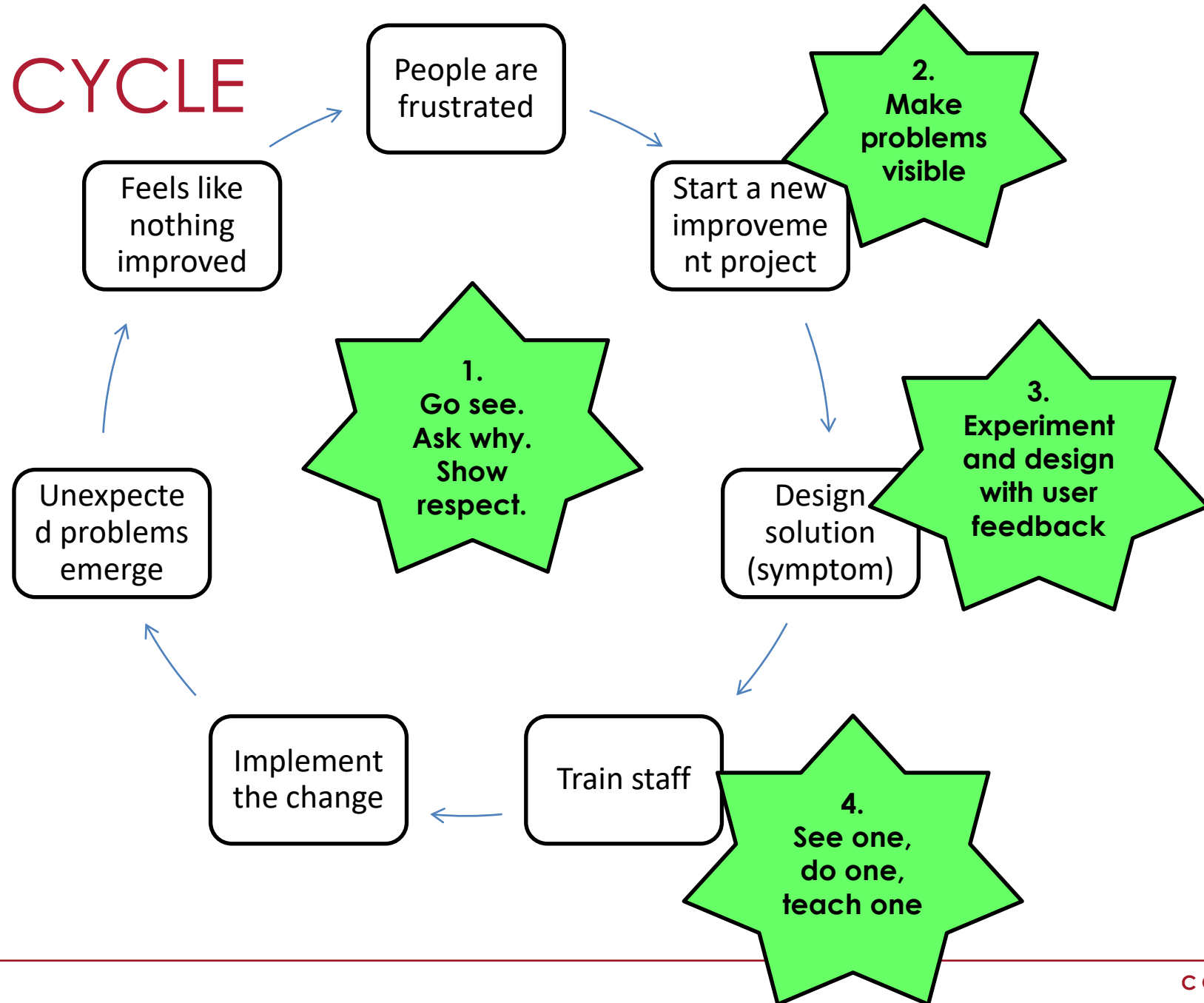
1. Improvements
are piloted
2. Tweaks made
before go live

Implement
the change

Train staff

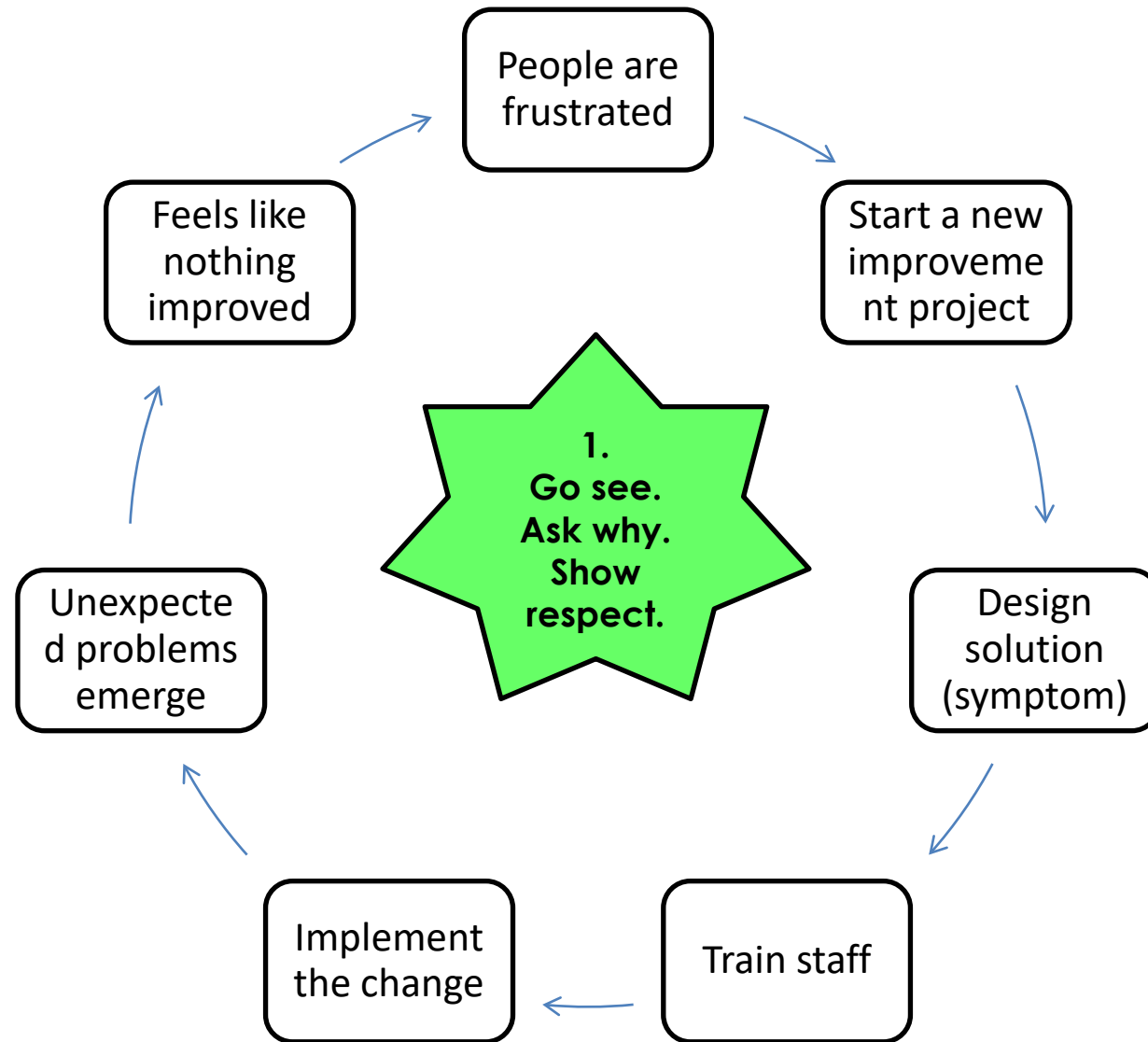
See one,
do one,
teach one

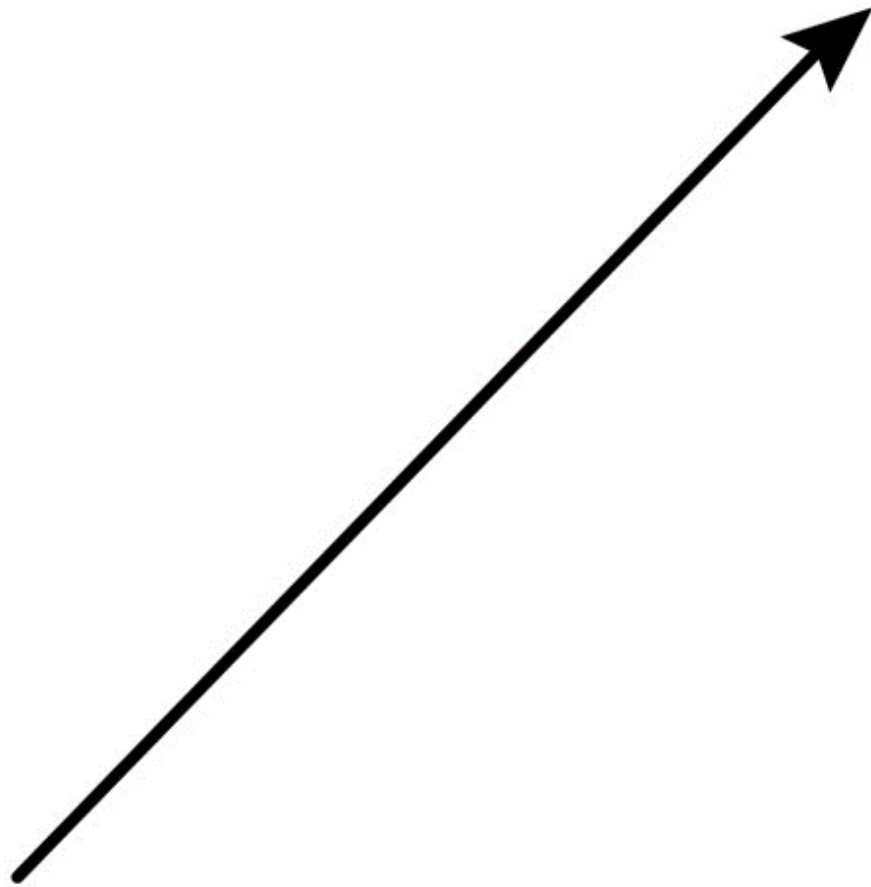
VICIOUS CYCLE



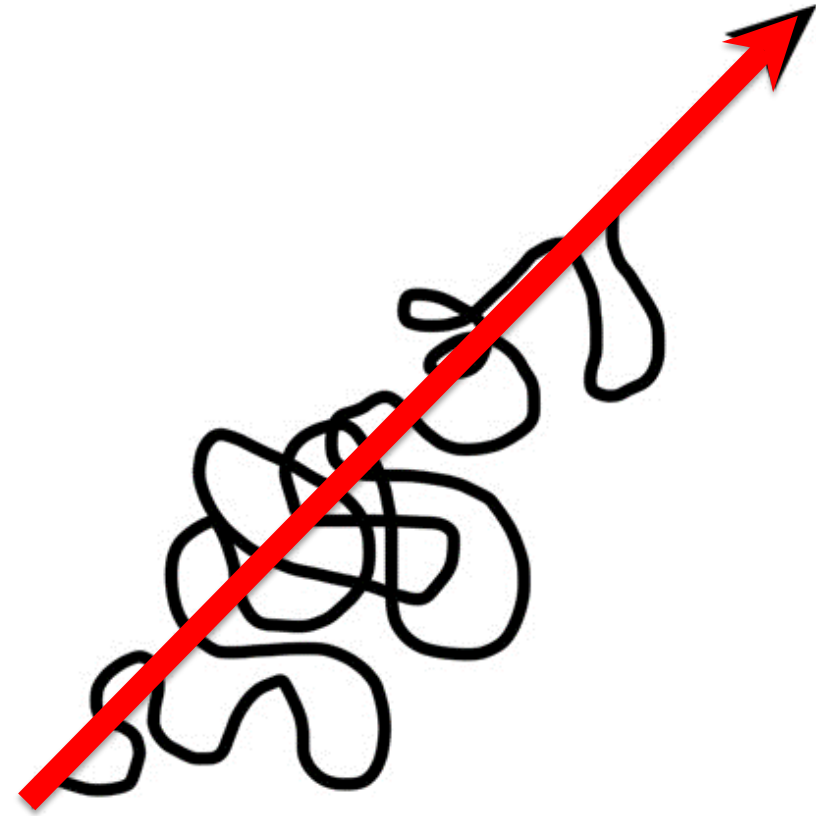
Go See. Ask Why.
Show Respect.







**what people think
it looks like**



**what it really
looks like**

GO SEE

The image displays eight icons arranged in a 2x4 grid, each representing a waste in lean manufacturing. The icons are as follows:

- wastes:** A grey square with a large white number '7' and the word 'wastes' below it.
- defects/mistakes:** A teal square with a white syringe icon and the text 'defects/mistakes' below it.
- waiting:** An orange square with a white clock icon and the text 'waiting' below it.
- transportation:** A light green square with a white cart icon and the text 'transportation' below it.
- overproduction:** A red square with a white icon of a truck carrying boxes and the text 'overproduction' below it.
- overprocessing:** An orange square with a white gear icon and the text 'overprocessing' below it.
- inventory:** A green square with a white icon of a building with a cross and the text 'inventory' below it.
- motion:** A maroon square with a white icon of a person walking and the text 'motion' below it.



GO SEE - DOWNTIME ACRONYM



- D - Defects
- O - Overproduction
- W - Waiting
- N - Not utilizing Talent**
- T - Transportation
- I - Inventory
- M - Motion
- E - Excess Processing

ASK WHY

Why in that sequence?



Why for that duration?



Why that supply or tool?



Blood pressure

Surgical mask

Stethoscope

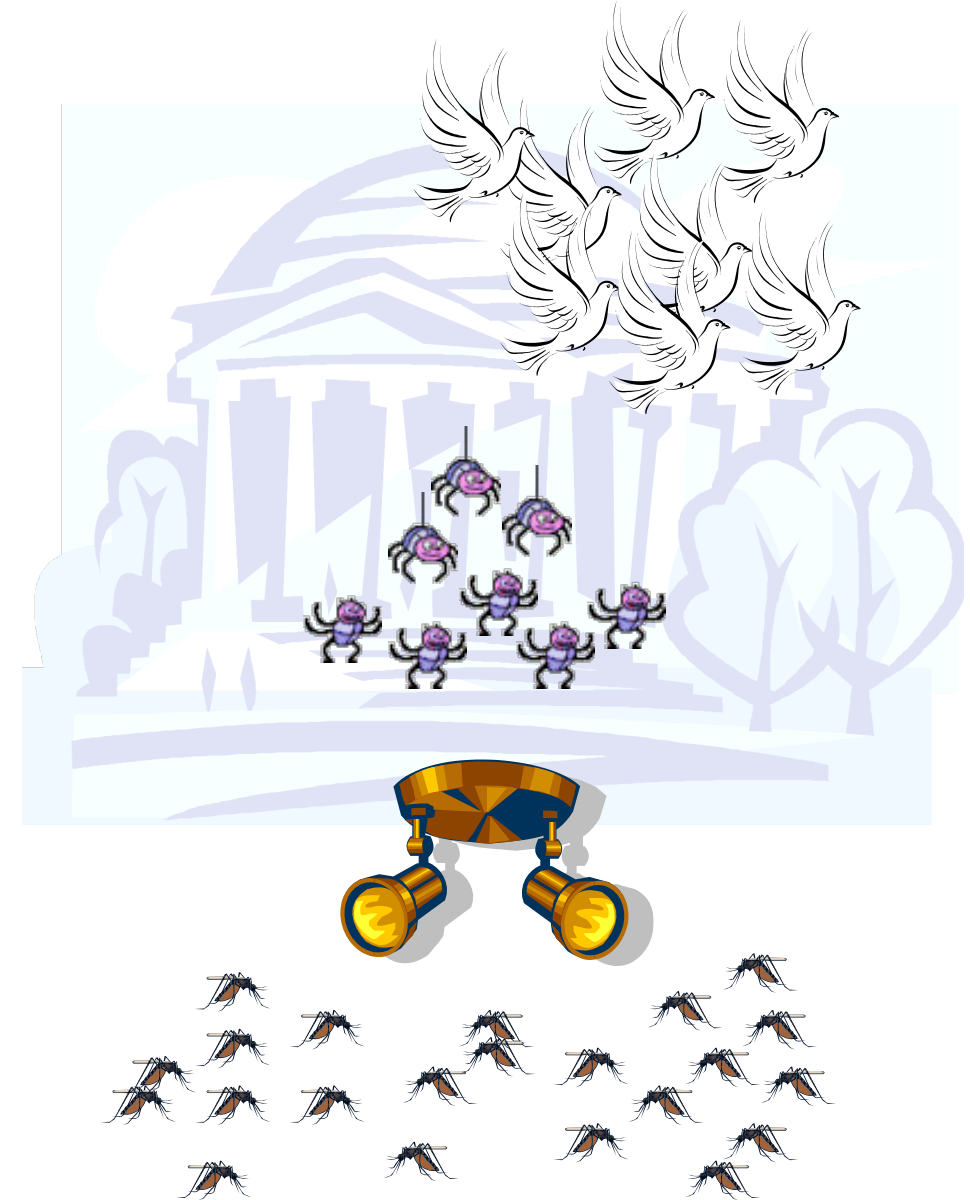
Why that way?

5 WHY EXAMPLE

The stone on the Jefferson Memorial was crumbling

- 1) Why was it crumbling?
Too frequent washings were causing the stone to crumble.
- 2) Why was it washed so often?
To remove bird droppings
- 3) Why were so many birds at the building?
There is an abundant food supply: hundreds of little spiders
- 4) Why are there so many spiders?
Spiders were attracted to the midges.
- 5) Why were there so many midges?
Every evening at dusk they emerge in a mating frenzy. At the same time the Park Service turns on its powerful spotlights. The midges are then attracted to the lights.

Solution: Delay the daily lighting to one hour after sunset. Midge population is down 90%, they have broken the food chain and there are less frequent washings.



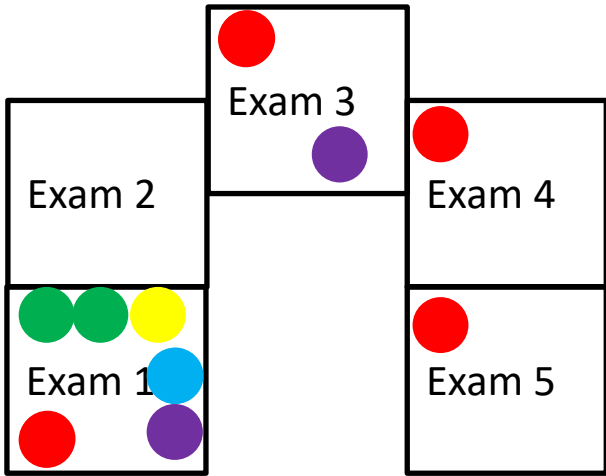
HOW MANY OF US WOULD HAVE STOPPED TOO EARLY AND SOLVED A SYMPTOM RATHER THAN FINDING THE ROOT CAUSE?

Example provided by Juran Institute

SHOW RESPECT



BURN CLINIC – LONG PATIENT WAIT TIMES



● Patient

● 1) Therapy enters

● 2) SW enters

● 3) THEN Physical Therapist enters

● 4) THEN APC enters

(EVERYONE IS STILL IN THE ROOM)

ROOMS	CLS	HCA	APC/MD	Therapy	SW	Notes
1 Hall	O	Kim	Daniel ✓	X	X	
2						
3 Smith	X	Carly O	molly ■	X	O	
4						

X = Not Needed
 O = Made contact
 ✓ = Done
 Magnet = Staff "in room"



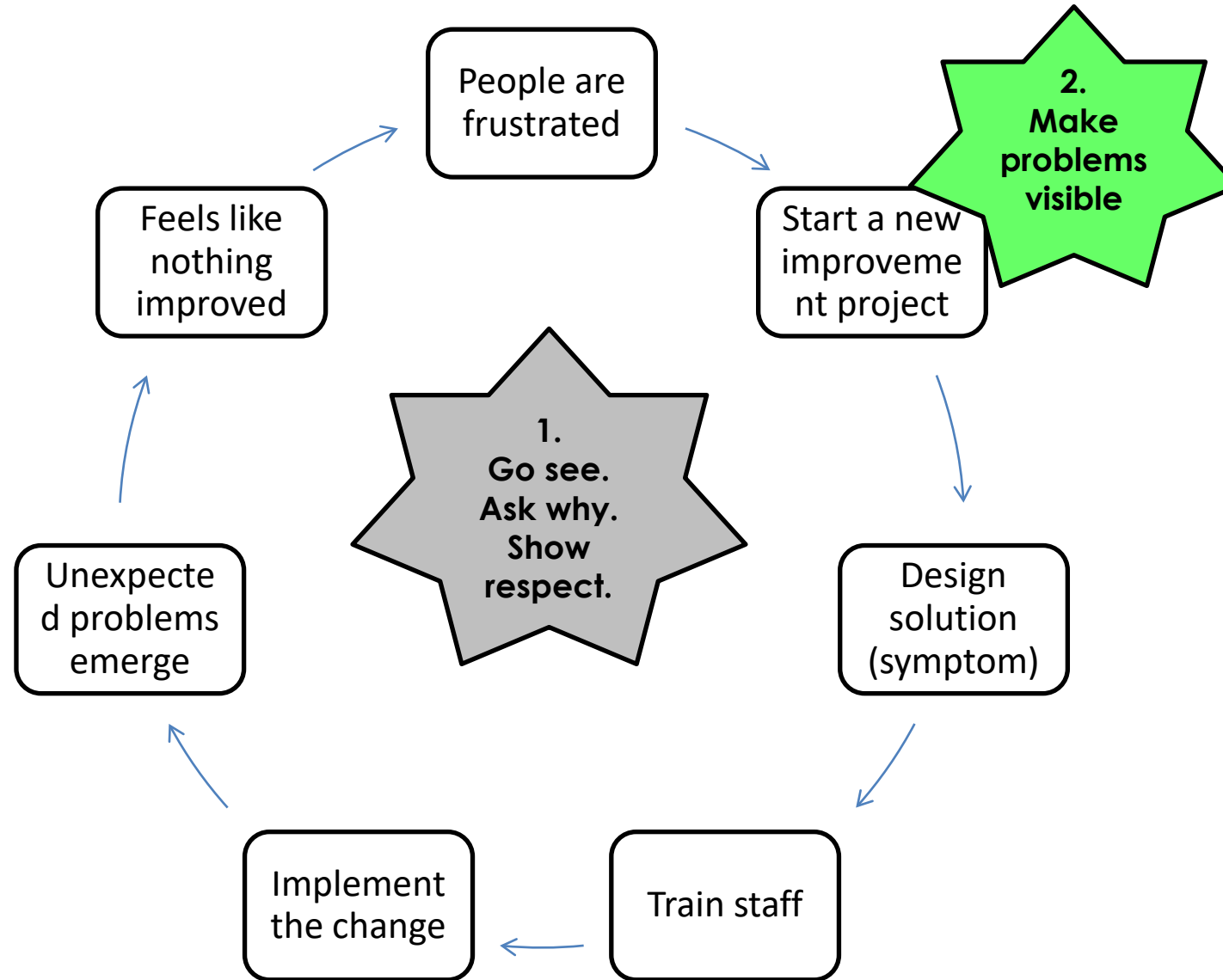
If you're not in the arena also
getting your ass kicked, I'm not
interested in your feedback.

— Brené Brown —

AZ QUOTES

Make Problems Visible

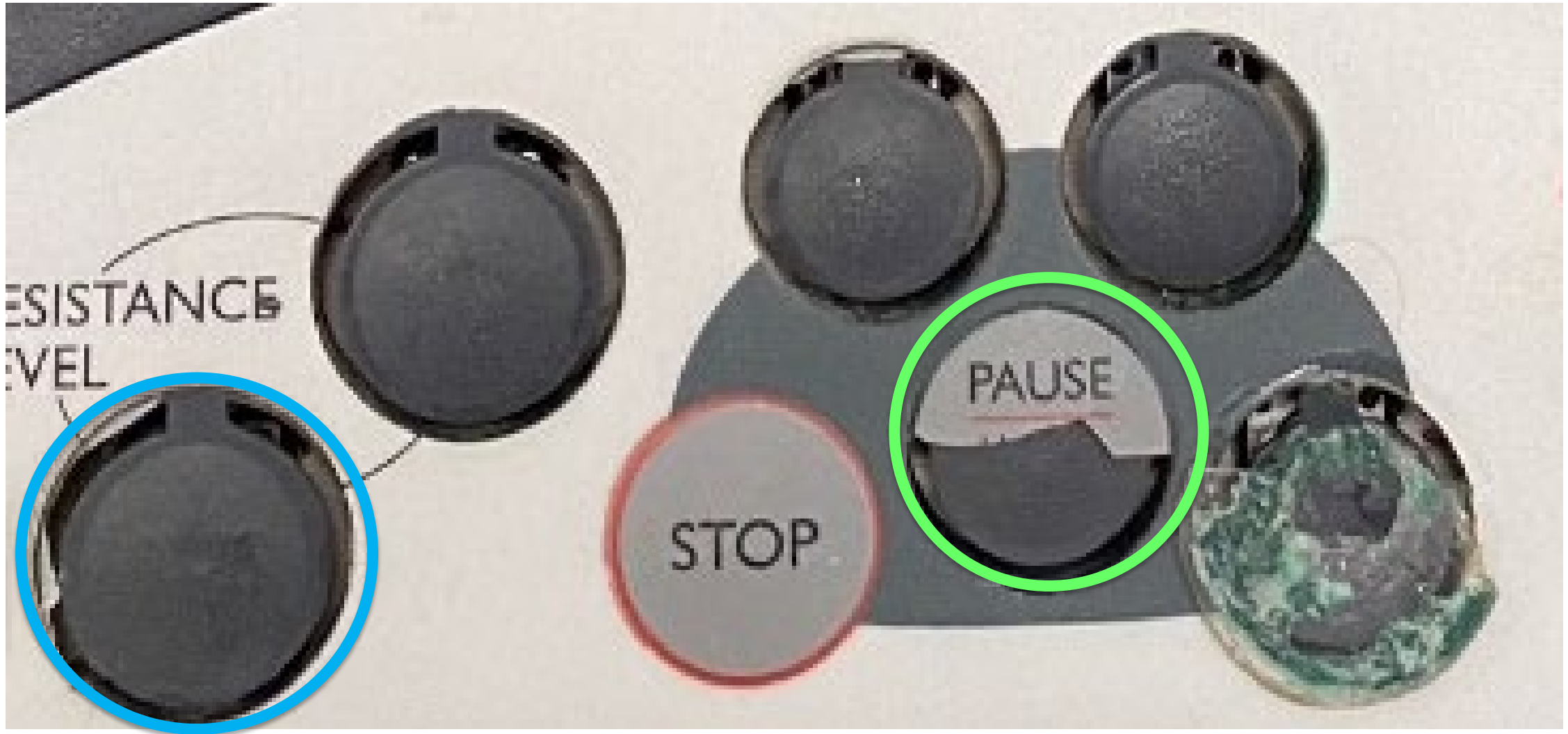




TAKE PICTURES (BIKE)



TAKE PICTURES (BIKE)



TAKE PICTURES (BIKE)



TAKE SCREENSHOTS (CLINIC)

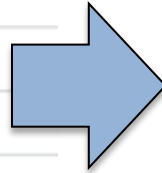
Slots	Time	Pri?	Length	Department	Visit Type
Clinic 1		MFDC MFM PERINATOLOGY			
2	1:00 P			CON(1),PPE(1),GYN	
1	1:15 P			PPE,GYN	
1	2:00 P			NOB	
1	2:15 P			ROB	
2	2:30 P			CON(1),ROB(1)	
1	2:45 P			ROB	
1	3:00 P			ROB	
1	3:15 P			NOB	
1	3:30 P			ROB	
1	3:45 P			ROB	
1	4:00 P			ROB	
1	4:15 P			ROB	
1	4:30 P			ROB	

Slots	Time	Pri?	Visit Type	Length
Clinic 2		SJHC MFM PERINATOLOGY		
📄	8:00 A		Please schedule appointments	
1	1:00 P			
1	1:20 P			
1	1:40 P			
1	2:00 P			
1	2:20 P			
1	2:40 P			
1	3:00 P			
1	3:20 P			
1	3:40 P			
1	4:00 P			
1	4:20 P			
1	4:40 P			

TAKE SCREENSHOTS (CLINIC)

Slots	Time	Pri?	Length	Department	Visit Type
Clinic 1		MFDC MFM PERINATOLOGY			
2	1:00 P			CON(1),PPE(1),GYN	
1	1:15 P			PPE,GYN	
1	2:00 P			NOB	
1	2:15 P			ROB	
2	2:30 P			CON(1),ROB(1)	
1	2:45 P			ROB	
1	3:00 P			ROB	
1	3:15 P			NOB	
1	3:30 P			ROB	
1	3:45 P			ROB	
1	4:00 P			ROB	
1	4:15 P			ROB	
1	4:30 P			ROB	

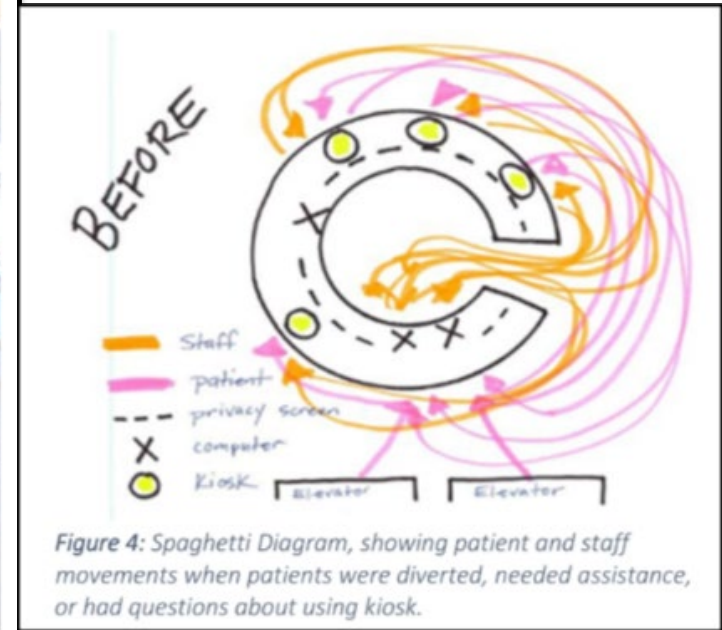
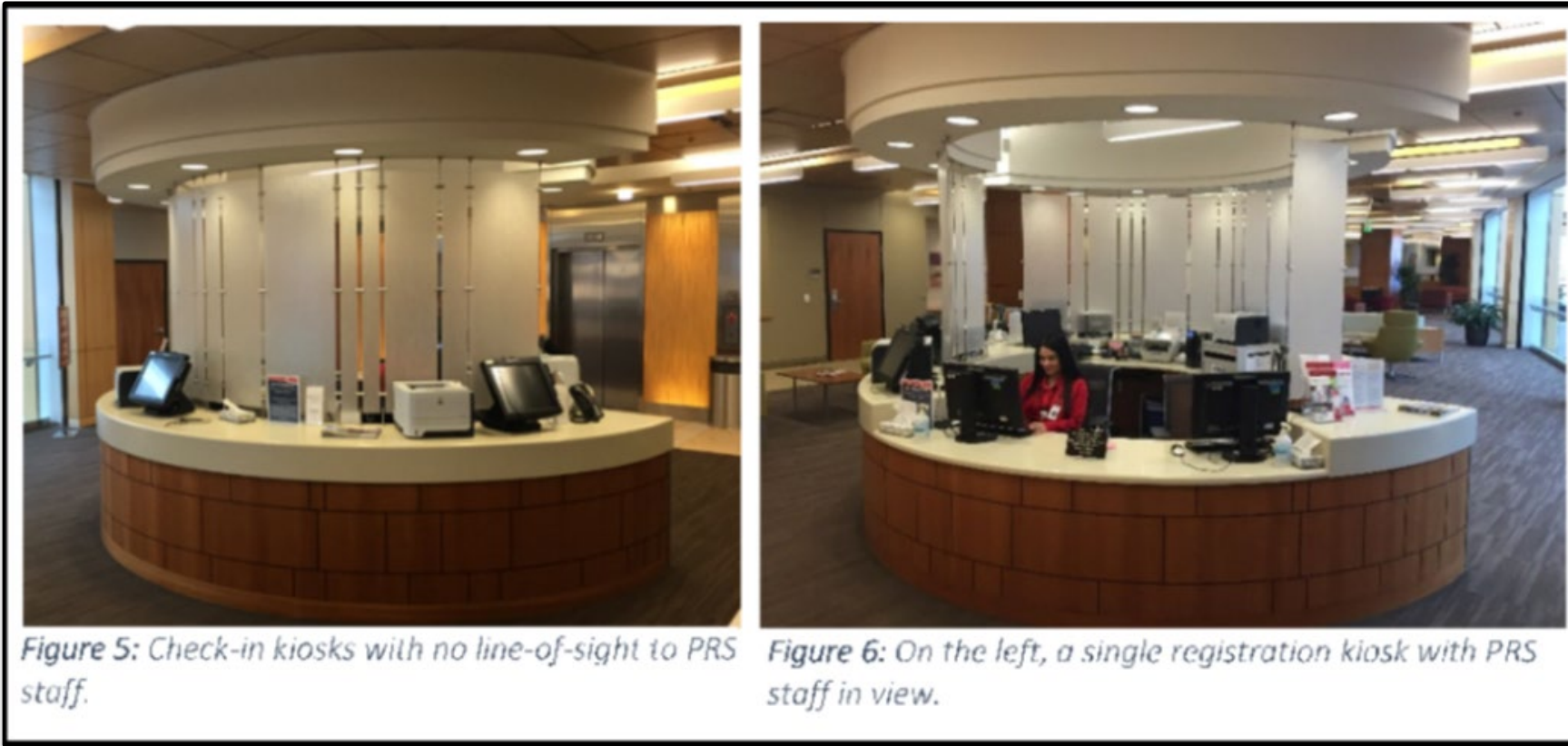
15 visits



Slots	Time	Pri?	Length	Department	Visit Type
Clinic 1		MFDC MFM PERINATOLOGY			
1	1:00 P	1			1:00 P
1	1:20 P	1			1:20 P
1	1:40 P	1			1:40 P
1	2:00 P	1			2:00 P
1	2:20 P	1			2:20 P
1	2:40 P	1			2:40 P
1	3:00 P	1			3:00 P
1	3:20 P	1			3:20 P
1	3:40 P	1			3:40 P
1	4:00 P	1			4:00 P
1	4:20 P	1			4:20 P
1	4:40 P	1			4:40 P

Up to 24 visits

TAKE PICTURES AND DRAW



TAKE PICTURES AND DRAW



Figure 8: Check-in kiosks with line-of-sight to PRS staff at all kiosks.

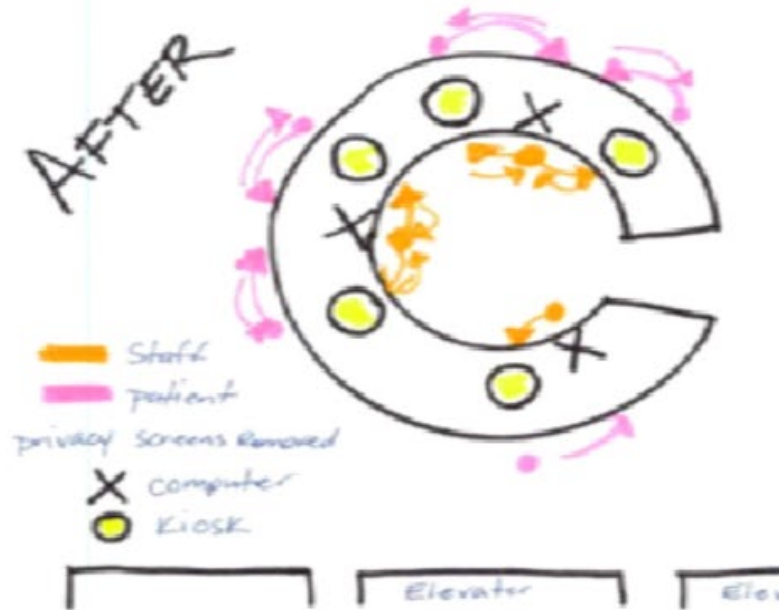


Figure 9: Spaghetti diagram with privacy panels removed showing much less motion for staff and patients.

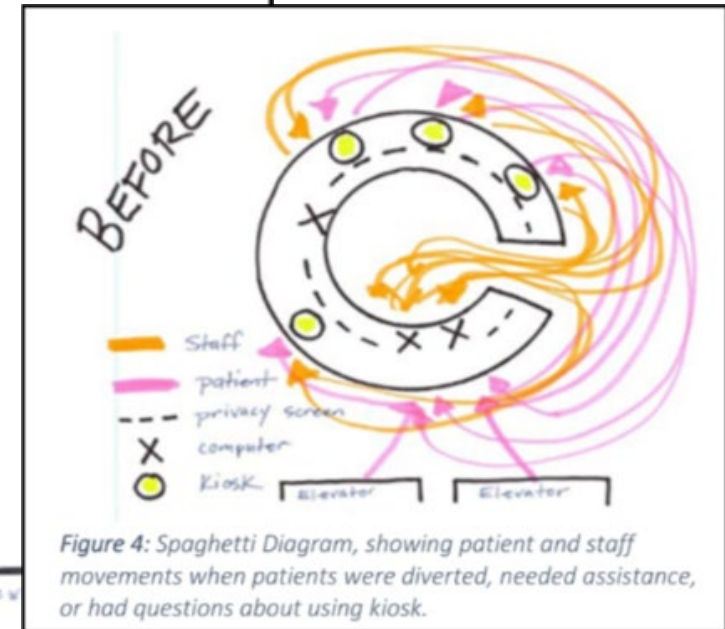
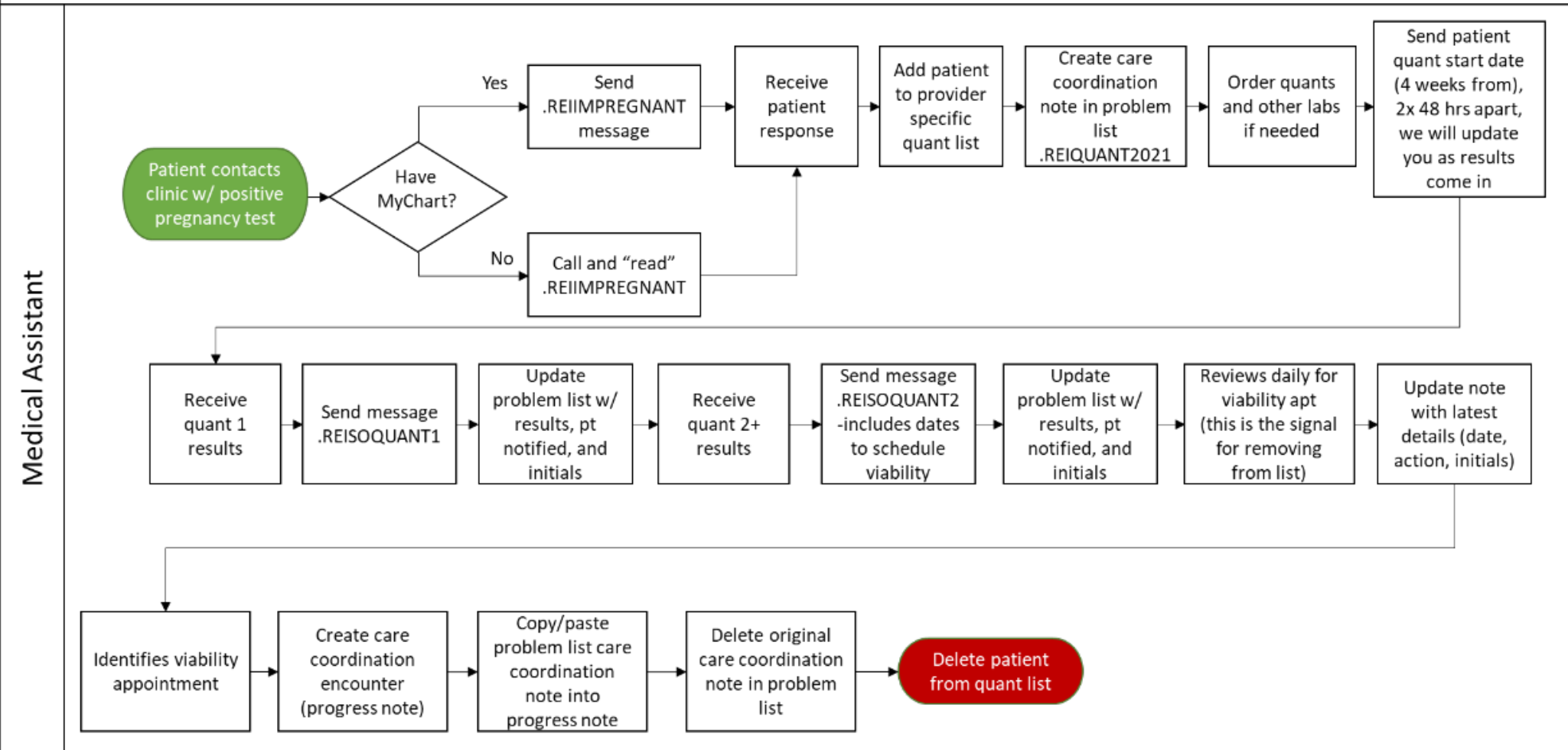


Figure 4: Spaghetti Diagram, showing patient and staff movements when patients were diverted, needed assistance, or had questions about using kiosk.

PROCESS MAP - DRAFT 1

IUI, Timed Intercourse, and Unplanned IVF Pregnant Patient Quant Tracking Process
 Process Owner: Ultrasound MAs M-F; Weekend MAs Sa-Su | Frequency: Review daily

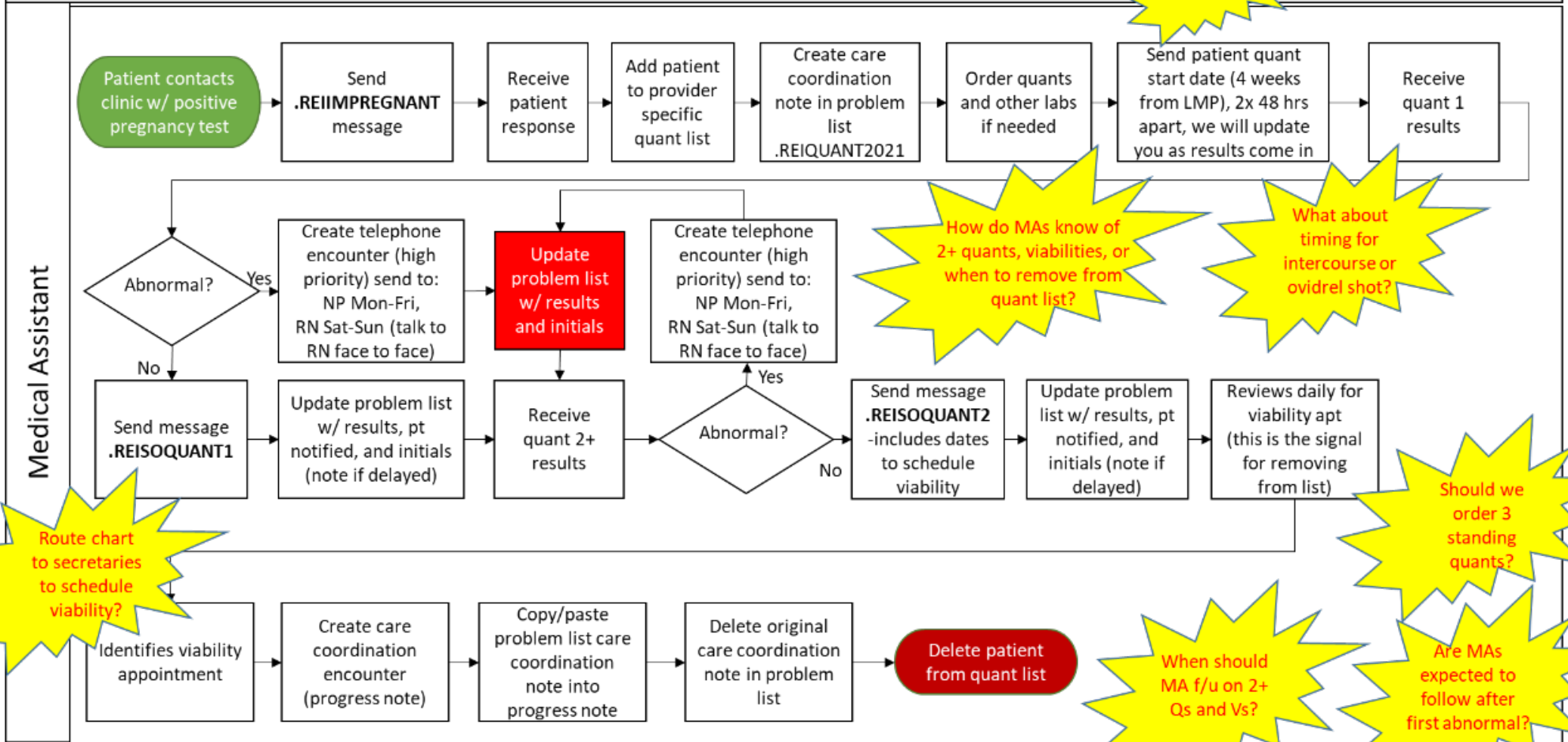
Draft 1: 4/27/2021



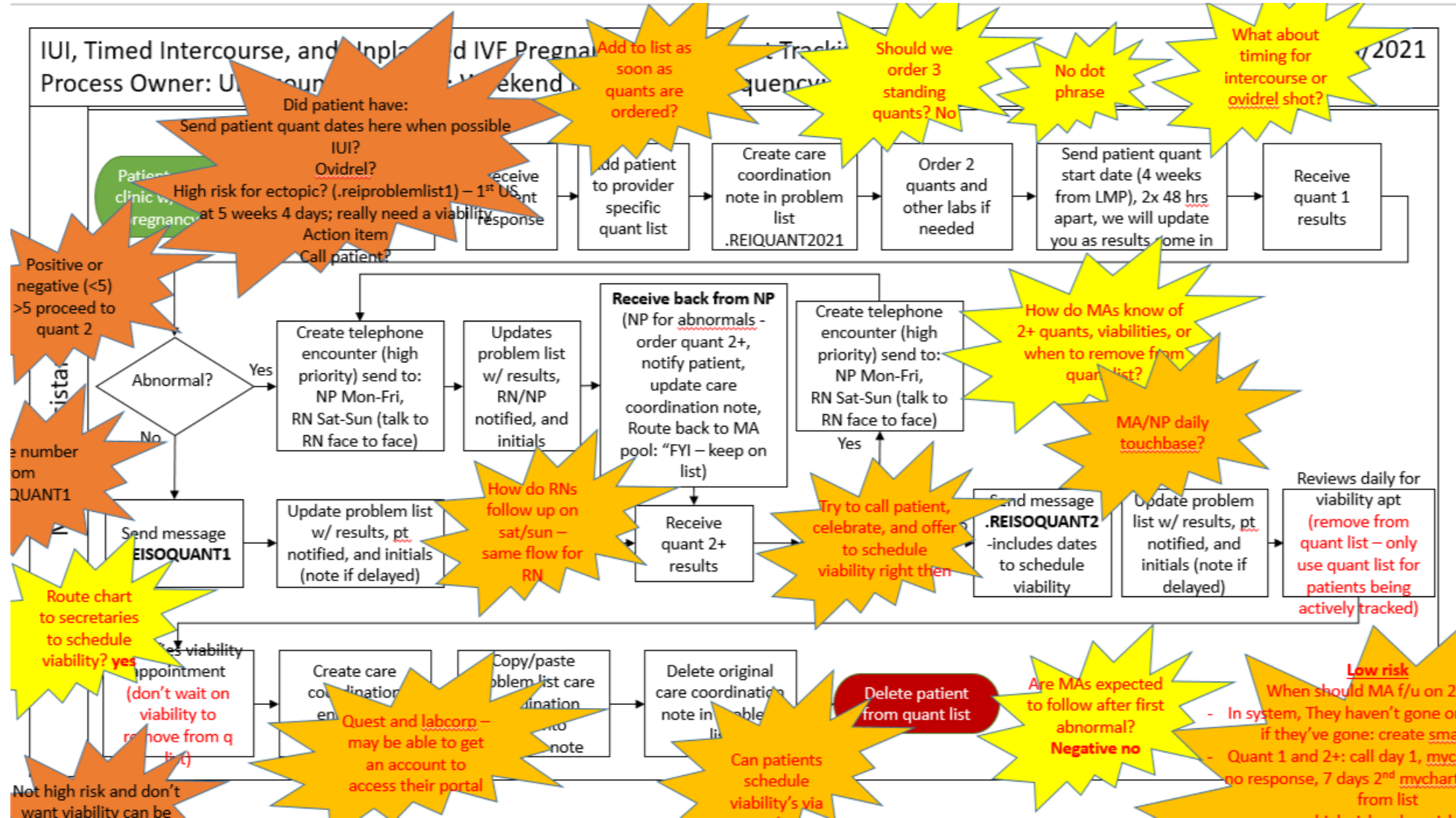
PROCESS MAP - DRAFT 2

IUI, Timed Intercourse, and Unplanned IVF Pregnant Patient Quant Tracking Process
 Process Owner: Ultrasound MAs M-F; Weekend MAs Sa-Su | Frequency: Review daily

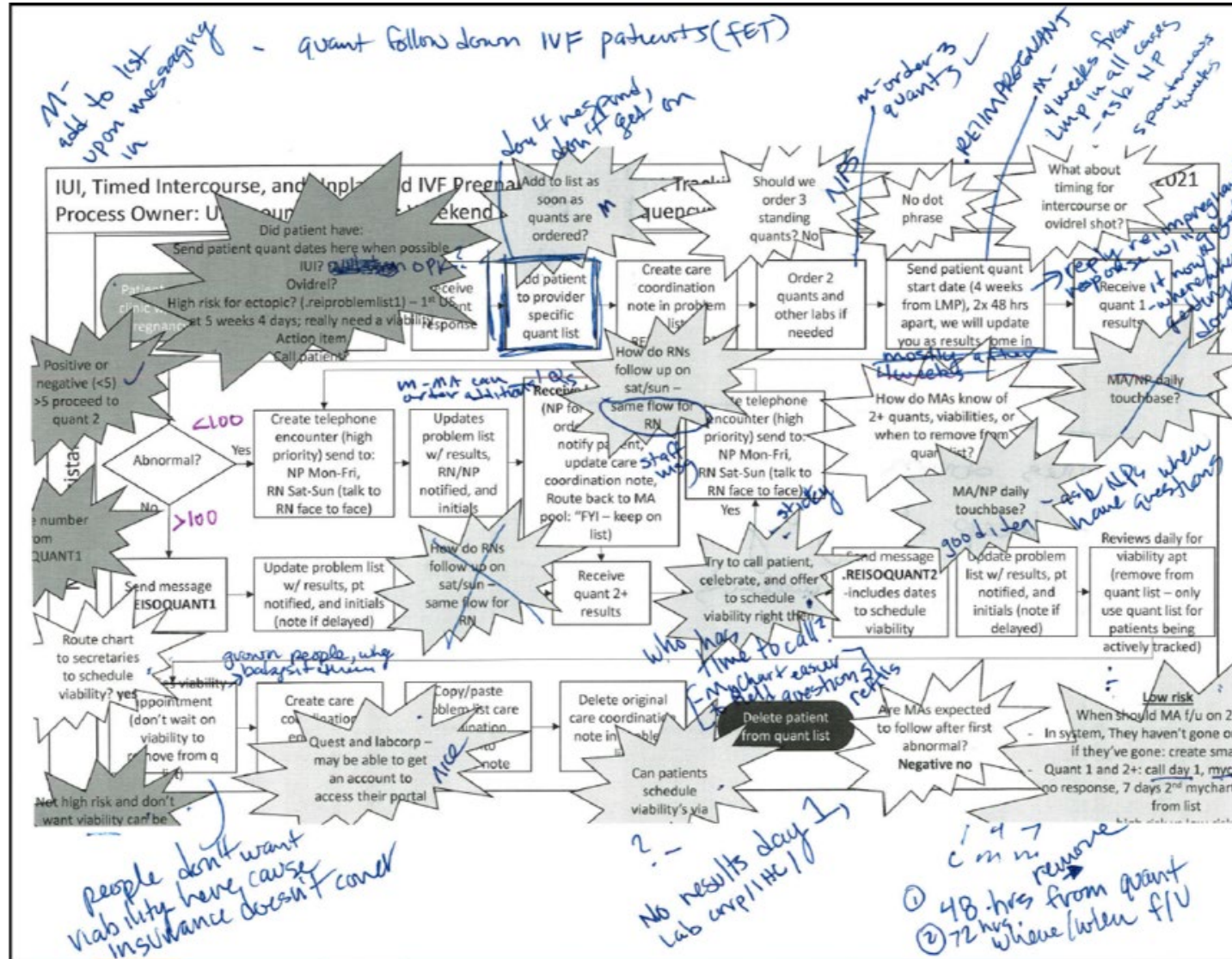
Draft 2: 4/28/2021



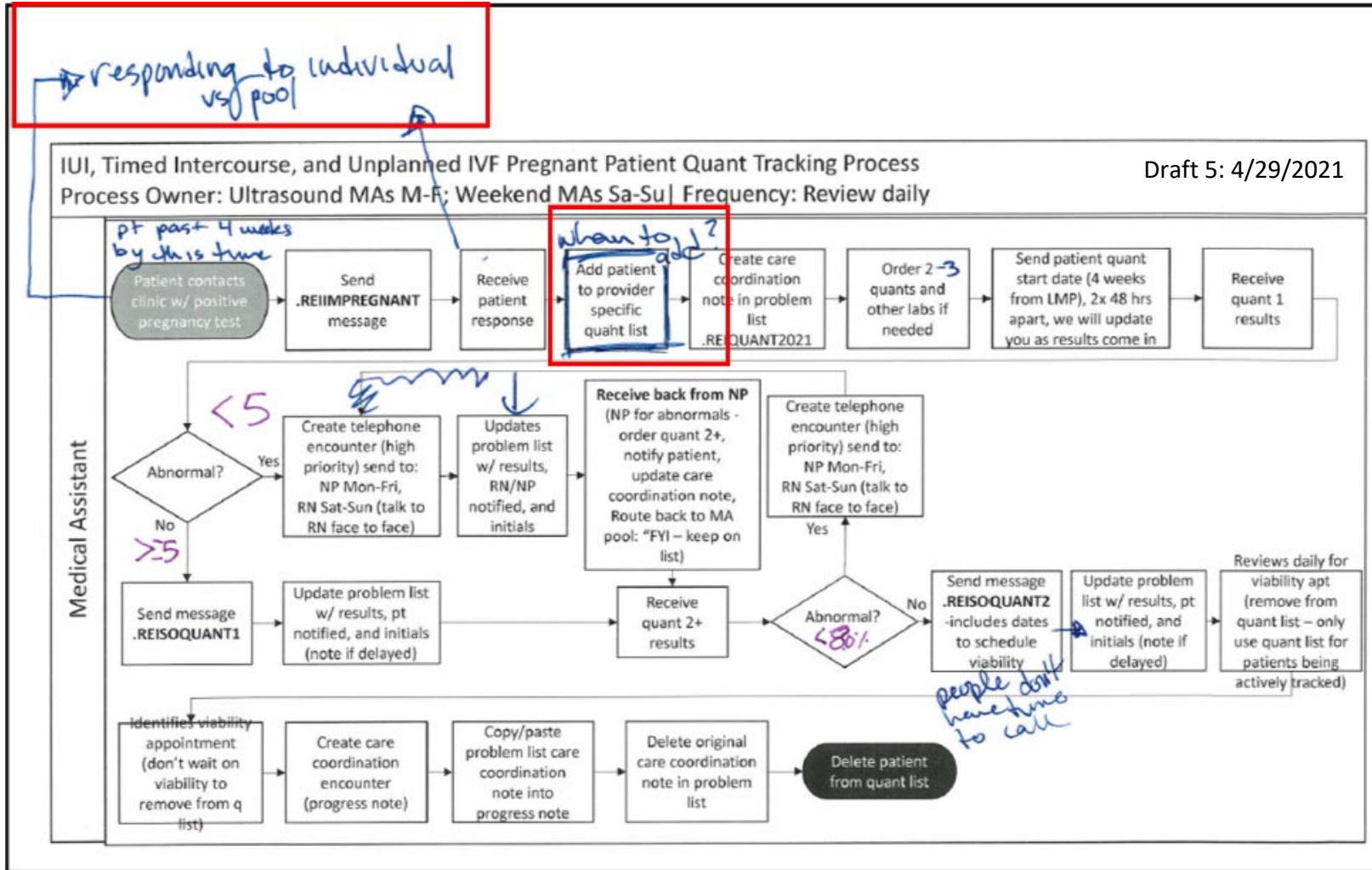
PROCESS MAP - DRAFT 3



PROCESS MAP - DRAFT 4



PROCESS MAP - DRAFT 5



1. Staff added patients to tracker at different points
2. Not all staff were setup to have patient responses route to a pool

“ROCKS IN THE SHOES”

Your Name: _____

Date Submitted: _____

What's the Problem?

How Problem Impacts Your Work:

"ROCKS IN THE SHOES"

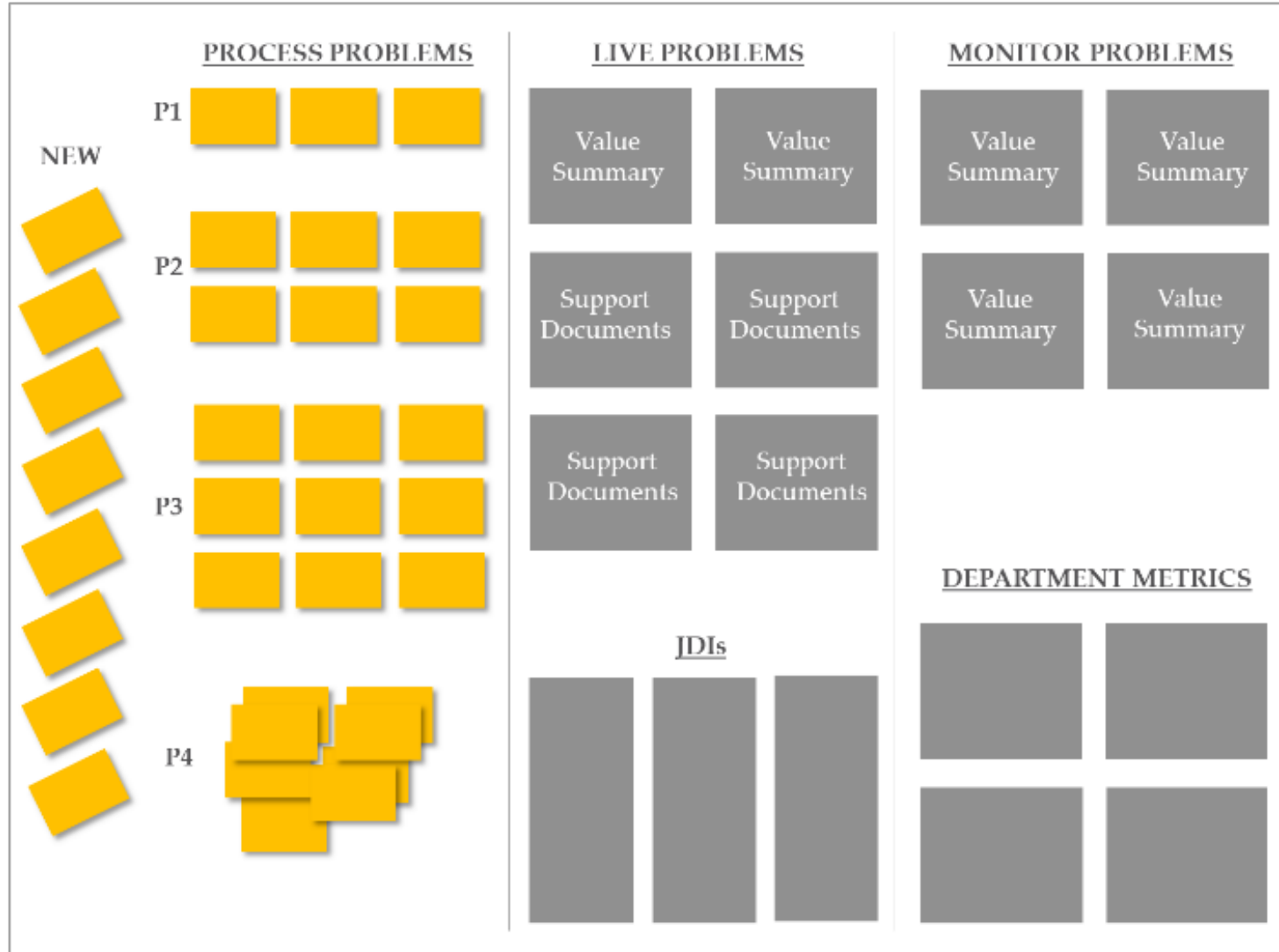
What's the Problem?	How Problem Impacts Your Work:
No printer in the new training room.	As a lead I was unable to print needed document while using a computer I can save to the hard drive.

What's the Problem?	How Problem Impacts Your Work:
UV Robot storage is too close to the scrubber cleaning area.	I have a picture of water flowing near the surge protector.

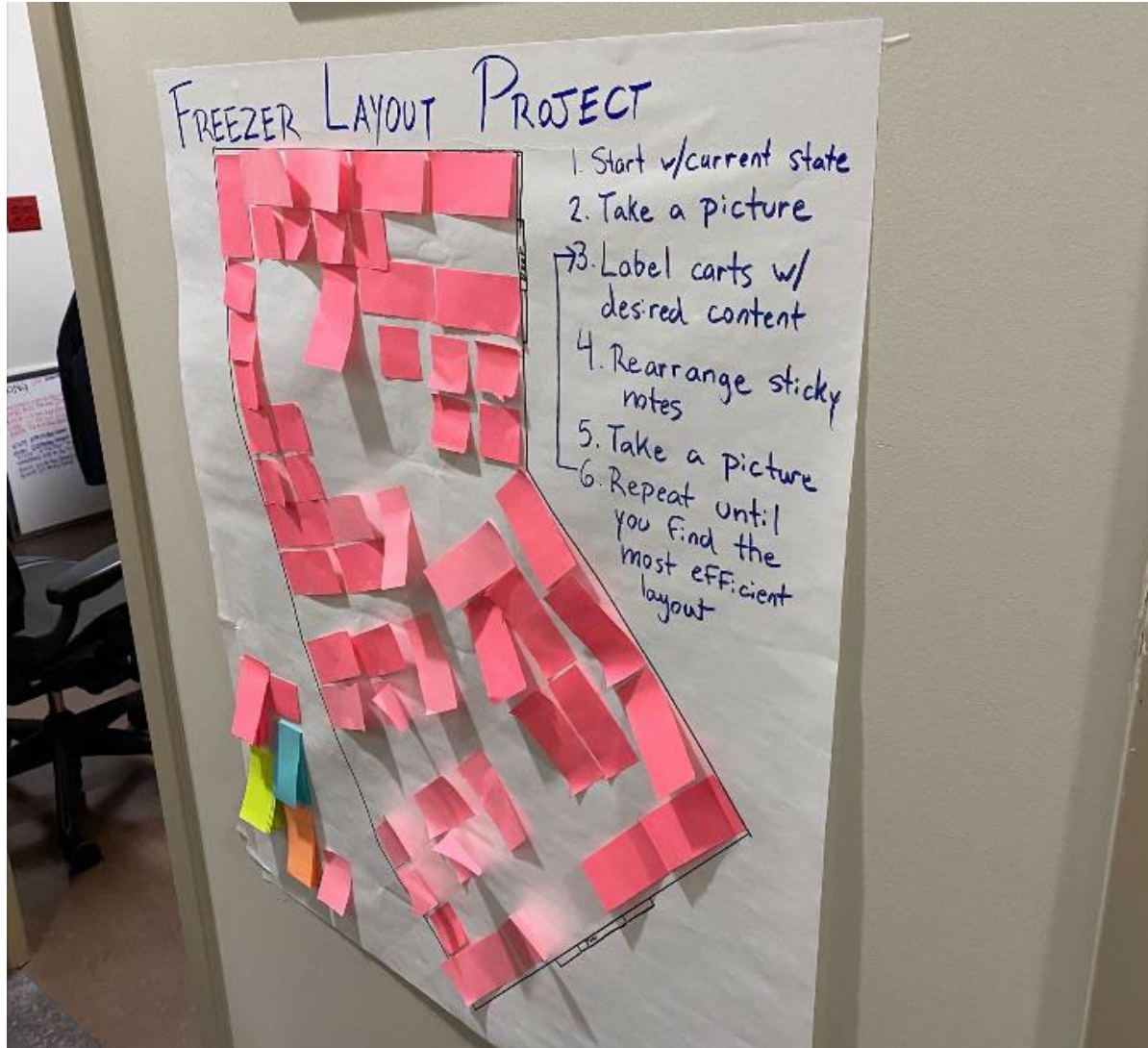
What's the Problem?	How Problem Impacts Your Work:
LND staff not paying when an OR is dirty	A OR can go hours without being cleaned

What's the Problem?	How Problem Impacts Your Work:
Needles being thrown in trash	could get poked and have to go to work wellness

“ROCKS IN THE SHOES”



VISUAL FLOOR PLAN LAYOUTS



TEAM METRICS

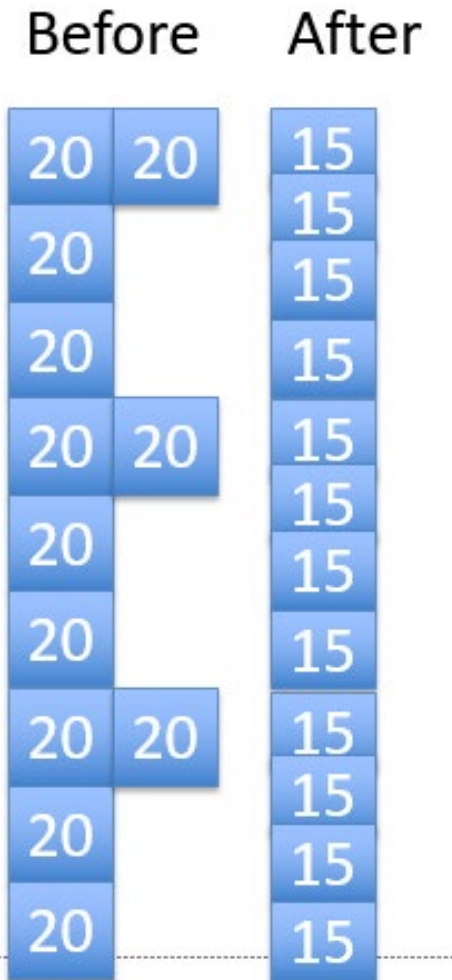


TEAM METRICS



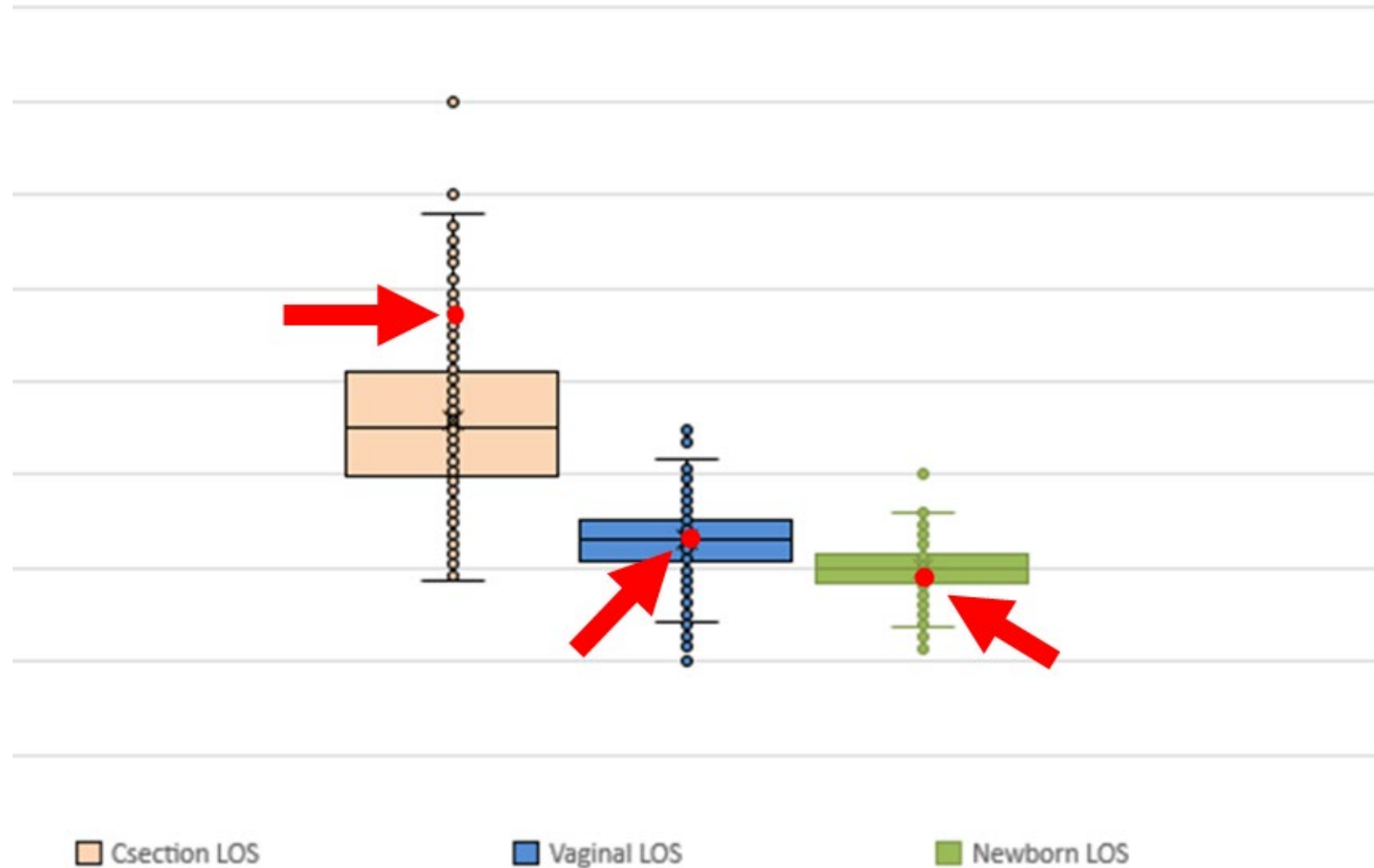
INDIVIDUAL BENCHMARKING

South Jordan - Dr. Press Ganey Survey Questions Goal: 90th Percentile	Trends/Suggestions:						
All scores are UHC percentile rank by received date	FY'17 Q1	FY'17 Q2	FY'17 Q3	FY'17 Q4	FY'18 Q1	FY'18 Q2	FY'18 Q3
Overall	35	30	29	23	18	28	26
Access	94	99	73	93	50	92	70
Ease of getting clinic on phone	95	92	90	94	35	87	79
Ability to get desired appointment*	99	99	38	99	31	34	68
Convenience of our office hours	99	99	68	91	68	98	66
Ease of scheduling appointments	95	99	69	99	65	78	63
Courtesy of registration staff	93	88	52	64	27	99	83
Moving Through Your Visit	76	71	70	28	28	75	69
Information about delays	48	64	61	20	22	47	81
Wait time at clinic	82	66	81	34	33	76	80
Nurse/Assistant	77	82	73	71	49	34	68
Friendliness/courtesy of nurse/asst	81	77	63	50	63	55	62
Concern of nurse/asst for problem	75	85	81	85	40	27	78
Care Provider	12	1	10	1	1	2	2
Friendliness/courtesy of CP	20	3	10	1	1	2	3
CP explanations of prob/condition	10	1	7	1	1	4	1
CP concern for questions/worries	12	1	11	1	1	1	2
CP efforts to include in decisions	12	1	11	1	1	1	3
CP information about medications	11	2	6	1	1	1	2
CP instructions for follow-up care	8	4	7	1	1	2	2
CP spoke using clear language	22	12	15	13	1	8	8
Time CP spent with patient	11	1	5	1	1	1	1
Patients' confidence in CP	11	1	7	1	1	2	1
Likelihood of recommending CP	10	1	2	1	1	1	1
Personal Issues	25	47	24	25	21	22	24
How well staff protect safety	26	44	20	57	21	29	35
Our sensitivity to patients' needs	19	25	17	14	6	10	12
Our concern for patients' privacy	29	31	25	26	22	28	29
Cleanliness of our practice	32	97	51	63	37	52	71
Overall Assessment	16	18	18	13	10	9	11
Staff worked together	17	17	18	14	12	8	19
Likelihood of recommending practice	16	18	16	10	4	8	9



SYSTEM BENCHMARKING

Length of Stay Comparison (350+ hospitals compared)



INDIVIDUAL METRICS

Hi Maddy [REDACTED]

Happy spring! We were a bit slow with your April Where You Stand Letter but it's here. The information should be current as of March 31st. If you see something that does not match your timecard, LMS, etc., let us know so we can look into it.

This month, RNs will notice new individual quality metric we are calling **Pain Matching**. This measurement indicates how often the pain medications you administer match the order and pain assessment associated with medication administrations. Since we are just starting to track this metric, our entire unit is far below goal at 53%. Don't stress! We will improve together as a unit and hospital system. (Shout out to our top two nurses Rachael and Ashton who are already sitting at 70%!!)



Thanks for your great patient care! We appreciate you.

Ann, Tom, Alaina, & Thomas

OTS Team Metrics

OTS EVALUATION GOALS (Fiscal Year '21)

Hospital Focus	Evaluation Goal	Quarter 2 (Oct 20-Dec 21)	Quarter 3 (Jan 21-Mar 21)	Quarter 4 (Apr 21-Jun 21)
Patient Experience	E60 OTS will reach 76.0% 'Always' for the HCAHPS question, 'How often did nurses explain things in a way you could understand?' for at least one quarter between FY21 Q2 and FY21 Q4.	84.1%	85.0%	-
Finance	E60 OTS will reduce missed lunches by 10% from 3.16% to 2.85% between FY21 Q2 and FY21 Q4.	2.0%	1.7%	-
Quality	E60 OTS HCAs will maintain a urinary catheter care compliance rate of > 90% between FY21 Q2 and FY21 Q4. HUCs support this goal through monthly audits.	100%	100%	-

OTS QUALITY INITIATIVES (Rolling Calendar Year)

Quality initiative	Average	Goal	Apr 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Pain Reassessment (RN)	98%	>= 95%		97%	98%	98%	97%	97%	99%	98%	98%	97%	97%	98%
BCMA Scanning (RN)	97%	>= 95%		97%	97%	97%	98%	98%	98%	98%	98%	98%	97%	94%
Advance Directives (RN)	94%	>= 95%		95%	95%	94%	95%	92%	94%	95%	92%	91%	95%	97%
Bedside Report (RN & HCA)	65%	>= 80%		46%	64%	65%	77%	50%	61%	68%	57%	86%	63%	72%
Hand Hygiene (RN)	91%	>= 85%		95%	92%	96%	92%	100%	88%	96%	92%	94%	82%	71%
Hand Hygiene (HCA)	65%	>= 85%		76%	79%	91%	86%	96%	75%	100%	96%	75%	78%	85%
CLABSI per 1000 pt days	0	0		0	0	0	0	0	0	0	0	0	0	0
CAUTI per 1000 pt days	0	0		0	0	0	0	2	0	0	0	0	0	0
Patient Falls	3.6	<= 2		2	2	4	4	6	3	5	1	6	1	9

Individual Metrics - Maddy

TIMECARD AND ATTENDANCE (Rolling Calendar Year – Last 12 Months) – Review policy [here](#).

	Total	Goal	May 2020	Jun 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021
Ill Occurrences	3	<= 5	1	0	0	1	0	0	0	0	0	0	0	
Missed Punches	4	< 15	0	0	0	1	0	2	0	0	1	0	0	
Timecard Approval	92% (22/24)	> 90%	2/2	2/2	2/2	2/2	0/2	2/2	2/2	2/2	2/2	2/2	2/2	
> 1 Min Late In	16% (22/134)	< 10%	1/6	1/12	2/14	1/9	1/6	4/14	3/13	3/14	2/12	3/12	1/13	
> 7 Min Late In	4% (6/134)	< 3%	0/6	0/12	2/14	0/9	1/6	0/14	1/13	0/14	0/12	1/12	1/13	
Missed Lunches	9% (0/134)	< 10%	0/6	0/12	0/14	0/9	0/6	0/14	0/13	0/14	0/12	0/12	0/13	
Late Outs RN > 8:00, HCA > 7:15	2% (3/134)	< 3%	0/6	0/12	0/14	0/9	0/6	0/14	2/13	1/14	0/12	0/12	0/13	

INDIVIDUAL QUALITY MEASURES (Rolling Calendar Year – Last 12 Months)

	Average	Goal	Apr 2020	May 2020	Jun 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
(RN) Pain Reassessment	N/A	>95%	-	-	-	-	-	-	-	-	-	-	-	-
(RN) Pain Meds Match Assessment	N/A	>75%	-	-	-	-	-	-	-	-	-	-	-	-
(RN) BCMA Scanning	N/A	>95%	-	-	-	-	-	-	-	-	-	-	-	-

STAFF MEETING PARTICIPATION (Evaluation Year – Apr '20 to Mar '21)

Attendance	Attendance Goal	Participation	Participation Goal	May 2020	Jul 2020	Sept 2020	Nov 2020	Jan 2021	Mar 2021
100% (6/6)	50% (3/6)	100% (6/6)	100% (6/6)	A	A	A	A	A	A

EDUCATION (Rolling Calendar Year – Last 12 Months + Current Status)

Trauma Queen	Goal	Apr 2020	May 2020	Jun 2020	July 2020	Aug 2020	Sept 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
73% (8/11)	(12/12)	-	1	1	1	1	0	0	1	1	1	0	1
		LMS			BERT Class			PPE Type / Fit Test Expiration					
		Complete			Complete			Halyard (regular) N/A					
		CNA Cert/RN License Expiration			BLS Expiration			Tele Competency Expiration (RN only)					
		N/A			N/A			N/A					

COMMENTS (Worker of the Shift, Reward Great Work, Kudos, Patient/Family Thank You Notes)

1/11/21 (WOS - Jen [REDACTED]: Maddy [REDACTED] is a great HUC and I love working with her. It was so busy tonight and she managed everything with ease. She was very helpful and supportive to the staff. She is amazing

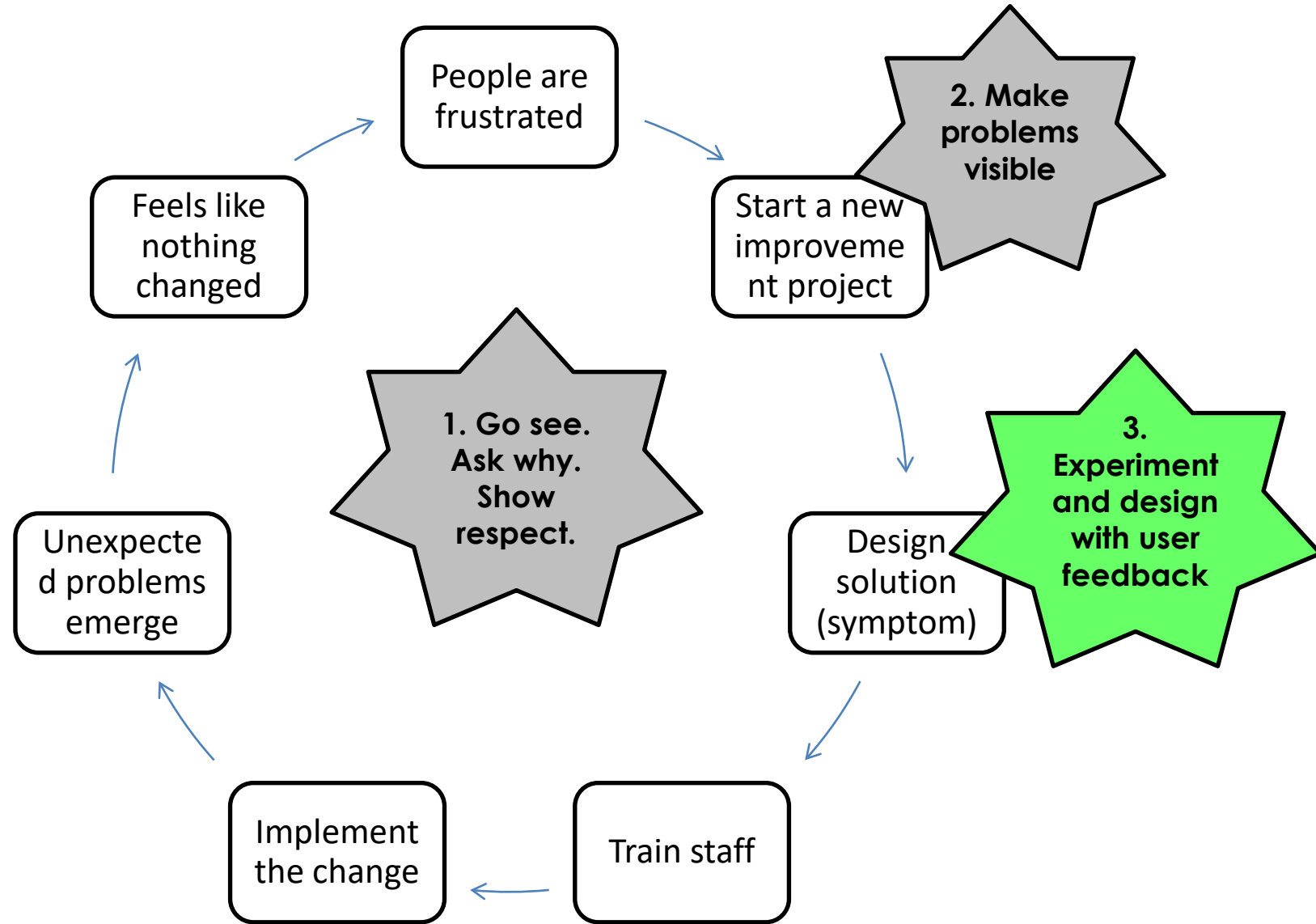
12/28/20 (WOS - Lorena [REDACTED]: Madylin [REDACTED] does a great job taking care of all new admissions and making sure pts. have what they need. Whenever I need help I know I can count on her. Thanks Maddy for always being ready to help.

10/26/20 (WOS - Lorena [REDACTED]: Maddy [REDACTED] HUC was a team player. When our floor was down 2 HCAs; she didn't hesitate to answer call lights and help checking VS on some patient.

6/7/20 (WOS -): Maddy gets worker of the shift for figuring out the new bed board/inpatient monitoring system! And then helping me with it!

Experiment and Design with User Feedback





What is on the other side of the ridge?

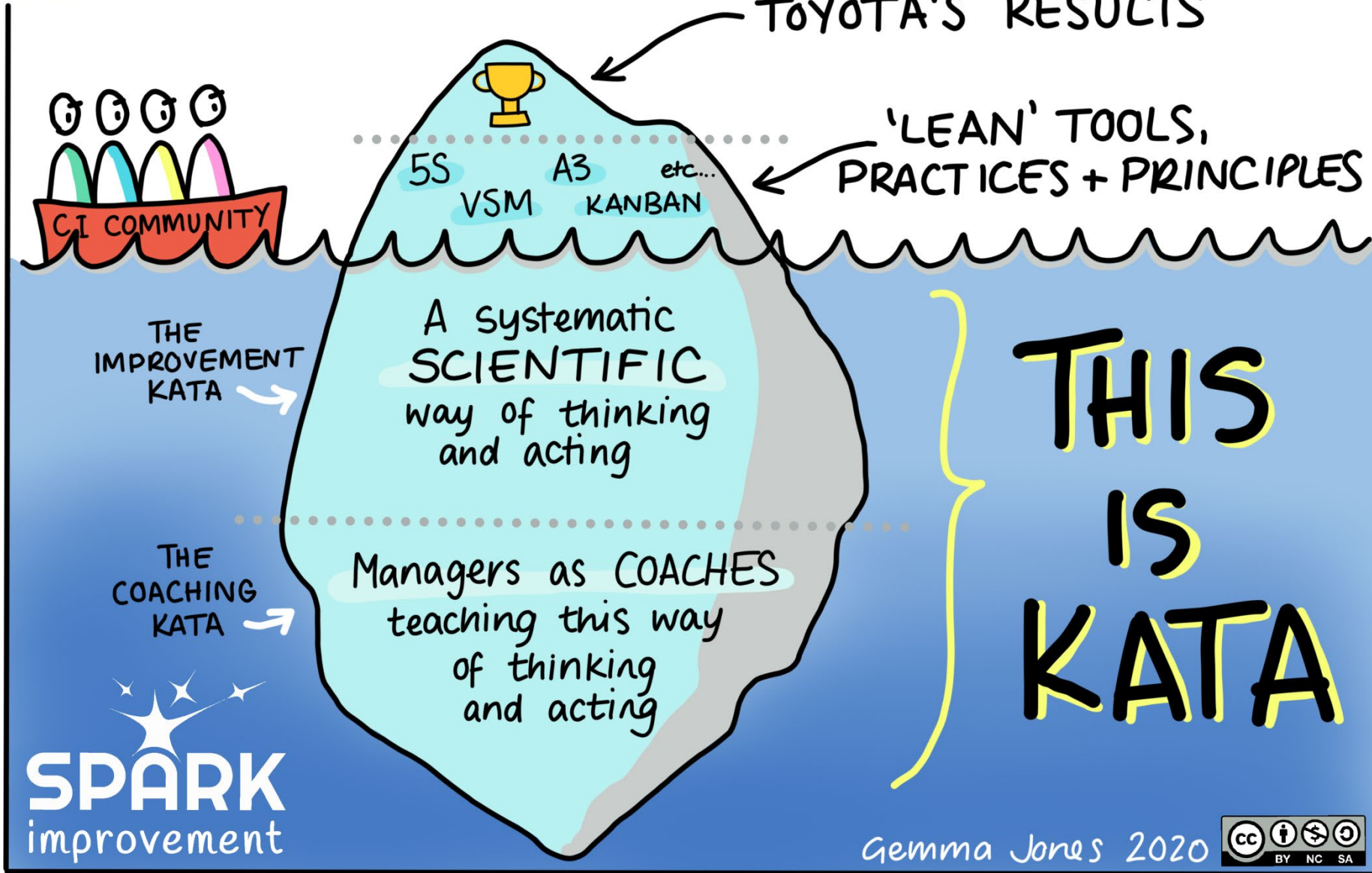


A **Kata** is a structured routine you deliberately practice at the start, to develop a habit leaving you with new skills



WHAT IS KATA?

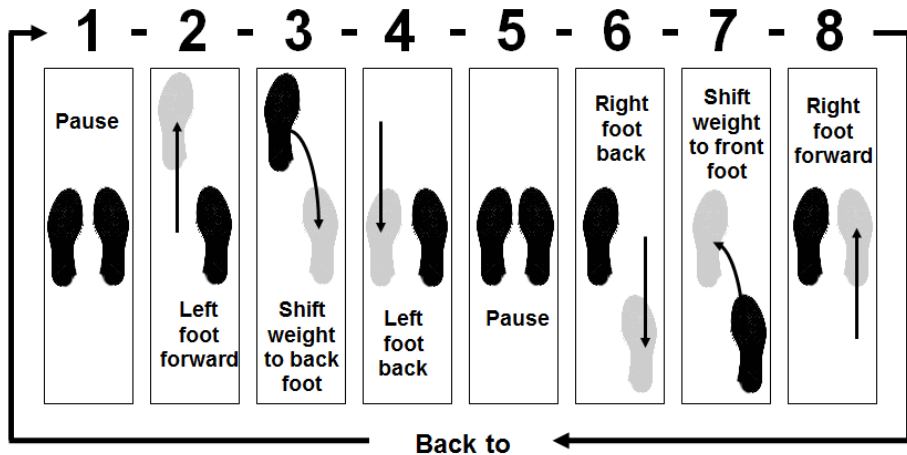
SOURCE: MIKE ROTHER, TOYOTA KATA 2010



EXAMPLES



Basic Salsa Steps

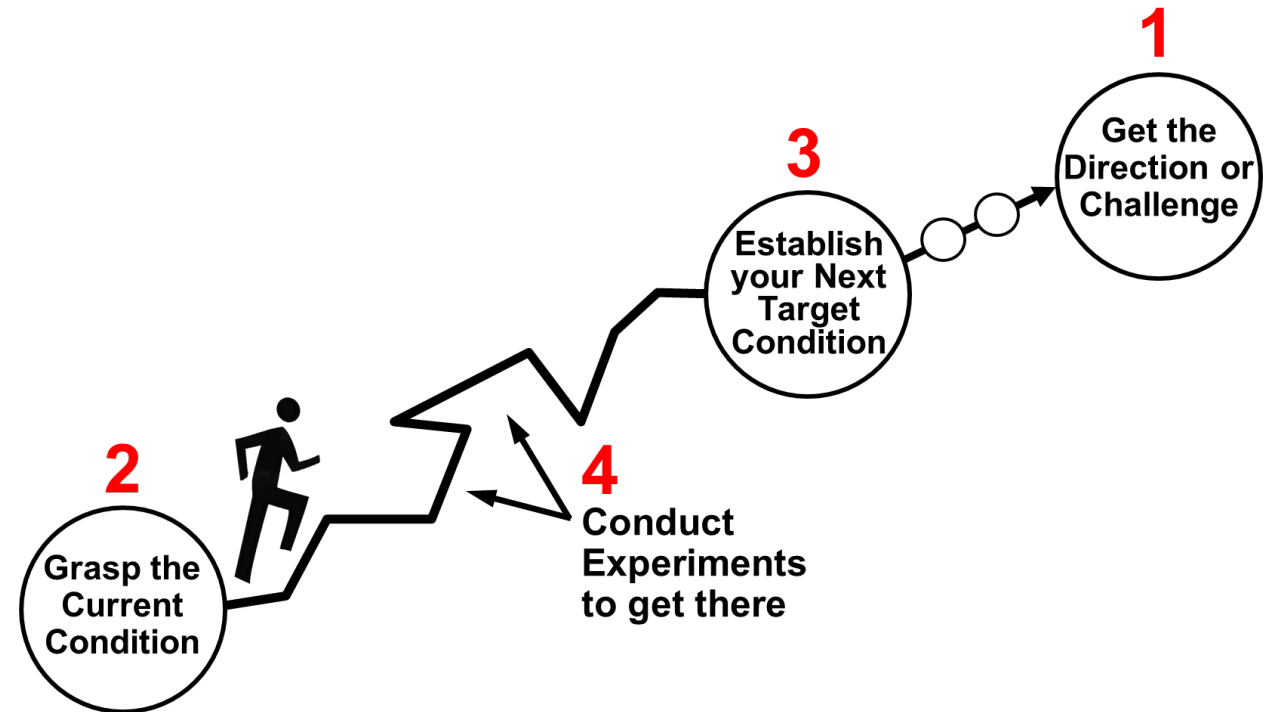


SUN SALUTATION Sequence A

- 1. Tadasana**
Standing Mountain Pose
- 2. Utthita Hastasana in Tadasana**
Arms Extended in Mountain Pose
- 3. Uttanasana**
Standing Forward Bend
- 4. Ardha Uttanasana**
Half Forward Bend
- 5. Chaturanga Dandasana**
Half-Plank Position
- 6. Urdhva Mukha Svanasana**
Upward-Facing Dog
- 7. Adho Mukha Svanasana**
Downward-Facing Dog
- 8. Ardha Uttanasana**
Half Forward Bend
- 9. Uttanasana**
Standing Forward Bend
- 10. Utthita Hastasana in Tadasana**
Arms Extended in Mountain Pose
- 11. Tadasana**
Standing Mountain Pose

healthline

THE IMPROVEMENT KATA



THE IMPROVEMENT KATA

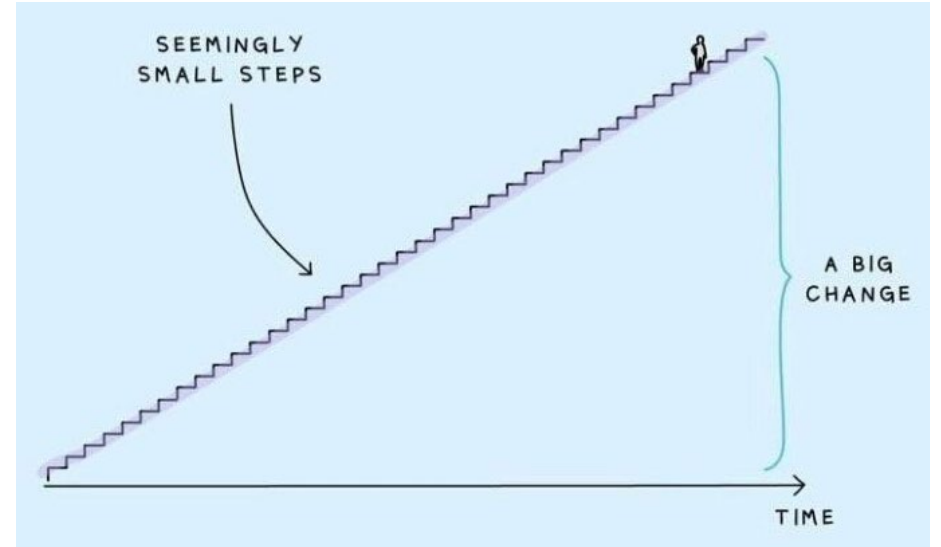
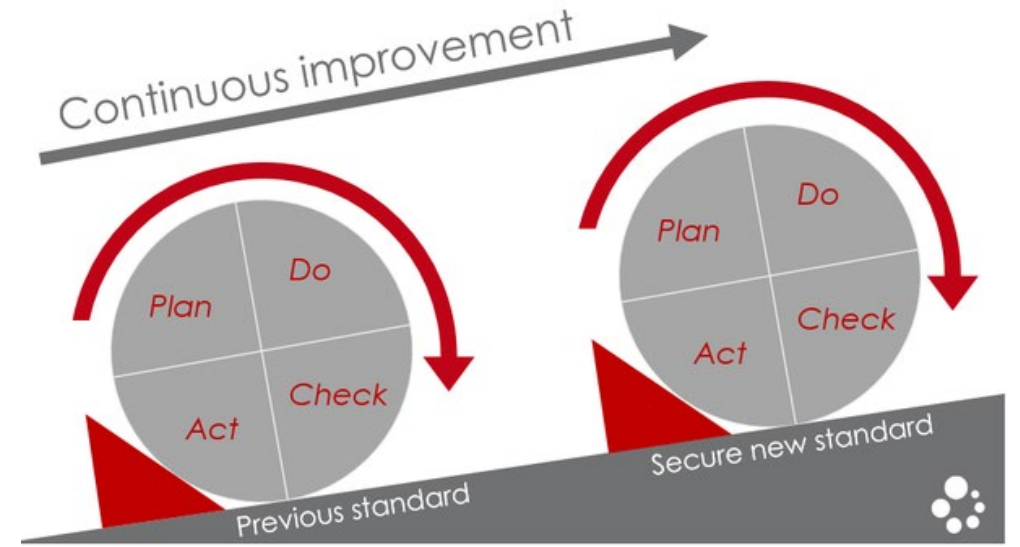


Think Big, Act Small

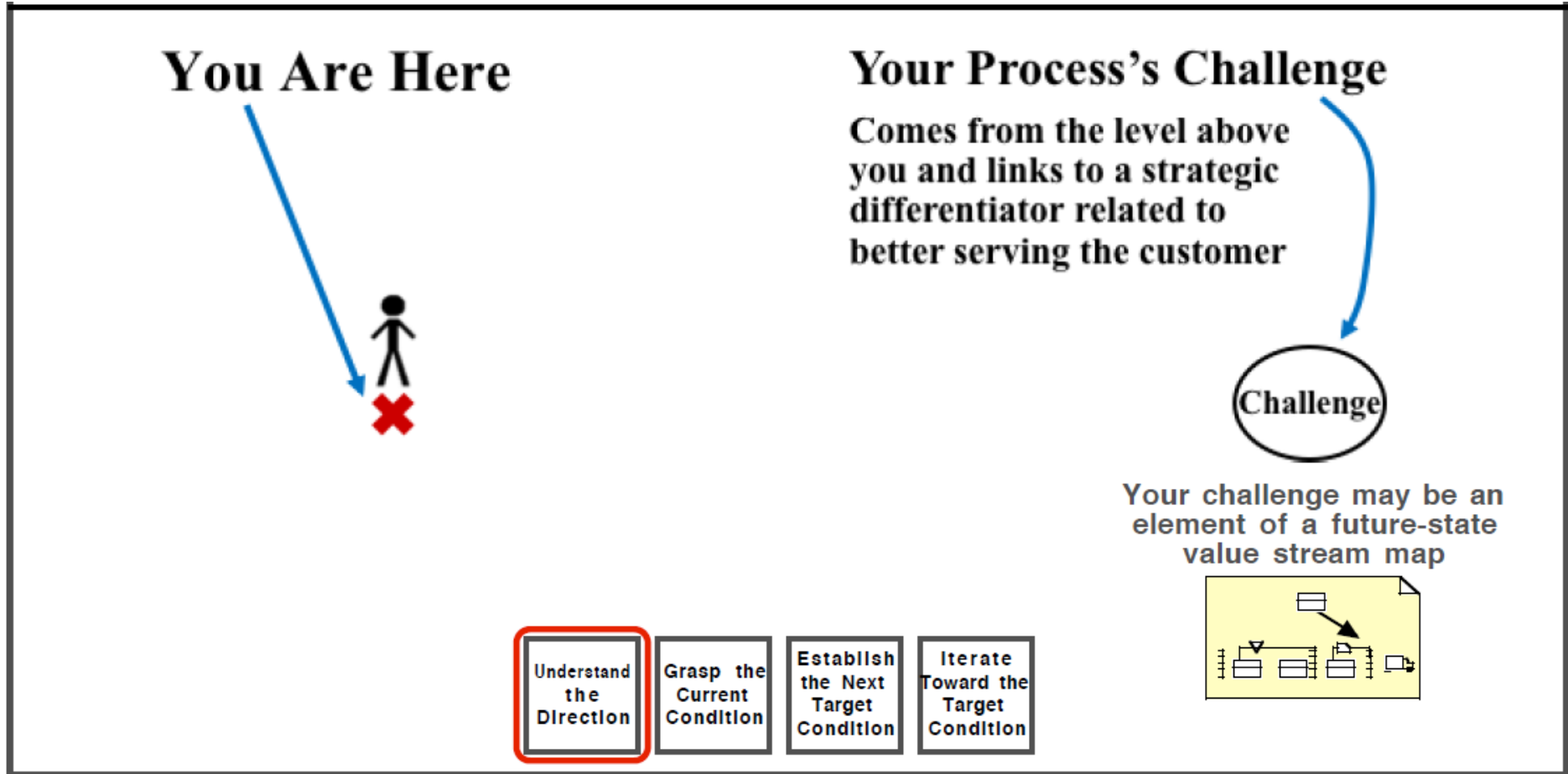
THE IMPROVEMENT KATA



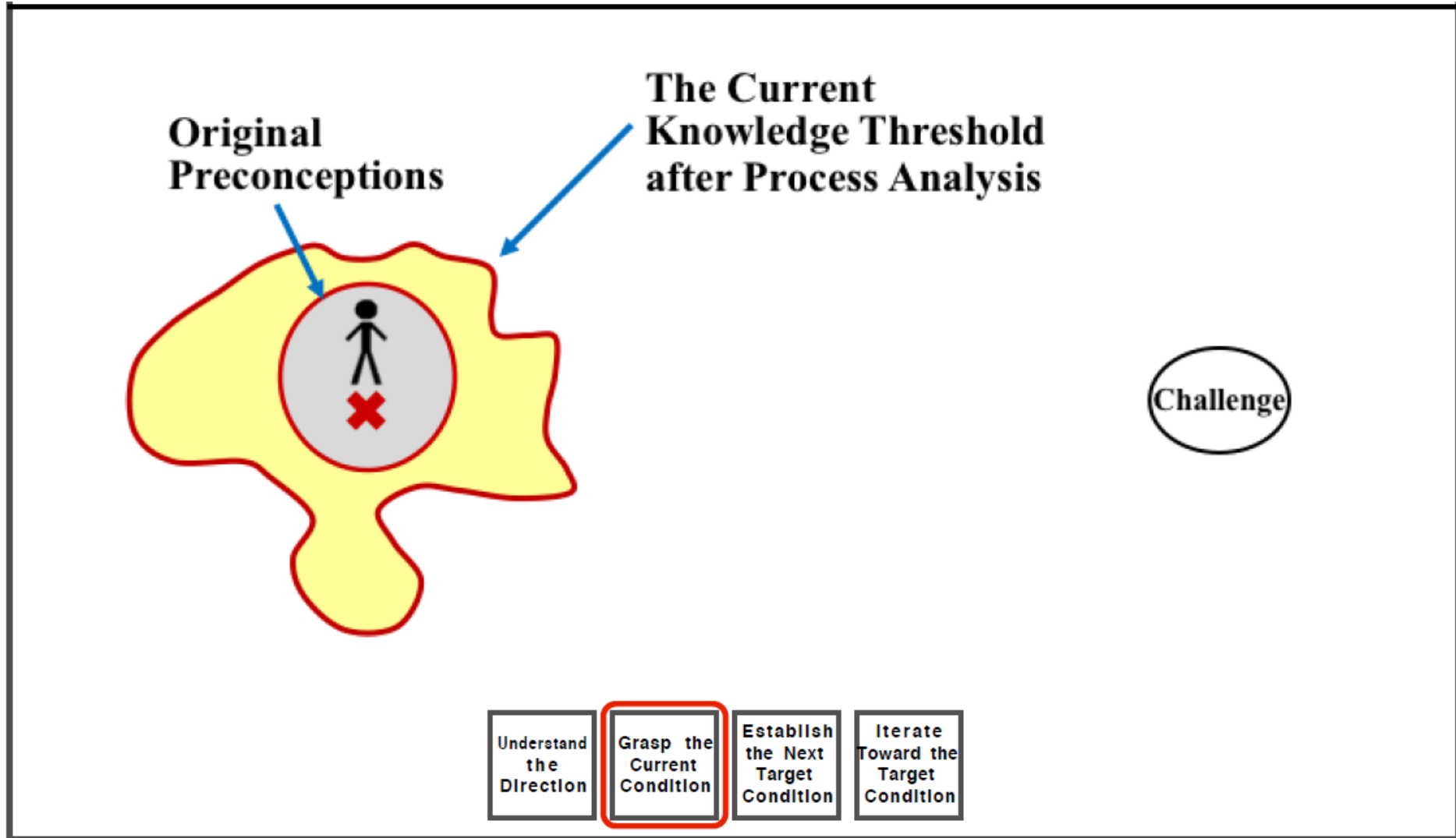
THE IMPROVEMENT KATA



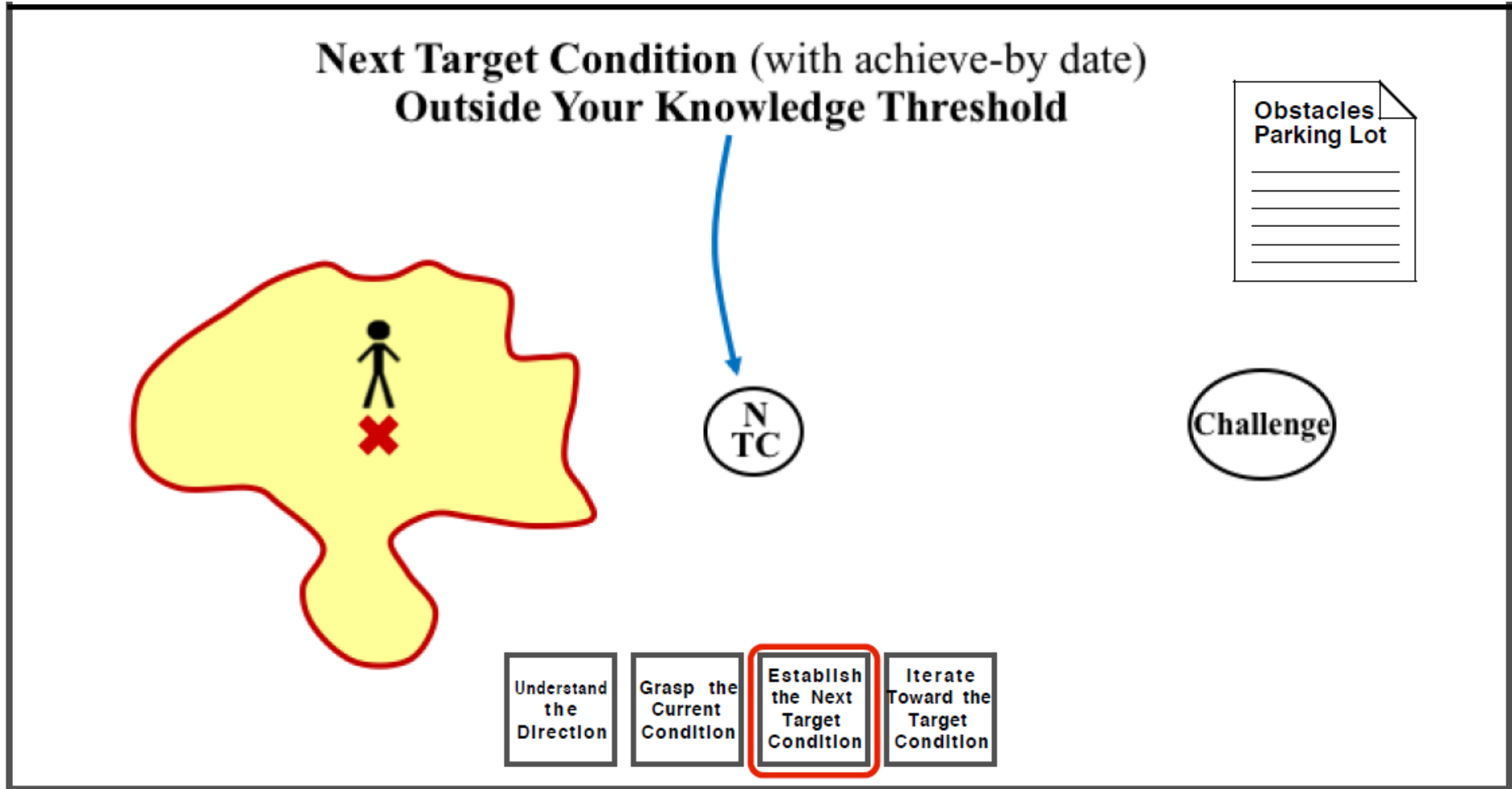
STEP 1: CHALLENGE



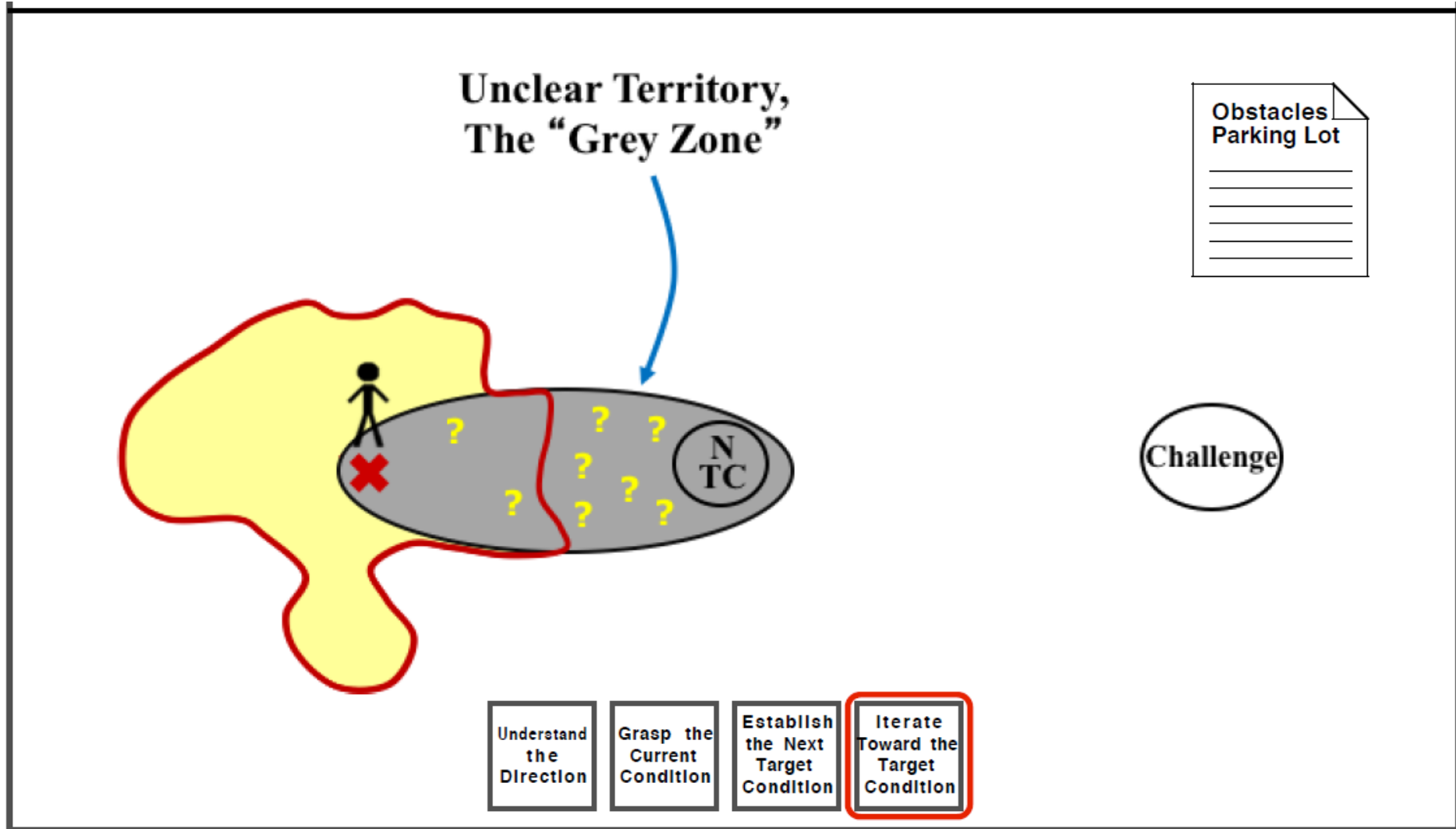
STEP 2: CURRENT CONDITION



STEP 3: TARGET CONDITION



STEP 4: EXPERIMENT



STEP 4: EXPERIMENT

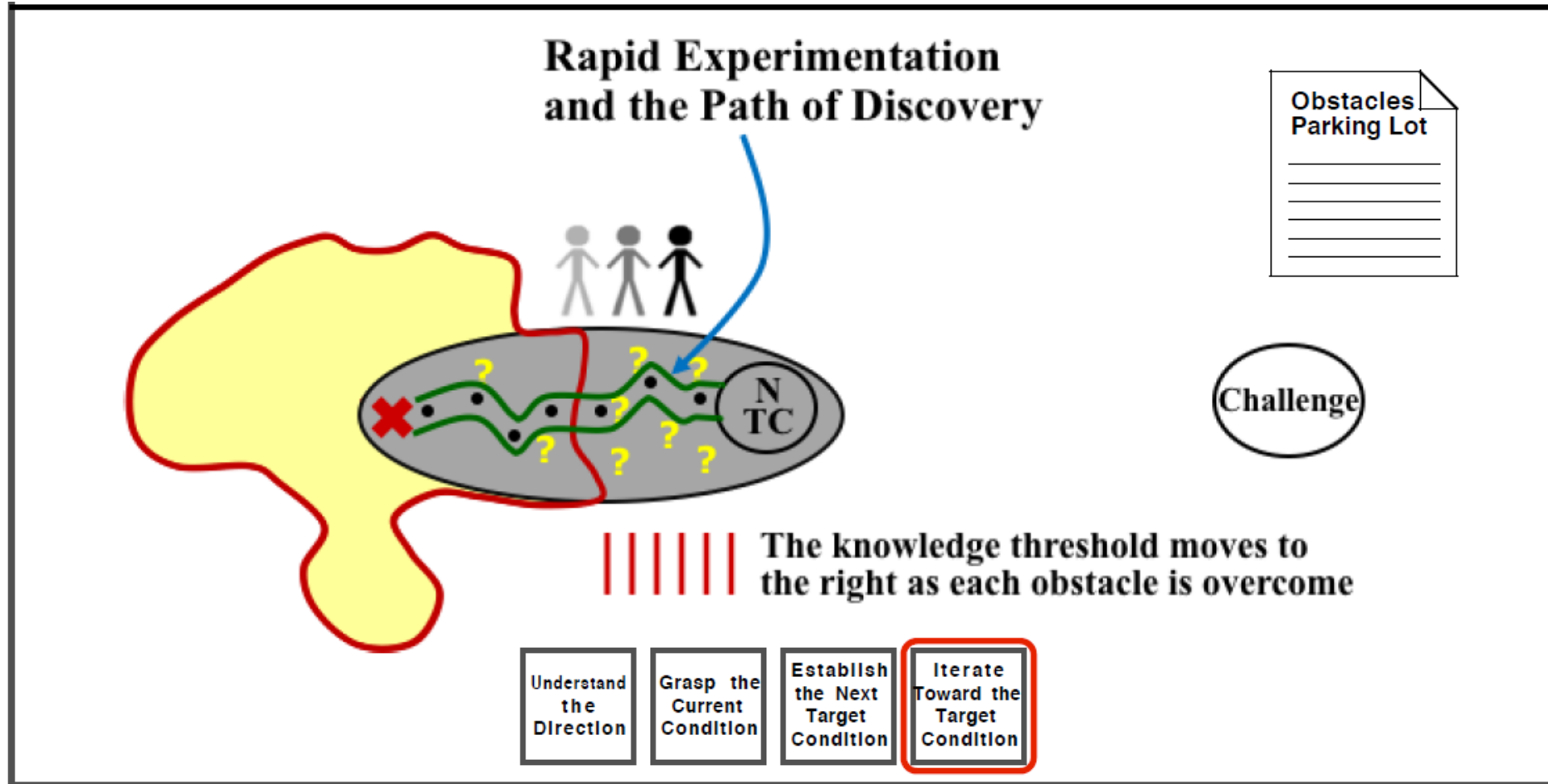
THE EXPECTATION DEPENDS ON THE TYPE OF EXPERIMENT

Type of experiment	What the Learner can expect
Go and See Observation and data collection, without changing anything, to learn more about a process or situation.	The Learner should expect that they will get information about how something is currently functioning.
Exploratory Experiment Introducing a change in a process to see, via direct observation, how the process reacts.	The Learner should expect to learn more than they can from direct observation alone.
Testing a Hypothesis Introducing a change, ideally in only a single factor, with a prediction of what will happen.	The Learner must predict the outcome of the change. This is the hypothesis to be tested.

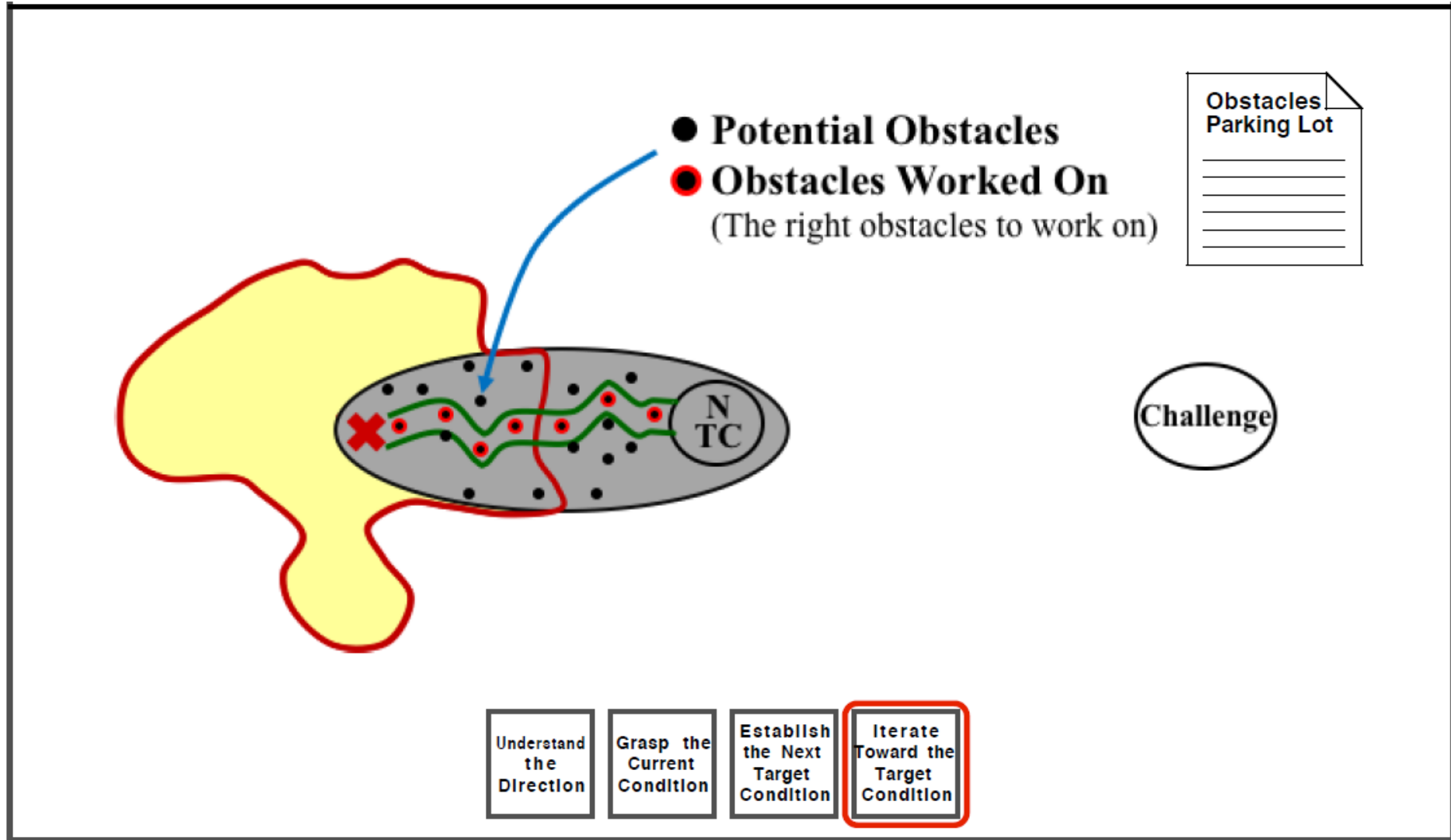
STEP 4: EXPERIMENT

PDSA CYCLES RECORD <i>(Each row = one experiment)</i>			
Obstacle:		Process:	
		Learner:	Coach:
Date, step & metric	What do you expect?		What happened What we learned
Plan		DO	Study
Act			
Plan		DO	Study
Act			
Plan		DO	Study
Act			

STEP 4: EXPERIMENT



STEP 4: EXPERIMENT



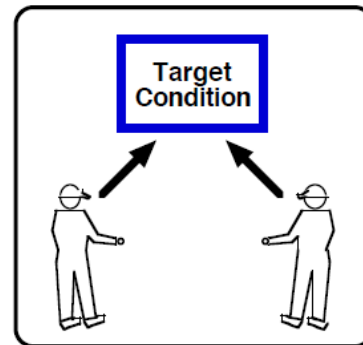
STEP 4: EXPERIMENT

WHAT CAN WE IMPROVE? versus WHAT DO WE NEED TO IMPROVE?

Simply asking people, “*What can we improve?*” is not an effective way of continuously improving, generating teamwork and empowering people:

- Everyone’s viewpoint is naturally limited and biased
- We quickly get overwhelmed with diverse action items going in different directions
- There’s only limited time available each day for working on improvement

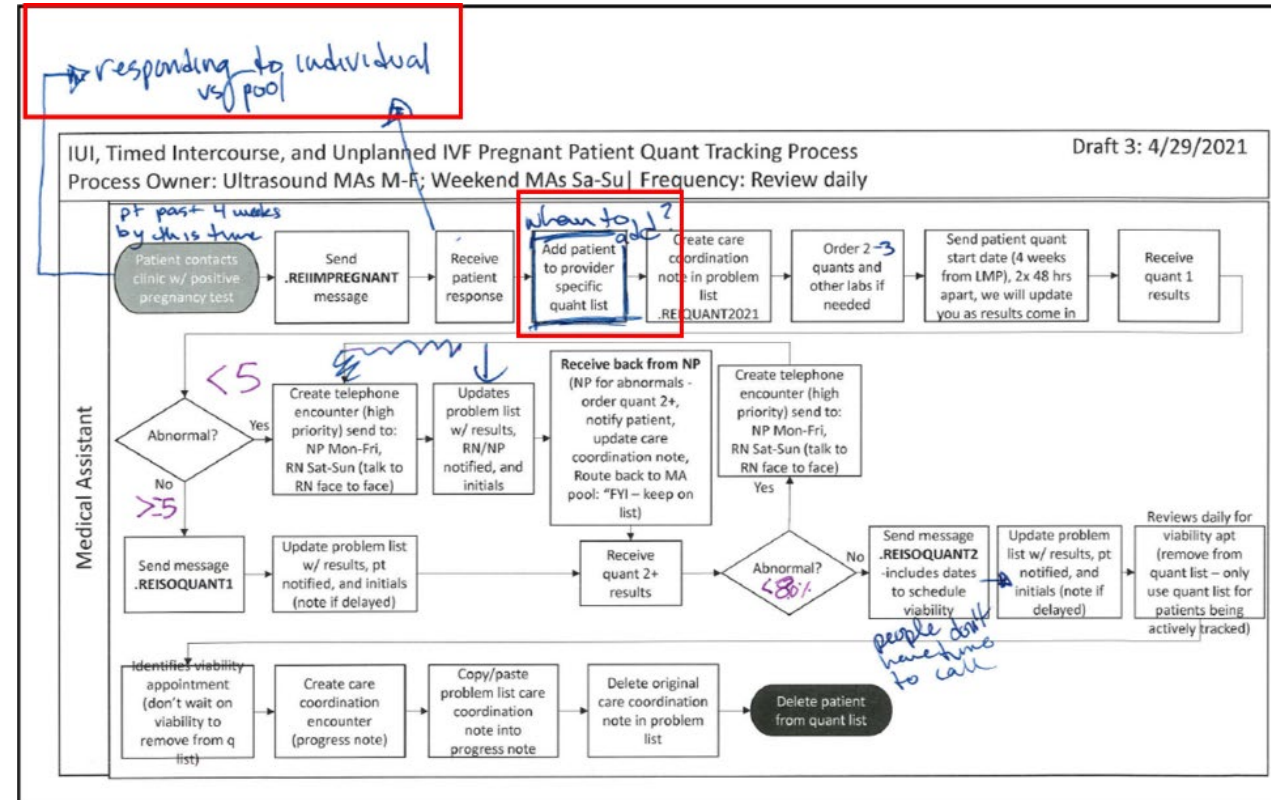
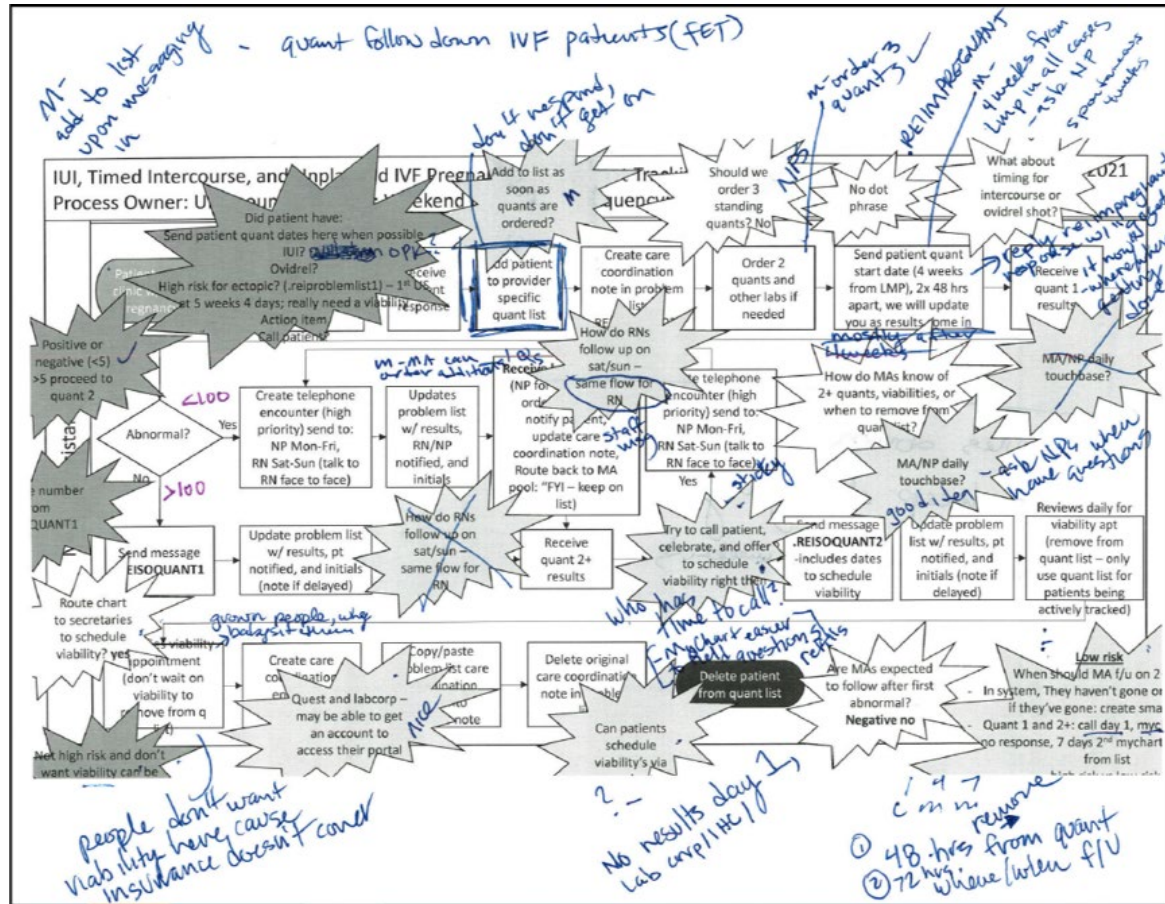
With the Improvement Kata a team instead focuses on what it *needs* to do to improve. This involves working on only those obstacles that the team finds are *actually* preventing the team from moving from its current condition to the next target condition.



Tackling the specific obstacles to a defined target condition is a great framework for bringing everyone’s ideas into play!

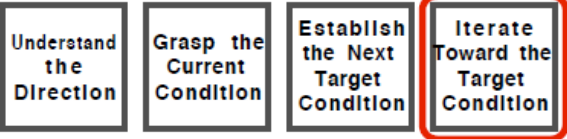
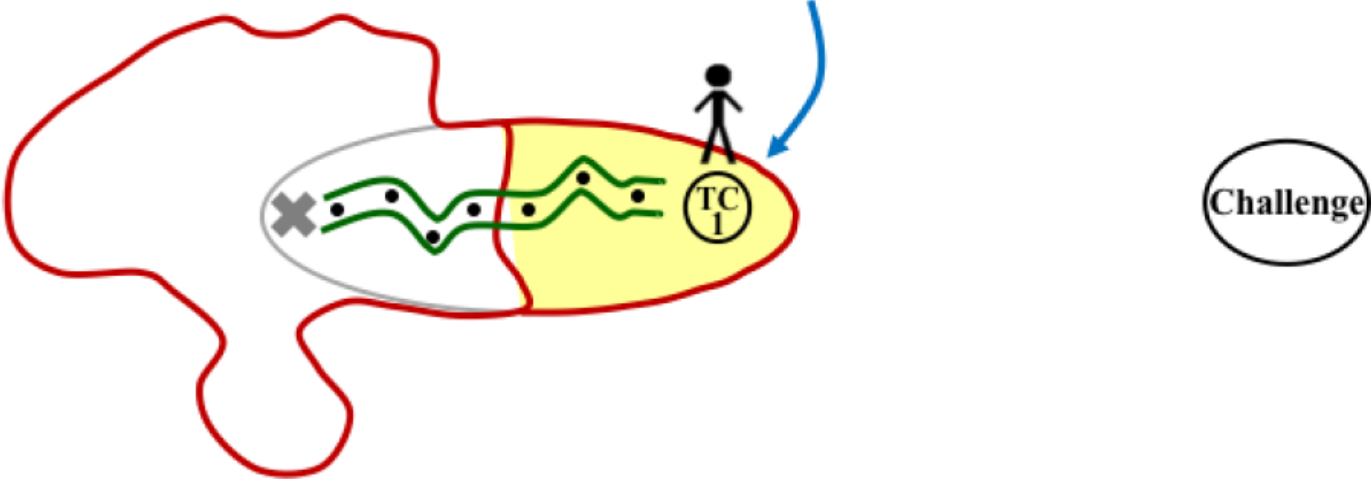
Our human ingenuity is activated and channeled when we operate with boundaries and limits.

WHAT CAN WE IMPROVE VS WHAT DO WE NEED TO IMPROVE

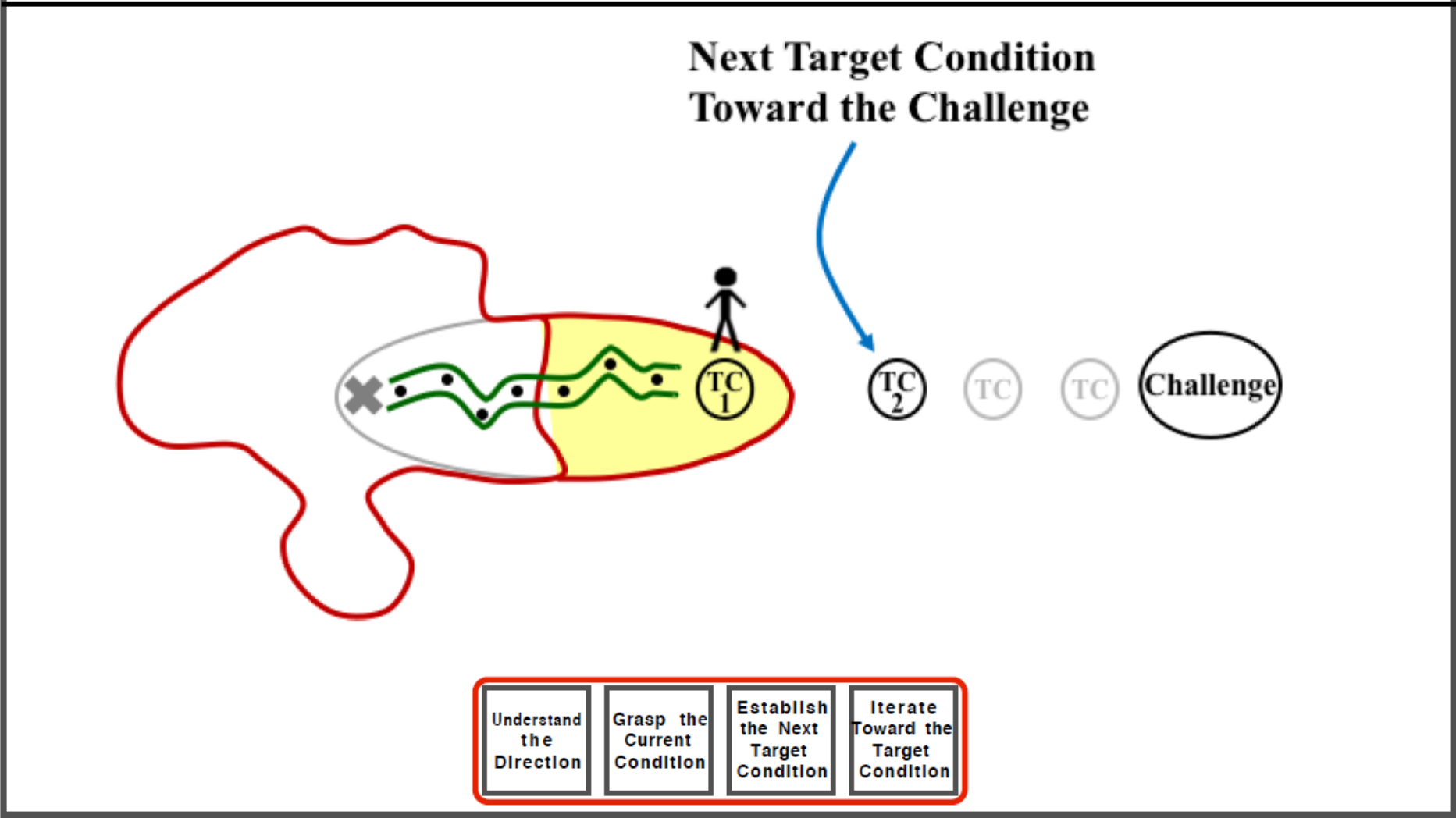


REPEAT STEP 2: CURRENT CONDITION

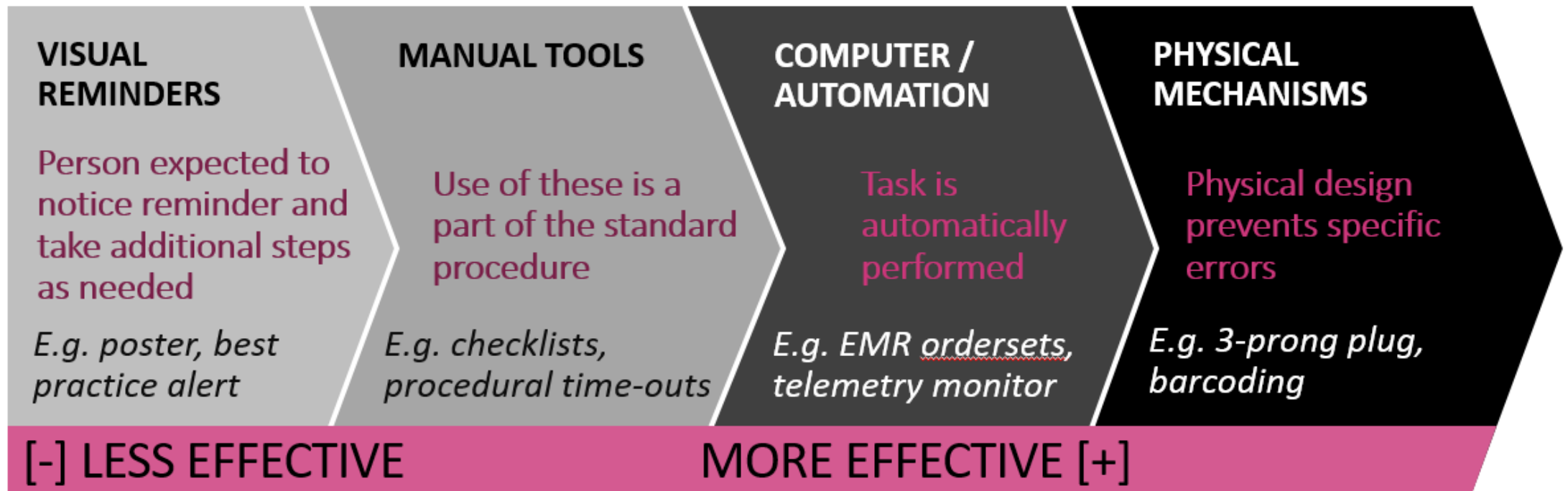
- ✓ New current state = improved performance
- ✓ Closer to the breakthrough challenge
- ✓ Expanding knowledge threshold
- ✓ Increased skill with the Improvement Kata



REPEAT STEP 3: TARGET CONDITION



SOLUTION DESIGN



STOP DECORATING THE FISH

More Technology



More Data



More Strategy



More Training



More Communication



More Reorganization



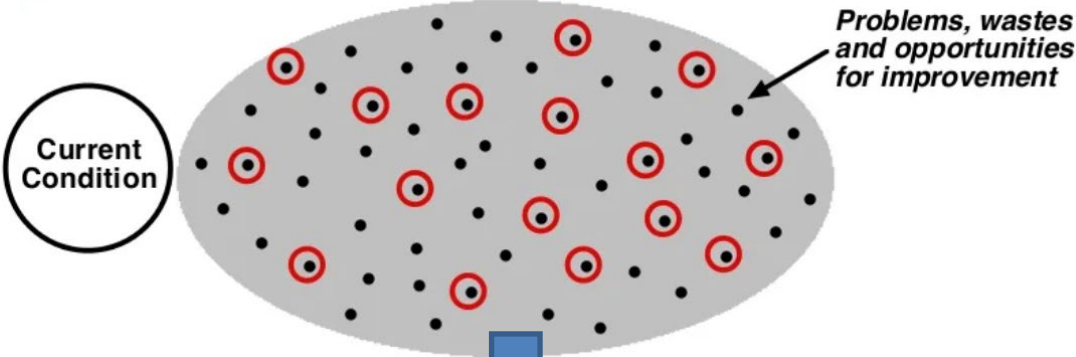
More Accountability & Assigning Blame



More Money



LET'S MOVE FROM THIS...



TO THIS

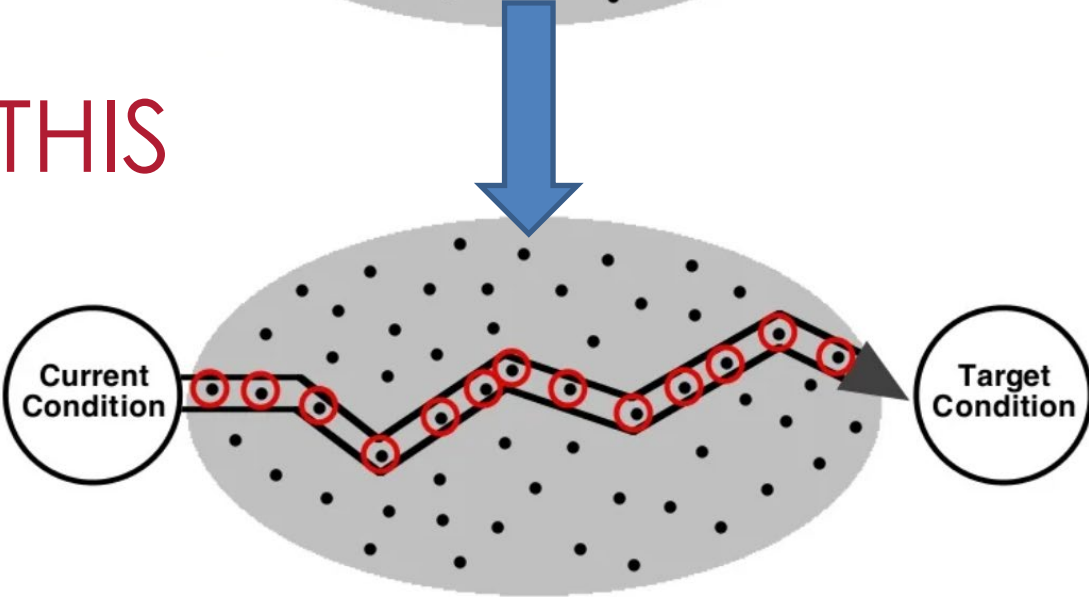


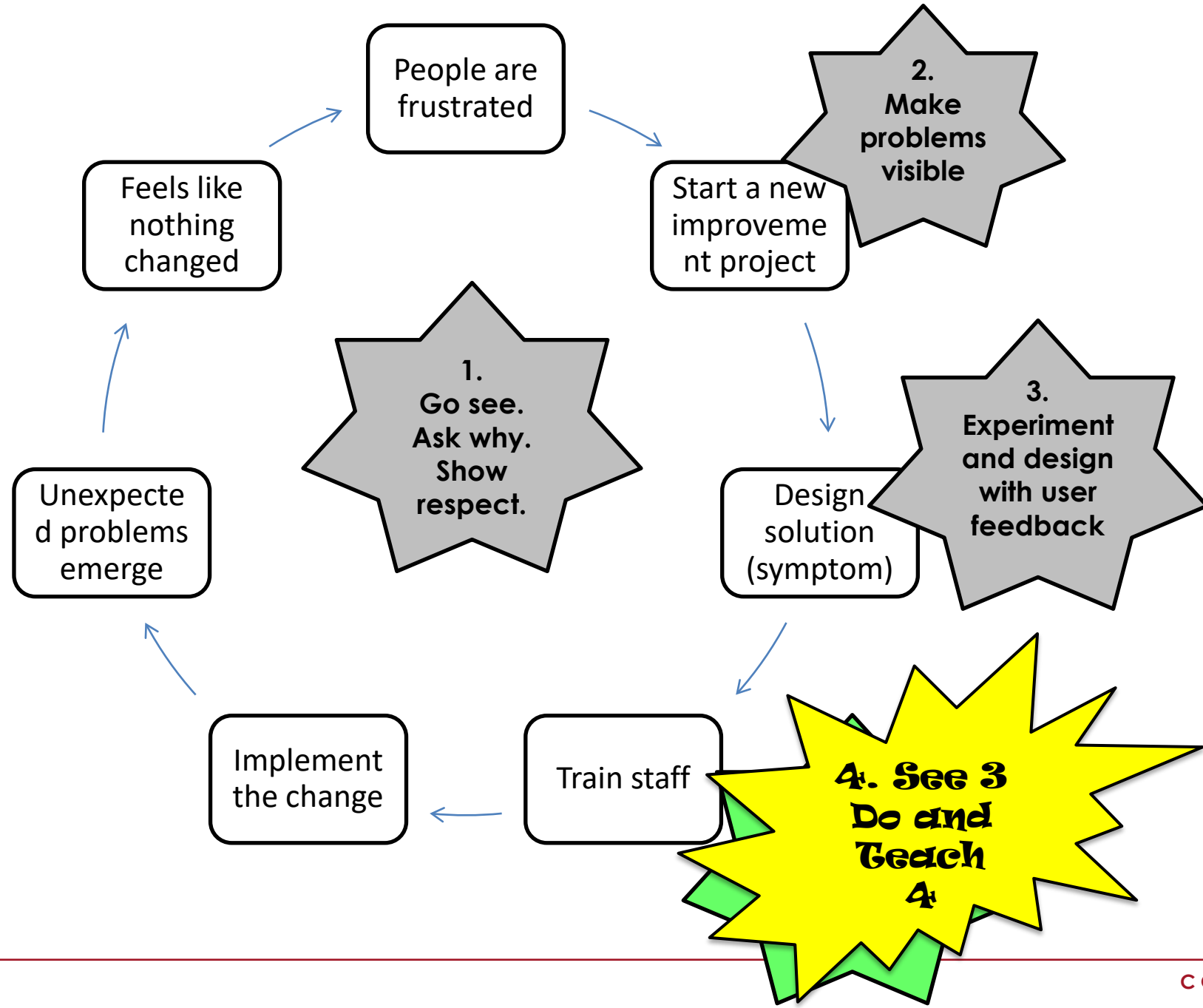
Diagram by Mr. Jeff Uitenbroek



See

no

**See 3
Do and
Teach
4**



DO THESE METHODS LOOK FAMILIAR?

Read and Sign



Sink or Swim

Buddy System



Death by Meeting

SEE 3 DO AND TEACH 4


	Important Steps	Key Points	Reasons
1	Break down the task		
2	See 3 (Teacher performs; Learner observes)		
3	Do and Teach 4 (Learner performs; Teacher observes)		


SEE 3 DO AND TEACH 4

	Important Steps	Key Points	Reasons
1	Break down the task	Document important steps, key points, and reasons	Set worker up to perform safely and correctly
2	See 3 (Teacher performs; Learner observes)	<ol style="list-style-type: none"> 1. Perform task and verbally walk through important steps 2. Perform task and verbally walk through important steps and key points 3. Perform task and verbally walk through important steps, key points, and reasons 	
3	Do and Teach 4 (Learner performs; Teacher observes)	<ol style="list-style-type: none"> 1. Perform task silently 2. Perform task and verbally recite important steps 3. Perform task and verbally recite important steps and key points 4. Perform task and verbally recite important steps, key points, and reasons 	

BREAK DOWN THE TASK

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points


What


How


Why

BREAK DOWN THE TASK (EXAMPLE 1)

Dispenser-Single Paper Towel Roll-Clean & Fill
EVS Technician

ADVANCING STEPS	KEY POINTS	REASON
1. Obtain dispenser key	1. Key has two prongs sticking out the side from main prong 2. Show other dispenser key	1. Fits these dispenser locks 2. So they recognize correct key
2. Open dispenser using key	1. Lightly press down on key 2. Cover or plastic hinges do not fall	1. So the lock will turn 2. Cover or plastic hinges do not crack
3. Remove roll	1. Remove when looks smaller than 1/2 inch 2. Empty roll-throw it away 3. Partial roll-place on cart	1. Ensures the towel roll will last through the next shift 2. So disposed properly 3. For re-use
4. Clean the interior and exterior of dispenser	1. Use 3M chemical quat disinfectant 2a. Bathroom rags-orange 2b. Surgery rags-green 2c. All other areas-blue 2d. Rag wrung tightly so liquid doesn't drip	1. Eliminate pathogens 2. Don't want bathroom pathogens in other areas 3. Protect batteries from water damage
5. Check Adjustable Settings	1. Sheet Length equals 8 inches 2. Time Delay 3. Sensor Range	1. Towel lasts longer 2. The towel doesn't dispense twice 3. The towel doesn't dispense if someone walks near dispenser
6. Check the battery light	1. If illuminated replace 4 "D" batteries	1. The dispenser will not operate
7. Take a new roll	1. 8 inch roll 2. Unroll about 6 inches	1. This size towel roll fits this dispenser 2. This helps reduce the towel from breaking off
8. Place the new roll in the holder	1. With it going over the top (waterfall) style	1. The roll will properly seat in the mechanism
9. Feed roll into dispenser	1. Fold up about a 1 inch piece paper towel 2. Place folded edge into mechanism slot	1. Creates an even line of paper 2. Ensures the roll will properly seat in the mechanism
10. Push the towel release feed button	1. Feed the paper until paper is visible in dispenser opening	1. Ensures long enough paper to dispense
12. Gently close the lid and re-lock it.	1. Ensure the lid doesn't open when pulled	1. Locking means public can't open and remove the roll

Dispenser-Single Paper Towel Roll
EVS Technician

12 steps

ADVANCING STEPS	KEY POINTS	REASON
1. Obtain dispenser key	1. Key has two prongs sticking out from main prong	1. To differentiate from other keys <i>show other key</i>
2. Open Dispenser using key	1. Hold the cover so it doesn't fall <i>-press down, use prong</i>	1. Cover or plastic hinges can crack
3. Remove roll	1. Remove when looks smaller than 1/2 inch 2. Empty roll-throw it away 3. Partial roll-place on cart	1. Ensures the towel roll will last through the next shift 2. So disposed properly 3. For re-use
4. Clean the interior and exterior of dispenser	1. Use 3M chemical #5, #40, #41 2. Microfiber cloth-orange bathrooms 3. Microfiber cloth-blue all other areas <i>not enough to remove dust but</i> 4. Do not get battery compartment wet <i>head doesn't pool or drip</i>	1. Infection prevention eliminate pathogens 2. Don't want bathroom pathogens in other areas 3. Don't want bathroom pathogens in other areas 4. Batteries will damage not work <i>protect batteries</i>
5. Check Adjustable Settings	1. Sheet Length equals 8 inches 2. Time Delay 3. Sensor Range	1. Towel lasts longer
6. Check the battery light	1. If illuminated replace 4 "D" batteries 2. Blue dispenser cover-battery pack removable from dispenser 2-Black dispensers battery pack NOT removable	1. The dispenser will not operate 2. Easier to replace outside 3. Not removable makes it harder to see and replace
7. Take a new roll	1. Unroll about 6 inches <i>8" roll</i> <i>8" roll - wants white</i>	1. This helps reduce the towel from breaking off
8. Place the new roll in the holder	1. With it going over the top (waterfall) style <i>Feed it into teeth</i>	1. Ensures the roll will properly seat in the mechanism
9. Pull the towel down	1. Under the blue bar <i>under the blue bar</i> 2. Fold up about a 1 inch piece 3. Place under the teeth of the blue bar. <i>press bottom</i>	1. Ensures the roll will properly seat in the mechanism 2. Even line of paper 3. Feeds into mechanism
10. Push the towel release button	1. This feeds the paper into the feeding mechanism 2. The paper should not be folded over or uneven	1. So the paper dispenses 2. This would cause jamming
12. Gently close the lid and re-lock it.	1. Ensure the lid doesn't open when pulled <i>lock it - it will auto lock</i>	1. Locking means public can't open and remove the roll

3. feed until visible in bottom dispenser
1. ensures long enough to dispense

BREAK DOWN THE TASK (EXAMPLE 1)

Enmotion Impulse 8" 1-Roll Touchless Paper Towel Dispenser



Replace when Empty or Partial Roll (less than 1/2")
Trainer to Set Expectations for this type of training: I will demonstrate to you 3 times how to complete this process while you observe. Then you will demonstrate to me 4 times repeating the steps back, this will help build muscle memory.

STEP	WHAT	HOW	WHY
1	Open Dispenser	STEP A Using key, press and turn	STEP A To engage lock
		STEP B Hold the cover so it gently opens to hang on its own	STEP B So it won't slam against the wall and break
2	Remove Roll	STEP A Dispose of empty roll or place partial roll (less than 1/2") on cart for use later	STEP A Ensures the towel roll will last through the next shift
3	Clean Dispenser (In & Out)	STEP A Use 3M Quat disinfectant & correct color of Microfiber Rag for the location	STEP A To eliminate pathogens
		STEP B Wring rag tightly so liquid doesn't drip	STEP B To protect batteries from water damage
4	Check Batteries	STEP A If you see the light, replace with 4 "D" batteries	STEP A Dispenser won't work
5	Insert Roll	STEP A Unroll Towel 6", with paper going over the Top, Like a waterfall	STEP A So it will feed correctly and not get jammed.
		STEP B Fold 1" of paper at the end and place into feeder, pressing feeder button	STEP B Creates a smooth line of paper for the feeder to grab on to
6	Close Cover	STEP A Making sure the towel is out, gently close & press the cover to lock	STEP A So it works for our customers











BREAK DOWN THE TASK (EXAMPLE 2)

Lab Collection Process (non-wristband environments)

STEP	WHAT	KEY POINTS (HOW)	WHY
1	Verify Patient 	A. "Can you please tell me your first name, last name, and DOB?"	A. Prevents drawing wrong labs on wrong patient
2	Print Labels 	A. Print one patient at a time B. Use 1 label per specimen C. Check that information on label is not out off D. Check for special processing instructions	A. Prevents mixing up labels B. Prevents errors with processing C. Cut off labels won't process D. Prevents need for recollection
3	Hand Hygiene	A. Perform hand hygiene and put on gloves	A. Prevents contamination
4	Gather Materials 	A. Check labels for materials needed B. Ensure tubes are not expired	A. Prevents recollection B. May not fill appropriately
5	Collect Specimen	A. See venipuncture/central line collection process	
6	Label Specimen 	A. Label specimen in presence of patient B. Match label to specimen C. Orient label per photo  D. Place label on top of manufacturer label	A. Prevents delay and rework B. Prevents delay and rework C. Bar codes need to be oriented properly for processing D. Prevents delay and rework
7	Patient Validates Specimen 	A. Show patient the labeled specimen and have patient validate name and DOB	A. Prevents incorrect patient results
8	Scan Labels 	A. Scan all labels	A. To capture accurate collection time
9	Transport Specimen 	A. Use one specimen bag per patient B. Follow special instructions for transport (i.e., ice) C. Use foam cushion when using pneumatic tube 	A. Prevents mixing patients up B. Some need to be walked or are time sensitive C. Can destroy sample

Last Updated: 5/18/2023 | Last Updated By: Dane Falkner |

Lab Collection Process (non-wristband environments)

Phase	WHAT	KEY POINTS (HOW)	WHY
Pre-Collection (Can be done in any order but all steps must be completed before moving to next phase)	Hand Hygiene 	Perform hand hygiene and put on gloves	Prevents contamination
	Verify Patient 	Ask "can you please tell me your first name, last name, and DOB?" and compare with EPIC	Prevents drawing wrong labs on wrong patient
	Print Labels 	Print one patient at a time Use 1 label per specimen Check that information on label is not cut off Check EPIC for special processing instructions	Prevents mixing up labels Prevents errors with processing Cut off labels won't process Prevents need for recollection
	Validates Label 	Show patient or verbally verify all labels by checking patient name and DOB	Prevents incorrect patient results
	Gather Materials 	Check labels for materials needed Ensure tubes are not expired	Prevents recollection May not fill appropriately
	Collection	Collect Specimen	See venipuncture/central line collection process
Post Collection	1. Label Specimen 	Label specimen in presence of patient Match label to specimen Orient label per photo  Place label on top of manufacturer label	Best control to make sure we aren't mislabeling Prevents delay and rework Bar codes need to be oriented properly for processing Prevents delay and rework
	2. Scan Labels 	Scan all labels	Scanning on tube helps ensure the label is placed correctly Label is on right tube
	3. Transport Specimen 	Use one specimen bag per patient Follow special instructions for transport (i.e., ice) Use foam cushion when using pneumatic tube 	Prevents mixing patients up Some need to be walked or are time sensitive Can destroy sample

Last Updated: 6/21/2023 | Last Updated By: Kayla Fritz

BREAK DOWN THE TASK

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
1. Wet hands	Without soap	Soap rinses away
2. Apply soap	Cover all surfaces	Kill all germs
3. Rub hands	1. Palm to palm 2. Palm to backs	1. Clean entire surface 2. Clean entire surface
4. Run fingers	1. Thumbs 2. Interlocking 3. Backs of fingers to palm 4. Tips of fingers to palm	1. Most active part of hands 2. Sides of fingers cleaned at one time 3. Cuticles and knuckles 4. Under finger nails
5. Rinse hands	Leave water on	Prevent recontamination of hands
6. Dry	Use towel to turn off water	1. Prevent recontamination of hands



SEE 3 (TEACHER PERFORMS; LEARNER OBSERVES)

1. Perform task and verbally walk through important steps

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
1. Wet hands		
2. Apply soap		
3. Rub hands		
4. Run fingers		
5. Rinse hands		
6. Dry		

SEE 3 (TEACHER PERFORMS; LEARNER OBSERVES)

1. Perform task and verbally walk through important steps
2. Perform task and verbally walk through important steps and key points

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
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4. Run fingers	1. Thumbs 2. Interlocking 3. Backs of fingers to palm 4. Tips of fingers to palm	
5. Rinse hands	Leave water on	
6. Dry	Use towel to turn off water	

SEE 3 (TEACHER PERFORMS; LEARNER OBSERVES)

1. Perform task and verbally walk through important steps
2. Perform task and verbally walk through important steps and key points
3. Perform task and verbally walk through important steps, key points, and reasons

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
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5. Rinse hands	Leave water on	Prevent recontamination of hands
6. Dry	Use towel to turn off water	1. Prevent recontamination of hands

DO AND TEACH 4 (LEARNER PERFORMS; TEACHER OBSERVES)

1. Perform task silently

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
1.		
2.		
3.		
4.		
5.		
6.		

DO AND TEACH 4 (LEARNER PERFORMS; TEACHER OBSERVES)

1. Perform task silently
2. Perform task and verbally recite important steps

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
1. Wet hands		
2. Apply soap		
3. Rub hands		
4. Run fingers		
5. Rinse hands		
6. Dry		

DO AND TEACH 4 (LEARNER PERFORMS; TEACHER OBSERVES)

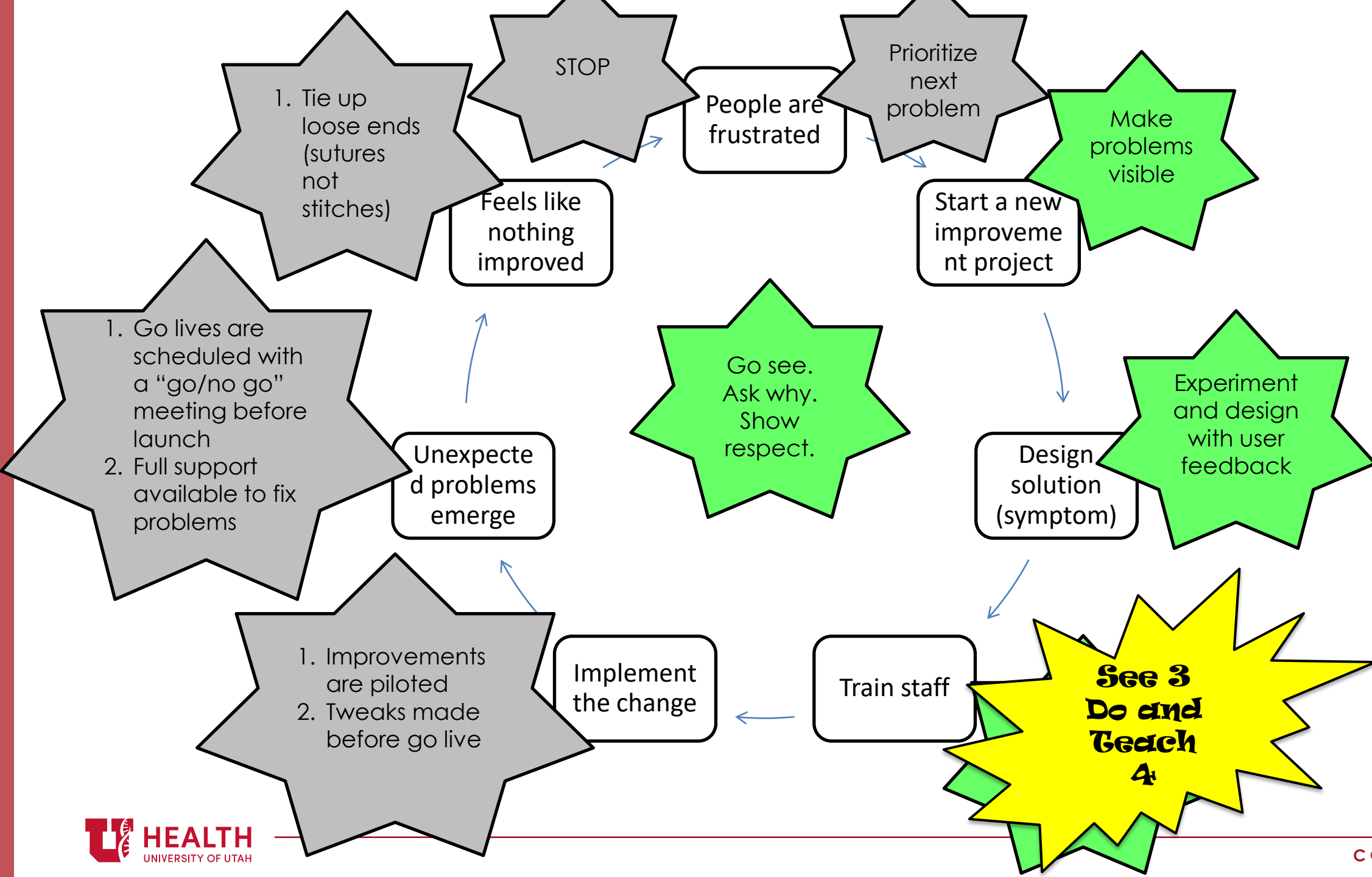
1. Perform task silently
2. Perform task and verbally recite important steps
3. Perform task and verbally recite important steps and key points

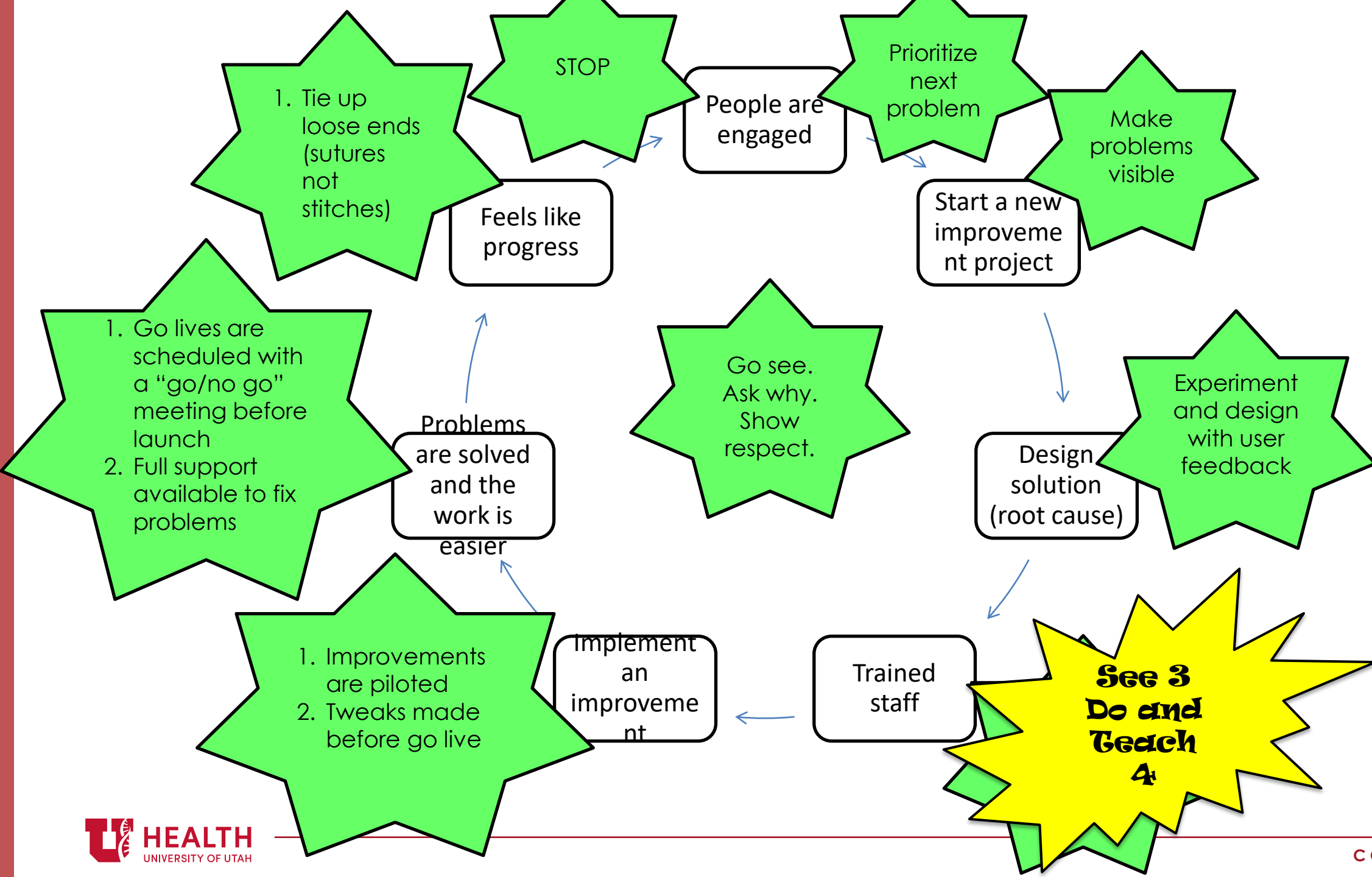
IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
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5. Rinse hands	Leave water on	
6. Dry	Use towel to turn off water	

DO AND TEACH 4 (LEARNER PERFORMS; TEACHER OBSERVES)

1. Perform task silently
2. Perform task and verbally recite important steps
3. Perform task and verbally recite important steps and key points
4. Perform task and verbally recite important steps, key points, and reasons

IMPORTANT STEPS	KEY POINTS	REASONS
A logical segment of the operation when something happens to advance the work.	Anything in a step that might— 1. Make or break the job 2. Injure the worker 3. Make the work easier to do, i.e. “knack”, “trick”, special timing, bit of special information	Reasons for the key points
1. Wet hands	Without soap	Soap rinses away
2. Apply soap	Cover all surfaces	Kill all germs
3. Rub hands	1. Palm to palm 2. Palm to backs	1. Clean entire surface 2. Clean entire surface
4. Run fingers	1. Thumbs 2. Interlocking 3. Backs of fingers to palm 4. Tips of fingers to palm	1. Most active part of hands 2. Sides of fingers cleaned at one time 3. Cuticles and knuckles 4. Under finger nails
5. Rinse hands	Leave water on	Prevent recontamination of hands
6. Dry	Use towel to turn off water	1. Prevent recontamination of hands





NO THANKS.
WE'RE TOO BUSY.



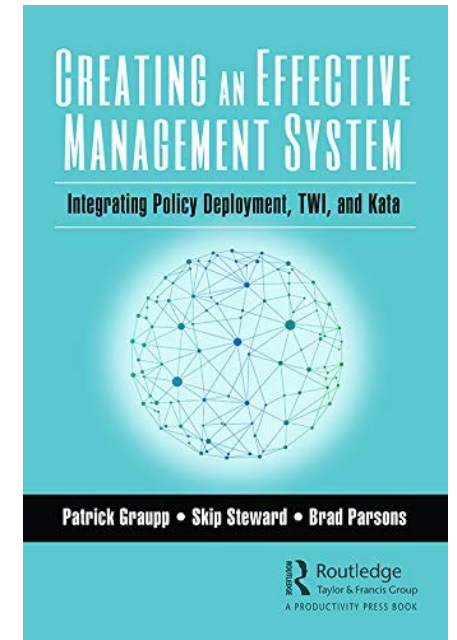
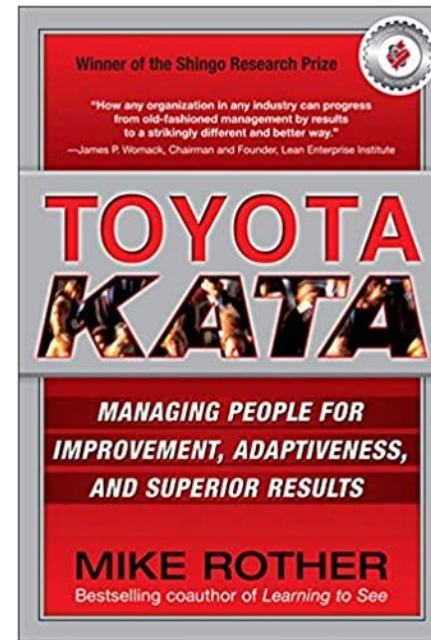
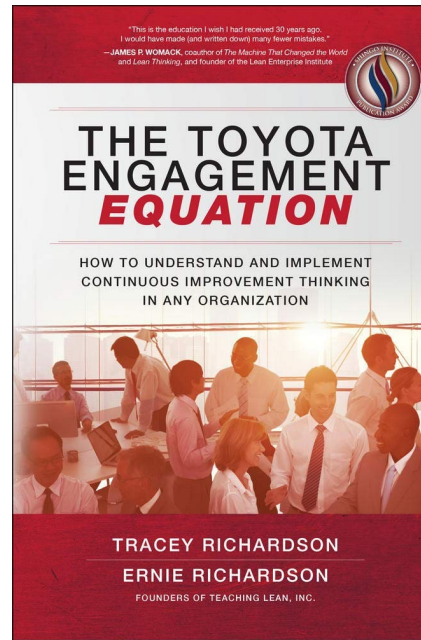
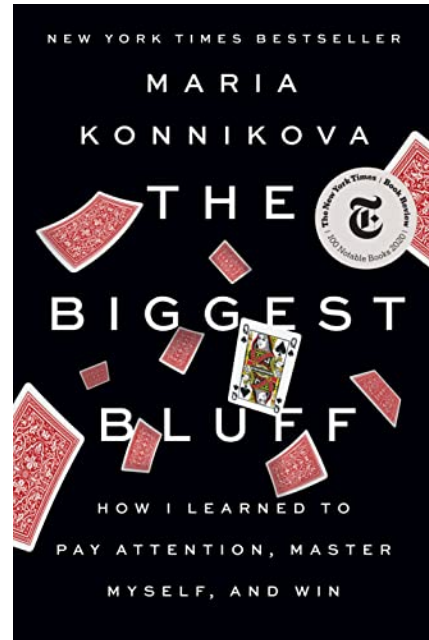
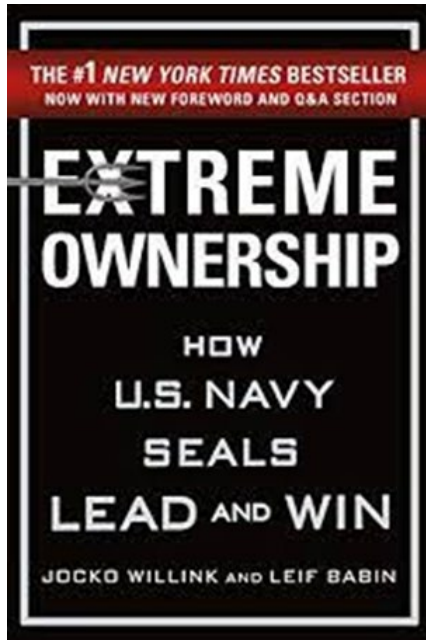
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THANKS!
WE'D LOVE SOME HELP



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ADDITIONAL RESOURCES TO EXPLORE



Links

TWI Institute - <https://www.twi-institute.com/>

Kata Handbook - http://www-personal.umich.edu/~mrother/Handbook/Full_IK_Handbook_v32.0.pdf

Shingo Institute - <https://shingo.org/shingo-model/>

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Questions?

