

Case examples and sample results

Did you know that 80% of serious medical errors can be traced to communication and handoff defects? (TJC 2012)

1 Rona Consulting Group helped one hospital engage in a four-day improvement workshop to address nursing-to-nursing shift reporting. After studying the current process, the team brainstormed ideas for improvements and tested tools with front-line staff. Not only did the team create new standard work and tools to ensure consistent communication at shift change, the hospital included patients and their families, so they too, would be part of the process.

The result:

Within 60 days, the nursing floors piloting the improvements eliminated defects with their key targets and were ready to spread improvements.

2 Rona Consulting Group supported another hospital with a five-day improvement workshop to improve detection and management of severe sepsis and septic shock, the leading cause of inpatient mortality. Despite evidence-based practice guidelines for sepsis care, current systems and resources were not set up to facilitate the best overall clinical care for patients. Timing and care coordination across care teams,

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Quality and patient safety

Delivering high-quality care and managing risk are top priorities for health care organizations. Significant barriers and competing interests, however, can get in the way of leadership and teams achieving tangible results with patient safety initiatives in a timely and effective manner.

We work with you to apply the innovative principles of the Toyota Management System. A key principle is establishing a culture that supports and builds quality into every step of a process. At Toyota, it is the responsibility of every employee to be a safety inspector and to signal leadership of a potential or actual problem in production. What follows is immediate correction or even a stop of an entire production line when there is a risk that a mistake will travel to the next step in the process and become a defect.

Rona Consulting Group brings that “stop-the-line” culture of safety to health care through the Patient Safety Andon System and workshops. Together, we can develop better ways to identify and immediately correct problems as we help you tackle complex and variable workflows. Our workshops effectively improve a wide range of processes, including medication errors, defects in care coordination, tubing misconnections, healthcare-acquired infections, surgical events, patient falls, the multiple communication and handoffs that increase the likelihood of unsafe care and generate higher costs, and much more.

Method and implementation approach

We provide teaching, workshop leading and coaching to focus your leadership and staff on addressing specific goals. We recognize and emphasize the importance of studying and analyzing processes, and testing ideas for improvements, before implementing changes.



including the ED, Lab, Pharmacy, ICU and Nursing were critically important but not well orchestrated. Before improvement, the hospital had a 74.1% defect rate with adherence to implementing all elements of bundles of care. The team studied the current process, mapped out the bottlenecks, envisioned a future state and created new standard work and tools.

The result:

Remeasures showed a 56.8% improvement at 90 days from the workshop. Energized by these improvements, the hospital continued its own improvements and decided to also spread the standard work and tools to 20+ hospitals within its system.

Other health-care organizations have achieved equally impressive results:

- 90% reductions in lead time from reporting of adverse and sentinel events to having resolutions and mechanisms in place to prevent recurrence.
- 77% improvement in reducing defects related to missed medications.
- 70% improvement in reducing patient falls.
- 100% improvement within 60 days in eliminating defects associated with bedside reporting and line review and reconciliation.

We typically begin with an on-site assessment of your Quality and Patient Safety program. From there, we provide assistance in developing a “stop-the-line” process. We also conduct a Value Stream Mapping Workshop on incident reporting and response processes, and can include Healthcare Failure Modes Effects Analysis to study and map high-risk processes and proactively create plans for improvement. Improvement workshops are focused on making existing processes better or, in some cases, redesigning processes.

Value stream mapping and improvement workshops vary in duration depending on immediate needs and scope of work. By involving executive leadership, quality staff, key leadership, and staff from various areas of a medical center, we address common challenges such as:

- Recognizing, reporting and learning from near misses, errors and defects.
- Instituting timely follow-up and documentation on reported incidents and improvement plans.
- Identifying missed opportunities to engage staff in finding and fixing defects at the source.
- Confirming that improvements are in place.
- Ensuring that leaders oversee and communicate to staff the results of actions taken for reported safety events.

From engaging your staff in simulations to employing a “Plan-Do-Check-Act” methodology, your organization will be aligned and focused on a new, robust culture of patient safety.