Lean Thinking: For a Safer Patient Care

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As we are in the International Patient Safety awareness week, one would ask: why should we consider Lean System Thinking to be a trusted methodology in helping achieve high quality and safe patient care?
Lean is based on 2 pillars: Operating Management System and People Management System. Leadership is needed to maintain a balance between the two: the Technical system and the Social system, so the advantages of the operating system (continuous improvement) are not wasted. It should be obvious that no matter how good the operating system is, Leadership has to engage with the staff via a daily Leader Standard Work in order for the operating system to be used and its result to be sustainable.

If Lean is fully pursued in our hospitals today, as commended by JCI in the journey to an HRO; Where technical and social come together, and this is only met by relentless Kaizen* (CI) practice, then, we can leverage the many advantages of this special enabler called lean for a better patient care, financially rewarded institutions, happier employees and satisfied patient/society.

Today we are going to talk about lean contribution for a better, safer patient care driven by engaged staff in problem solving activities.
Unfortunately, Patient Safety backslides sometimes, and we will try to explore in the following paragraphs the reason behind this.

Patient safety degrades for many reasons:
• When there is a ***Tool focused initiative***, not a process focused one. Minding the process in real time will shift our behavior from a firefighting mode to a preventive mode. Why do I need Work Place Organization (5S+Safety) for my drug storage cabinet if I am going to neglect the 5th S for Sustaining what I organized? Why do I need (5S+Safety) for if I am not going to improve it?
• When there is a ***lack of support and empowerment from senior managers***. Demming says: Quality and Safety start in the boardroom. To engage staff, the role of a lean leader should reflect Najib Mahfouz's statement: "you can tell whether a man is clever by his answers but you can tell whether he is wise by his questions." The Lean management style is a coaching, facilitating style: "follow me and we will figure it out together"
• When ***not everyone is accountable***: everyone means all employees, including Leaders. In Lean we have two types of CI initiative: top down & bottom up CI initiative, practiced alone they are incomplete. For everyone to benefit and to sustain the gain, we need a vertical integration of both initiatives so:
  - Patient journey will flow better.
  - Staff will find more time to organize around patient care
  - Management can use gained resources and time for further improvement via Hoshin Planning**

The Institute for Healthcare Improvement (IHI) published a white paper*** in this regards and here is an excerpt of the article: "The key to sustaining improvement is to focus on the **daily work of frontline managers**, supported by a high-performance management system that prescribes standard tasks and responsibilities for managers at all levels of the organization".

Patient safety may also backslide:
• When Healthcare, like other industries try to ***rely on final check.*** If we want to target zero defect, healthcare practitioner should learn to do their work **right the first time** (by practicing Check-Do-Check technique so staff can identify and root out error)
• When Healthcare practitioners ***do not practice: pull the andon*** (cord) ***to correct a problem***, like in a shop floor

(no pun intended, just to secure our effort will get us to HRO's standard quickly). If there is a concern about a situation Lean practitioners immediately take action to fix it and avoid defect, for examples: if a physician taking the patient history got interrupted, he should say to the patient: sorry I was interrupted and want to make sure we covered everything. "Stopping and making time for corrective action is not just acceptable Behavior, it is Imperative" (Mark Graban).
• When there is a ***narrow focus on People not the Process***, just blaming and punishing, rather than looking for the root cause of the problem. A just culture is much needed to foster openness where staff are encouraged to alert us where to investigate and identify process issues or system issues. Near misses should be considered our friends because they help identify a risk that might be harmful. If we want a patient safety culture to prevail, we should be proactive rather than reactive.

Although consisting of powerful stakeholders, Healthcare situation today is facing a big challenge to healing its fragmented status. As Lean at heart is a philosophy of (CI)= PDCA****, Lean is a method to always seek the ideal, the gap to the ideal. Therefore, Lean can bring back the hope that things can get better.

In Conclusion, if Lean:
1- Has a technical problem solving side and is continuously closing gaps in our practice
2- Has a People side where everyone is developed to Do and Lead through challenges
3- Has Kaizen framework, Respect for People and teamwork
We may now understand why Lean is a trusted methodology in helping deliver a safer patient care. Because Lean is first and foremost a culture of high levels of Employee Engagement. From that comes the process improvement focus and from that comes use of the tools. From all of that comes increased patient satisfaction and safety - in other words the result.

The question that remains is: are we going to use this Lean leveler to our advantage and reap its huge benefit in our hospitals by Engaging Everyone Everyday in identifying problems and solving them?

*Kaizen=Continuous Improvement (CI) It consists of a 5 day long event where cross functional group of people meet to study a process, remove waste and restudy the area to check what improvements were achieved.
** Hoshin Planning is a process where senior managers communicate clearly the goal of the org with the staff so process, people and purpose are aligned and everyone is looking in the same direction.
***http://www.ihi.org/resources/Pages/IHIWhitePapers/Sustaining-Improvement.aspx
****PDCA: Plan Do Check Act. the Demming cycle for continuous improvement.