Starring in this issue:

Masters of Change Show How It’s Done
Performance Improvement? Why a Union Member Cares
Three Tips to Get Your UBT Working on Patient Safety
It’s no secret that hospitals can be dangerous places.

Nasty germs have a habit of congregating in hospitals, and it’s a short hop from counter surface or railing to surgical incision. Patients, relatively immobile in their beds, are vulnerable to pressure ulcers. Drugs are dispensed multiple times a day to multiple patients, creating the possibility of a mistake in the quantity given or a mix-up in who gets what.

The list goes on. The nation was startled into awareness of the problem in 1999, when the Institute of Medicine published “To err is human: Building a safer health system,” which got widespread coverage in the media. That report estimated there were up to 98,000 deaths per year in the United States due to medical errors and made recommendations on how to address the issue.

There’s been a tremendous amount of work done in the years since to improve, but there’s much more to be done.

A 2010 Department of Health and Human Services report concluded that 13.5 percent of Medicare patients—that’s one in seven—experiences a serious adverse event during a hospital stay, and that many again experience temporary harm. The dollar cost of those events adds up to some $4.4 billion a year for the country. The emotional toll can’t be calculated.

The “Safepathy” cover story of this issue of Hank takes a look at unit-based teams at Kaiser Permanente that are taking steps to ensure the care we offer our patients and members is the safest, highest-quality care available.

Members of unit-based teams have worked together to reduce the incidence of medication errors, pressure ulcers and hospital-acquired infections. They have worked together to improve outcomes for patients with diabetes and heart disease. They have worked together to improve our screening rates for breast and colon cancer, and they have upped immunization rates.

And there’s much more that can be done.

“Three patient safety strategies for UBTs,” on page 11, suggests a variety of ways that unit-based teams can incorporate patient safety work into their daily work.

Many studies have determined specific best practices that can be instituted to reduce the frequency of medical errors. But research also indicates a hospital’s culture has everything to do with how safe its patients are: Hospitals that rely on teamwork and innovation are safer for patients than those with a more rigid, hierarchical structure.

It’s easy to point a finger of blame at an individual when there’s a mistake. But typically, the failure is that of a faulty system, one that didn’t build in safeguards to protect against the reality that to err is human.

At Kaiser Permanente, unit-based teams build trust and rapport between union workers, managers and physicians. At Kaiser Permanente, unit-based teams provide a systematic, systemic solution that helps keep our patients free from harm.

What is Hank?

Hank is an award-winning journal named in honor of Kaiser Permanente’s visionary co-founder and innovator, Henry J. Kaiser.

Hank’s mission: Highlight the successes and struggles of Kaiser Permanente’s Labor Management Partnership, which has been recognized as a model operating strategy for health care. Hank is published quarterly for the Partnership’s 120,000 workers, managers, physicians and dentists. All of them are working to make KP the best place to receive care and the best place to work—and in the process are making health care history. That’s what Henry Kaiser had in mind from the start.

For information about the management and union co-leads advancing partnership in your region, please visit LMPartnership.org.
Unit-based teams have huge potential for improving patient safety—so why are so few taking it on?

The patient in the operating room was moaning and suffering sudden seizures. A half-dozen caregivers crowded around him, attempting to stabilize him as they watched his vital signs on a monitor.

Now, he says, “The idea is that by working together as a team, everyone has an equal role with the patient. Everyone is equally important.”

The summit included a presentation on the importance of developing a culture of safety. “Team behaviors do matter,” says Lutfiyya. “Team behaviors affect clinical outcomes.”

Research backs him up. A 2009 study published in The American Journal of Surgery tracked nearly 300 observations by RNs of operations at four Kaiser Permanente sites. The conclusion: Patients whose surgical teams exhibited fewer teamwork behaviors were at a higher risk for death or complications. These observable behaviors revolved around information sharing during various phases of surgery.

In short: Patient safety depends on good communication. From there, it’s easy to see that, since unit-based teams provide a structure and the tools for improving team communication, they are a path to improving patient safety.

Perfectly logical, right? Yet only a tiny fraction of UBT projects aim to improve patient safety, according to data in UBT Tracker, the programwide system for reporting on unit-based teams.
What’s going on? Patient safety projects seem like ideal candidates for unit-based teams, touching all four points of the Value Compass. Keeping patients safe from harm delivers on best quality and best service. Such projects address affordability: In the Northwest, the decrease in infections for the specific procedures being monitored has resulted in an estimated cost avoidance of $220,000. Patient injuries can be devastating to individual and team morale, so intentional efforts to minimize them help create the best place to work.

And who benefits or suffers most if teams do or don’t take on this work? “We all owe it to the patient,” says Doug Bonacum, Kaiser Permanente’s vice president of Safety Management. “We need to find ways to help people reach deep down and say, ‘I am not comfortable, I have a safety concern.’ It is top down and bottom up. It has to be both.”

When top-down transforms into teamwork

The fact is, there is plenty of work going on throughout Kaiser Permanente on patient safety. Much of it, however, has a top-down, mandatory quality to it—with little or no emphasis on involving frontline staff on how to go about meeting the goals and improving performance.

In the Northwest, for example, switching to a new dress code based on Association of periOperative Registered Nurses (AORN) recommendations was a top-down mandate. One of the changes included replacing the skull cap, which did not always cover all of a person’s hair, with a bouffant cap.

“We assumed, “Well, this is the right thing to do for the patient,” and staff would just do it,” says Claire Spanbock, the regional ambulatory surgery director, acknowledging the limits of the approach. But, “We had people we had to tell again and again. We realized we were making a big change and not involving them….We got there, but it was tough.”

In contrast, when it came to hand hygiene, members of the regional OR UBT sat down together and revised the audit tool several times before settling on the best version. “You are never going to do this until you have the hearts and minds of the staff,” says Spanbock.

WHEN THE RIGHT EYE IS THE WRONG EYE

One reason relatively few teams are working on patient safety may be that until a team has strong communication skills in place—developed in the course of working on simpler improvement projects—its members may shy away from high-stakes efforts.

The Northeast Ohio ophthalmology team already was one of the highest-performing UBTs in the Ohio region when it decided to not take the team’s clean safety record for granted. Its co-leads—the ophthalmologist, ophthalmic technicians and manager—worked together to implement a patient safety briefing immediately prior to all eye procedures.

The idea is an enhanced version of a timeout, when a surgery team pauses before a procedure to engage in a structured communication with the patient to verify key information. It came from the ambulatory
What do metrics have to do with patient safety?

Early in 2008, the 59-bed medical-surgical unit-based team at Fontana Medical Center began a remarkable two-year run in patient safety. It was a sharp contrast to the 2006-2007 period, when 17 patients had developed pressure ulcers, a painful, dangerous and expensive complication of inpatient care.

That record was unacceptable to everyone on the team.

“We all shared a commitment to create a safe healing environment for patients and build a culture of safety,” says Kathy Smith, RN, the assistant department administrator and management co-lead at the time, along with labor co-leads Toni Leonen, RN, and Zeny Bauzon, RN, both UNAC/UHCP members.

The team launched several tests of change to eliminate the problem, involving wound-certified nurses, nutritionists, and new training and care procedures. It also made smart use of metrics, which were collected and shared every day—giving team members a clear picture of whether the changes they were making were having the desired effect.

‘Exciting and motivating’

“Our metrics were easy to follow,” Smith says. “It was exciting and motivating to go each month and see we’d kept our record going.”

With the increased vigilance, the team went nearly two years—from February 2008 to January 2010—without a single hospital-acquired pressure ulcer. The data team members were collecting allowed them to quantify their success and gave them evidence the improvement wasn’t coincidental or merely an anecdotal impression.

“And if we missed a target,” Smith says, “the data let us respond quickly, go back and see what’s not working.”

That occurred in mid-January 2010, when the team tested a soft boot that was supposed to reduce pressure on patients’ feet—but found it made things worse. Three patients using the device that month developed heel blisters.

“If the foot was not kept at a constant 90-degree angle, the boots caused more irritation,” Smith says. “We stopped using them, and the next month were back to zero.” The next incident occurred in September 2010, when the unit had staff turnover. It then went till March 2011 without another incident.

For more information on the Fontana team’s work, see LMPartnership.org/snapshots/ubt-success-big-fat-0.

surgery center at the Parma Medical Center, where several ophthalmology staff members work.

“We just felt that it would be wise to be proactive,” says Ralph Stewart, MD, the team’s physician co-lead. “There’s no danger of cutting off a leg in our department, but you do need to think about right eye or left eye.”

The team already had worked together to improve wait times and courtesy and helpfulness of staff, so had built the trust and free-flowing communication culture that is at the heart of patient safety efforts. It embraced the idea and, after resolving concerns about the time the safety briefing would take, began brainstorming about what the ophthalmology timeout would be like.

“We split into two different groups that included physicians and technicians, and we discussed which part was going to be the responsibility of the ophthalmologist and which was going to be the responsibility of the technician,” says Renee Paris, a lead ophthalmic technician and an OPEIU Local 17 member.

“It took us a couple of months to get it together,” says Bonna Gochenour, an RN and the team’s management co-lead. “We had to create some ‘smart phrases’ to help us with documentation. When the technician goes into the room with the patient, they’re going to confirm with the patient which eye it is, and the tech puts a little smiley face over the correct eye.” The doctor then does a second verification before beginning the procedure.

(continues on page 6)
In late January, in a textbook small test of change, the team piloted the safety briefing for one month with one physician and one tech. After a few adjustments—like making sure each procedure room has its own supply of the stickers—the UBT implemented the procedure throughout the department, which encompasses teams at four different facilities in three counties.

Sandy Cireddu, a certified ophthalmic technician and the team’s labor co-lead, is proud of the accomplishments. She thinks the open channel of communication developed through the UBT has been critical to its success. “Everybody needs to be heard,” says Cireddu, a member of OPEIU Local 17, “and everyone needs to feel you’re on equal ground when you’re discussing these things, so that you can get buy-in.”

**Surgical Site Infections Down**

At the Woodland Hills Medical Center in Southern California, a campaign to reduce surgical site infections in the labor and delivery department is working. The department dropped from a rate of five surgical site infections per 100 cesarean sections performed in the second quarter of 2009 to none in the second quarter of 2010.

After a brief rise, the rate headed down again, and at the end of the first quarter of 2011, it was less than one per 100. Moreover, the only infections since the third quarter of 2009 have been superficial; there have been no deep or organ-space infections. The campaign includes a focus on pre-op skin prep, educating new moms on post-op wound care, prophylactic antibiotics, hand hygiene, and trying to reduce traffic flow of staff and families near the operating rooms.

And, as in the Northwest, the effort included enforcement of the AORN guidelines for surgical attire. Out went the skull caps sewn by Min Tan, an obstetrics tech and SEIU UHW member, who helped her colleagues spice up their scrubs by making them custom caps with their favorite patterns—anything ranging from the L.A. Lakers basketball team to spicy-colored chili peppers. She took the new dress code in stride. “The Labor Management Partnership is about fixing things,” says Tan. “It helps us in not finger-pointing and blaming. It’s not as intimidating as ‘the old days.’”

The department’s labor co-lead, Robin Roby, an RN and UNAC/UHCP member, agrees. “We are becoming part of the solution,” she says. “You feel like you are more involved with what goes on in the unit.”

That involvement is what makes UBTs a foundation for improving patient safety; engagement is the key to effective implementation.

Louise Matheus, the department administrator at Woodland Hills’ labor and delivery unit, acknowledges that focusing on reducing infections was a management decision. But, she says, the department’s progress in controlling infections “is a UBT effort because we involved the whole staff” in implementing the changes.

And Matheus makes it clear she’s looking forward to the day when frontline physicians, managers, nurses and techs use the leverage created by unit-based teams to accelerate improvements in patient safety. When that day comes, she says, “It won’t be small test of change—it will be large test of change.”

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**Daunted by data? Tips for getting started**

Consider these elements as you make your plan:

- **Collection.** Use metrics that are easy to collect—for instance, observations made during shift rounds that can be tracked on a checklist. Stick to measures that are readily and regularly available.

- **Display.** Use metrics that can be plotted on a run chart, and display the chart where the whole team can see it. A run chart shows what you’re tracking over the period of time you’re tracking it (see example, page 5). Keep the chart up to date and mark it with the time, date and nature of the change you’re testing, so you can monitor in real time whether improvement is occurring.

  *Note: Don’t display data that can be tracked to an individual patient.*

- **Data definition.** Spell out what you’re collecting. For instance, you need to know:
  - Your number of successful interventions (which will be the numerator in the fraction that expresses what percentage of your patients were helped by the test of change) and the total number of patients included in your test group (the denominator).
  - Included and excluded patient populations. For instance, in tracking pressure ulcers, a team would include all patients at risk for heel ulcers and exclude those with an amputated limb or who are otherwise not at risk.
  - When and how often the data is collected. For example, “at team huddles,” or “on every shift, during rounds at 7 a.m., 3 p.m. and 11 p.m.”

  “To improve, you need good information about what you’re doing today, how consistently you’re doing it, what’s working and what is happening or not happening when things don’t work,” Schilling says. “It’s important to collect and display information in real time so people can see where they stand.”

To get started in a patient safety improvement project, check out the tips on the opposite page or talk to your UBT consultant or an improvement adviser in your facility.

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**TEAM BEHAVIORS DO MATTER. TEAM BEHAVIORS AFFECT CLINICAL OUTCOMES.**

—Waled Lutfiya, MD (Northwest)
Since the Institute of Medicine estimated in 1999 there are up to 98,000 deaths a year in the United States due to medical errors, much has been done to improve patient safety. There’s still more to do—and at Kaiser Permanente, unit-based teams are getting directly involved in that work. Doug Bonacum, vice president, Safety Management, offers three strategies that teams can use to accelerate their progress toward doing no harm.

STRATEGY No. 1: Align with regional priorities

Most KP regions have patient safety priorities, and effective UBTs align their projects with their region’s goals. Here are examples of targeted patient safety goals from several KP regions. Check with your department administrator or medical center leadership for the priorities in your region.

» Reducing the percentage of hospital readmissions (within 30 days of discharge) and other handoff-related events.
» Reducing the occurrence of “never events,” also known as “serious reportable adverse events.” These include wrong-site surgeries, pressure ulcers, falls with injuries, foreign objects left in a patient, or comparable events in ambulatory settings.
» Reducing the rate of hospital-acquired infections (HAIs) and effectively treating infections regardless of source—sepsis care, for example.
» Improving the reliability of diagnostic-related processes. This might be, for instance, ensuring that lab and test results are entered into KP HealthConnect and confirming they are received by the practitioners who need them; ensuring correct specimen labeling and handling, and so on.
» Improving medication safety.
» Improving care team response to urgent/emergent situations via Critical Events Team Training (CETT).
» Improving the early identification, reporting and resolution of events, including member service breakdowns with quality of care concerns.

Resources to speed you on your way

To learn more about how you and your team can help build a safer environment for all patients, check out the following resources on the KP Intranet.


Patient Safety University: Four self-paced patient safety modules are available on KP Learn for UBT members, co-leads and consultants. To access the modules, log on to http://learn.kp.org and search for “Patient Safety University for Frontline Staff.”

Patient Safety IdeaBook group: This online forum supports the exchange of ideas and effective practices for performance improvement advisers and clinicians. Visit https://ideabook.kp.org/groups/patient-safety-affinity-group.

STRATEGY No. 2: Implement ‘vital behaviors’

Vital behaviors are the few high-impact actions—things others can recognize and do—that, if routinely enacted, will lead to the results you want. There are four safety-related vital behaviors that can apply to any care area. They are:

» Work safely. Follow correct policies, procedures and effective workflows.
» Speak up. For instance, if a colleague has drifted from safe practice and is putting a patient or him- or herself at risk of harm, don’t just stand by—say something. This practice alone can have a huge impact on building a culture of safety.
» Offer help. If you see someone else is having trouble safely and reliably accomplishing a task, ask whether you can help.
» Ask for help. If you need help to safely and reliably accomplish a task, ask for it. Some vital behaviors are specific to a particular safety-related practice. For example, three vital behaviors related to hand hygiene are:
» Wash your hands before and after touching a patient.
» Speak up when you see a colleague not washing his or her hands.
» If someone speaks up to you and reminds you to wash your hands, say “thank you”—and immediately proceed to wash your hands. No ifs, ands or buts!

STRATEGY No. 3: Include a ‘do no harm’ measure in every UBT project

Consider a measure, or balancing measure, related to worker and patient safety for each project, as appropriate.

The minimum requirement would be to “do no harm.” For example, if your project is to speed throughput of patients in your clinic, do so without sacrificing safety.

The stretch goal would be to measurably improve safety where relevant. This lets you address multiple Value Compass points:

» Improving OR turnover times (Most Affordable) and reducing surgical site infection rates (Best Quality).
» Improving HCAHPS scores (Best Service) and reducing falls with injuries or pressure ulcers (Best Quality).
» Enhancing employee engagement (Best Place to Work) and improving handoffs (Best Quality, Service).

Service to others: Kristin Postlethwaite, RN, an OFNHP member, helps patient Shari Harwood at Sunnyside Medical Center in Clackamas, Oregon.
Meet some teams and the people who train and support them. Their strategies will help get you—and your team—through personnel changes, shift changes and more.

**Even keel:** Ian King (above), a performance improvement adviser in Georgia, helps teams stay focused when change is afoot.

**On track:** Bernadette Haggett, pharmacy technician; Ali Ghazavi, director; Philip Liu, clerk; Kumar Atmuri, manager; (left to right on opposite page) and Crystal Iyo, clerk, all work at the South San Francisco Outpatient Pharmacy, which improved its low patient satisfaction scores despite a period that saw a lot of management turnover. Haggett, Liu and Iyo are SEIU UHW members.
Change might be necessary, inevitable or even the only constant.

In driving performance improvement, unit-based teams are in the business of change. But when, instead of being the agents of change, change is happening to them—when co-leads leave a team, or shifts are being revamped or an entire facility is closed and a new one opened—even the most stalwart of teams can come apart at the seams.

That sort of change, says Ian E. King, a performance improvement adviser for UBTs in the Georgia region, “tends to redirect a team’s focus” away from performance.

Sometimes, King says, teams need outside help staying pointed in the right direction. But individuals on teams and teams themselves also are coming up with ways to stay on track. The Outpatient Pharmacy in South San Francisco, which went through months of changes and turnover on the management side, is one of them.

Despite the lack of continuity during that period, the team changed its reputation for having some of the lowest member-satisfaction rates around: From March 2010 to December 2010, the team reduced complaints by 45 percent. In order to serve members better, the unit—which once had almost 200 complaints in a single year—tackled wait times, patient instructions and other measures of the unit’s efficiency. Led by management co-lead Kumar Atmuri and labor co-leads David Hong and Philip K. Lieu, both of SEIU UHW, the team kept tracking and reviewing quarterly complaint data and creating tests of change to deal with the subject of each complaint as it came in. The team’s secret to staying on track:

Educating new staff members and temporary transfers keeps everyone focused on efforts to reduce member complaints.

Niambi Lincoln, a senior consultant for UBTs, says the team’s focus was a money-saver. Each complaint costs about $300 to address and resolve—not to mention the potentially significant cost to KP’s reputation for each complaint.

“It’s a real testament to this team that it showed sustainability in the midst of many lead role changes,” Lincoln says.

Lincoln cites another reason why the team is so strong and was stable through the changes in management:

Everyone in the department takes a turn serving on the team’s representative body, with new representatives rotating in every three months.

It takes time for new representatives to get up to speed, but Atmuri says the time spent is worthwhile. Rotation allows team members to participate directly instead of always providing ideas through someone else.

“The staff gets an opportunity to…become a part of the decision making,” Atmuri says.

The strategies that help teams can help an individual, too.

Avis Yasumura, RN, stepped into the role of labor co-lead of the Ambulatory Surgery Recovery team at Moanalua Medical Center in Hawaii before she had even completed LMP training. It was a taxing situation. Her team was a latecomer to the region’s roll-out party, replacing another team that went through a major staff reorganization. It was having to get up to speed fast. And although she’d been a KP nurse for 17 years, she was new to the unit.

How did she manage? Yasumura, a member of Hawaii Nurses Association, OPEIU Local 50, gives credit to the assistance provided to her and her management co-lead, Janet Lundberg.

Just-in-time training helps develop better communication and coaching skills.

‘He who rejects change is the architect of decay.’

—Harold Wilson, former British prime minister

PROACTIVE CUSTOMER SERVICE

Read more about the work of the South San Francisco pharmacy online:
LMPpartnership.org/snapshots/proactive-customer-service-reduces-pharmacy-complaints

Coping with an onslaught of CHANGE

Sometimes change just brings more change.

In January of this year, the Mid-Atlantic States region opened the Capitol Hill center, a four-level, 170,000-square-foot facility, relocating 100 physicians and more than 400 clinical and administrative staff. Two longstanding facilities merged in the process, and one of those then closed.

The center offers medical services that previously weren’t available, such as peritoneal dialysis and transfusion services, and it changed some services such as laboratory, pharmacy and urgent care to 24 hours a day, seven days a week, creating shift—and lifestyle—changes for staff.

To assist with the move, the region’s transition team, with management and labor partners, prepared a comprehensive plan for hundreds of staff members as well as KP members and patients. The team spent six months addressing issues ranging from staffing levels to parking and orientation.

For members of unit-based teams, the new facility caused a wave of changes:

» leaving a clinic they had worked at for 20 years,

» facing, in some cases, a new one- or two-hour commute to the new clinic, and

» reapplying for jobs they had held for years.

Labor partners were instrumental in helping provide coaching, résumé writing, interviewing and technology skills, says Pati Nicholson, the region’s union co-lead.

The transition team will perform a post-occupancy evaluation to assess lessons learned and ferret out best practices, information that will help them in planning for the opening of new centers, such as the Gaithersburg Medical Center in 2012.

“I don’t think they could have done this without engaging the frontline,” Nicholson says.
Have you ever stopped a pharmacy tech or a nurse or an EVS worker in the hall and asked them, “So, what do you care about your job, anyway?”

I’m guessing probably not, because you know they’d look at you like you’re crazy. It is kind of a crazy question, isn’t it?

But people ask a very similar question all the time: Why should unions care about workplace performance? Why, indeed, should unions care about the work of the workers they represent?

The answer is simple. Unions care about performance because workers care about performance. Personally, I have met very few people who don’t care about doing a good job. Of course, I’ve met plenty of people who are angry and frustrated—but usually that’s because they can’t do a good job in a poorly organized, under-resourced or dysfunctional workplace.

How do you spell frustration?

While a dysfunctional workplace produces frustration, a high-functioning workplace produces the satisfaction of doing a good job. A high-functioning workplace requires workers who are empowered and engaged as part of a learning organization.

That’s why the Institute for Healthcare Improvement (IHI), the nation’s leading health care improvement organization, counts “improving joy in work” as one of its five key strategies: “We seek to improve joy in work, and to help all who work in health care to become better able to help improve care.” Work that inspires joy is directly linked to our ability to continually improve the care we give. I think IHI might be on to something here!

These days, the word performance has lost its connection to the joy of work well done. But take it out of the context of our daily grind. When you think about the last great performance you attended, what comes to mind? The inspiration of a great movie? The breathtaking, split-second teamwork of a great dance troupe? Maybe even, joy? Though the connection between work and the joy of performance is as old as humanity, you don’t often hear much about joy from “the labor movement” (or from “management,” either, for that matter). That’s a relatively recent phenomenon.

Boxed in by good intentions

“When people retire and look back on their lifetime of work, they want to know they made a contribution to something greater than themselves,” says John August, the executive director of the Coalition of Kaiser Permanente Unions. August points out that the union movement grew in part as industrialization distanced workers from their own work in a way that was deeply alienating to the human spirit.

So where did we get the idea that the worker organizations we call unions should focus on the money but not the meaning in work? How did the bread get separated from the roses?

Peter diCicco, founding executive director of the coalition, explains that over the past half-century, unions got stuck in the “NLRA box.” The 1935 National Labor Relations Act requires employers to negotiate with duly elected unions—but only over wages, hours and working conditions. Performance, service, quality, affordability—they are all outside the “NLRA box.”

At Kaiser Permanente, we exploded the box in 1997 when we created the Labor Management Partnership. Here, workers have a voice in all the issues related to performance. We are reuniting the joy and meaning of performance with the security of industry-leading wages and benefits.

Quality, service and affordability are reconnected with the best place to work. We sing, we dance, we perform, we care for the health of our communities every day—and we are creating a revolution. Don’t be shy—join the dance! (I.M.)

‘If I can’t dance, I don’t want to be in your revolution!'

—Emma Goldman, writer and anarchist
Each issue, Hank features a team that has successfully used the “plan, do, study, act” (PDSA) steps of the Rapid Improvement Model (RIM). Find out about other teams’ best practices and learn more about how to use the PDSA steps by visiting LMPartnership.org/ubt.

Getting timely results for inpatient blood work

**Department:** Laboratory, Anaheim Medical Center  
**Value Compass:** Service  
**Problem:** Blood draws weren’t being processed in a timely manner  
**Metric:** Percent of blood draw results completed by 9 a.m.  
**Labor co-leads:** Francine Hintzman, clinical laboratory scientist, SEIU UHW, and Cathey Emond, laboratory assistant, SEIU UHW  
**Management co-leads:** Debbie Chantry, department administrator, and Jan Crowther, assistant department administrator  
**Small tests of change:**  
1. Instead of having samples delivered by a runner, lab assistants pick up blood drawn on the hospital’s 6th and 7th floors at 6 a.m.  
2. Lab assistants, not runners, drop specimens off every half-hour throughout the day.  
3. Clinical lab scientists come in at 6 a.m. instead of 9 a.m. on the weekends.  
**Result:** Blood work was processed by 9 a.m. 93 percent of the time between August and November 2010, up from 20 percent when the project started in February 2010. “We are still doing the same things,” labor co-lead Hintzman says. “We just shifted the work so it’s being done by different people at different times.”

**Biggest challenge:** It took some time to achieve results because the team gave each member of the lab’s five departments an opportunity for input. “We got suggestions from everyone,” management co-lead Chantry says. Emond adds, “We wanted to make sure that everyone was on board.”

**Side benefits:** The night crew members pitched in by cleaning up work areas and doing other prep work before the end of their shift. The focus on improving the blood work turnaround time “really affected every shift,” Crowther says. “We were amazed at how it made everyone want to get involved.”

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(continued from page 9)

That training, she says, also helped the pair, who were working closely together for the first time, understand each other’s working styles. “Trust, communication and a good work environment,” Yasumura says, “makes it easier for us to achieve our goals.”

The team got past the early hiccups at launch to become the Hawaii region’s high-performance poster child. It chronicles a myriad of successes in its quarterly, widely read newsletter: The team saved about $10,000 a month over three months in a project to streamline supply orders, has helped improve patient flow in the operating room, and increased staff satisfaction with huddles that pass on information and recognize individual employee achievements. “Our traditional ways of decision making have changed. (With) a new generation of nurses, the likelihood of success in decision making, problem resolution or issue resolution on any level involves more of a collaborative approach,” management co-lead Lundberg says.

In addition to the work co-leads must do to address change, a team’s consultants, facilitators and advisers have a key role to play in coaching UBTs through transition, says King, the UBT adviser in Georgia, where departments have weathered mergers and unit restructurings.

King coaches several teams and their co-leads, including one pair that is working with a team with just two original members left after a staff reorganization.

He recommends a three-step process for navigating these waters:

1. **Recognize that change can be frustrating or scary.**
2. **Allow team members to openly discuss changes and the impact on their department.**
3. **Keep the focus on the work at hand.** “The more the team (members) can put their feelings or reactions on the table, the easier it is to see how we can harness any negativity and turn that into positive energy for the work,” King says.

In a recent meeting with the facility operations team at the newly retooled Town Park medical offices, he marveled as the co-leads decided this was a great chance to rebuild the team and promote performance improvement. “They came up with a ‘divide and conquer’ plan to reach out to facility staff and encourage their participation,” King says. “Even in the aftermath of a major organizational restructure, this team was able to focus on what needed to be done to move improvement work forward.”
1. Set up an email list.

Start an email list that includes the email addresses for everyone who belongs to the team—not just the representative group members. Send out a weekly or bimonthly email with updates on the latest meeting, the team’s recent test of change and any other important UBT news.

2. Put out a newsletter.

Newsletters can be just one or two pages. You can include articles about your team’s recent successes and challenges. Go to LMPartnership.org/tools/more-tools/1539 for a newsletter template that you can modify, print out and put in everyone’s mailbox.

3. Assign “one-on-ones.”

Designate one or two people in the UBT to be communicators. Their job is to check in regularly with each individual in the department and give them an update on the team’s projects. Start with someone who is already very social or wants the opportunity to meet new people in the department.

4. Rely on huddles.

These quick meetings are an easy way to get everyone on the same page without slowing work down. Huddles help colleagues stay informed, review work and plan small tests of change—and because they’re highly visible, they reinforce the message communication is important.

5. Organize occasional unit- or department-wide meetings.

Once a month or once a quarter, organize a potluck lunch and invite everyone in the department to hear news about the progress of their UBT. Not only will you spread information about the work of the UBT, you’ll also build more team spirit in your department.

6. Design a storyboard for your staff lounge.

Storyboards are illustrated outlines of your team’s journey: challenges, metrics, tests of change and results. Think of a storyboard as an illustrated flow chart. Grab a poster board and use team photos, run charts and other illustrations to visually inform team members about the UBT’s progress.

7. Place a suggestion box in a common area.

Encourage the feedback of your colleagues. Make sure team members on all shifts have input. Collect the comments regularly. Provide answers to questions and report on the feedback in your newsletter, emails and/or huddles.

8. Create a phone tree.

A phone tree is a network of people organized to pick up the phone and quickly spread information to team members in outlying areas. Phone trees are easy to design: One person calls two people, then they each call two more people, and so on, until every person in the phone tree has been called.

Two 8.5” x 11” versions of this poster can be downloaded at LMPartnership.org/tools/eight-great-tips-spreading-word.