IMPROVEMENT WORK

A HANDBOOK FOR LEADERS IN THE MENTAL HEALTH SERVICES OF THE CAPITAL REGION OF DENMARK
This is not a project that ends,
it’s the way we work
The work on this book "Improvement Work – A Handbook for Leaders in the Mental Health Services of the Capital Region of Denmark" was ended in February 2017. However, improvement work is a continuous process. Monitor its progress at PsykIntra.

Thank you to everyone who has contributed to and is part of this book. Thanks to all managers, staff, patients and their family members, who have made their experience and thoughts available. Thanks to Lean Manager Jens Normand, former Head of Centre Anne Mertz and Head of Communications Rune Syberg for preparing and editing this book.
About this book

This book is addressed at persons in leadership positions in the Mental Health Services of the Capital Region of Denmark

In our efforts to materialise the joint regional strategy – Focus & Simplification, and to create value for patients, we in the Mental Health Services of the Capital Region are working to introduce systematic improvements on a continuous basis. We do this by means of lean methods and by developing as leaders. We develop the quality of treatment, our work processes and the competences of ourselves and our staff. In this work, we base ourselves on the patient’s wishes and needs.

The methods of our improvement work require that we do things together. Together, across units and professional groups, and with patients and their families. As one joint hospital. In the work of continuous, systematic improvements, persons in leadership positions at the hospital have a central role to play. A number of new methods and concepts have to be learned by everyone; at the same time, however, this improvement work also requires a new kind of thinking at leadership level. Leadership is very much about being able to transform and convert, and our decision to be a hospital with a strong improvement culture requires a change to leadership roles in some respects. With this book, we wish to give everyone in a leadership position in the Mental Health Services of the Capital Region a shared basis for working and leading in an improvement culture.

The book is intended as a tool helping all persons in leadership positions with the methods of improvement work, with using these methods in daily work, and with understanding why it is that we are working with continuous, systematic improvements. Chapter 1 provides a brief explanation of why we want to improve our mental health services. Chapter 2 gives a brief outline of the developments and results achieved in recent years. Chapter 3 explains our V and the four dimensions of the V as well as five basic lean principles. Chapter 4 explains the tools and analytical methods we use in our improvement work. Chapter 5 describes how, as a MHS (Mental Health Services) leader in the Capital Region, you are to work with these tools. We have chosen to name this “the 8 leadership actions”. Chapter 6 looks to the future, describing how we see our development work in the coming years. Chapter 7 offers a number of cases of successful improvement initiatives from the MHS centres for general inspiration.

Improvement work is well underway and we are doing it together. Consequently, we are cooperating at all leadership levels to improve the hospital – to develop as leaders and to develop our skills. This book will help you on that journey – as will your own leader.

Enjoy your reading
The Executive Hospital Management
# LIST OF CONTENTS

1. Why improve mental health services? ................................................................. 10

2. The story behind and the first results. ................................................................. 16
   - The first lean projects – and a new strategy .............................................. 20
   - New rights, pathway descriptions and central triage .................................. 21
   - Accreditation ................................................................................................. 22
   - Recovery ....................................................................................................... 22
   - Development of central data ...................................................................... 23
   - Patient-safe medication .............................................................................. 23
   - USA – ThedaCare as an inspirational hospital ........................................... 24
   - Our ambition – value for the patient ........................................................... 24
   - Progress report on developments, early 2017 ............................................ 25
   - The results so far .......................................................................................... 26

3. Value for the patient - what does that mean? ..................................................... 28
   - The patient’s wishes and needs ................................................................. 31
   - Quality of treatment ................................................................................... 32
   - Competent staff members ........................................................................ 33
   - Effective and efficient work processes .................................................... 33

4. Toolbox - methods and analytical tools ............................................................. 36
   - Methods ...................................................................................................... 38
   - Management by objectives, data-driven management and improvement meetings 38
   - PLAN-DO-STUDY-ACT (the improvement wheel) ...................................... 46
   - Standards ................................................................................................... 51
   - Gemba – go out and see what is happening ................................................ 54
   - Improvement event ..................................................................................... 57
   - 5S .................................................................................................................. 59
   - Analytical tools .......................................................................................... 61
   - Value stream mapping (VSM for short) ....................................................... 61
   - Waste .......................................................................................................... 63
   - Improvement template/A3 .......................................................................... 66
   - 5 x Why ....................................................................................................... 69
   - Pareto analysis: 80/20 ............................................................................... 70
5. Leadership actions ................................................................. 72
   Know your valuestreams and eliminate waste ................................ 76
   Conduct meaningful, value-adding improvement meetings .............. 77
   Promote continuous, systematic improvements ............................. 79
   Request standards: what does “good” look like? ........................... 82
   Create stability and control the core tasks ................................. 83
   Assume responsibility for instruction, guidance and further training .... 86
   Visual management .................................................................. 88
   Go to the gemba ..................................................................... 91

6. Improvement work - the next steps ........................................... 94

7. Cases ................................................................................... 98
   From feedback to action ........................................................... 100
   Implementation of cognitive behavioral therapy (CBT) in the bed units 102
   Increased quality and safety of the overall medication process at a centre 106
   On the way to a belt-free centre .................................................. 110
   Competence development through competence profiles .................. 116
   Reduction of the use of coercive measures and of absenteeism due to illness in bed units for children and adolescents 120
   Compliance with the assessment and treatment right through reduction of waiting time in the outpatient clinic ................................. 124
   Optimisation of rounds walked in bed unit ..................................... 128
   Change-of-shift meeting ensures good quality and working environment 130
   Reduction of the number of fully treated patients ......................... 134
   Week plans as a tool ................................................................ 136
   Reduction of no-shows and cancellations in the outpatient clinic ....... 138
   Reduction of waiting time in the outpatient clinic ......................... 142

Literature and articles for inspiration ............................................ 146
Glossary ..................................................................................... 147
IMPROVEMENT WORK IN THE MENTAL HEALTH SERVICES OF THE CAPITAL REGION OF DENMARK
Why improve mental health services?
When we are admitted to a hospital, we all have the same wishes and expectations. We expect professional, competent help to recover or at least get better. We expect to meet skilful healthcare professionals who know what to do. We want to receive an accurate diagnosis and the best treatment. We also want to be met by an effective and efficient system and by caring people who are good communicators and understand what we need.

In the MHS of the Capital Region, our staff members are competent and everyone is doing their very best to offer good, professional treatment and to deliver a high level of service. Our treatment has high professional quality and our patients and their families are normally pleased with the services we offer. So to a very great extent we can take pride in the work we do.

**SO WHY IMPROVE MENTAL HEALTH SERVICES?**
First and foremost, our attitude is that we can and must improve. We are able to see where there is room for improvement and our cooperation with patients and their families also gives us a lot of input.

Furthermore, we know that if we work with continuous, systematic improvements and standardised work processes, we can remove waste, so as to free up resources and have a more confident and calmer everyday working life that allows us to improve our skills, maintain good job satisfaction and create even better value for our patients. Thirdly, this is necessary if we are to maintain our level going forward in a situation in which funding will be reduced, while expectations and the number of patients will be higher. There is a need to focus, simplify and improve.

Improvement work is not a goal in its own right. It is a method and a tool helping us to deliver more value to more patients – together. It will also put us in a better position when it comes to handling the challenges facing the Danish national health service in the year 2017.

**WHY HAVE WE CHOSEN TO WORK WITH LEAN?**
Lean is an improvement model originally developed in the manufacturing industry. Most people associate lean with the Japanese car maker Toyota, which was one of the first companies to seriously pursue lean with great success, as they embarked on a process of continuous, systematic improvements in which everyone in the organisation participates and has a role to play. Subsequently, many others have engaged in lean as an effectiveness and efficiency enhancing method, but many of those fell short, so lean does not always have the best reputation. One of the reasons why lean has not lived up to expectations everywhere is that lean has been perceived as a project – an initiative with a beginning and an end. Another problem is that many have used lean as a method to identify cutbacks in the form of fewer employees. If, as an employee in a company, you find that by working with lean you are making yourself dispensable, your motivation is obviously not the greatest. However, lean is not just about a quick fix.

Lean is based on generating continuous, systematic improvements which create value for the customer (the patient). The model requires a highly involved leadership approach, which is about working more systematically and believing that staff members and patients are the best at finding good, durable solutions, so that work is optimised and
The greatest possible value is created with the resources available. Lean is leadership-driven staff innovation – a culture that takes time to implement and a culture that never ends. Lean focuses on work culture, leadership behaviour, tools and methods. Lean stands for slim or trimmed, which refers to removing waste in work processes. To trim an organisation and make it slim means that the activities which do not create value for the patient should either be minimised or removed completely. To make an organisation slim, i.e. to remove waste and create the best possible value for patients by jointly making continuous, systematic improvements is thus of the essence in our work with lean.

As a leader in the MHS of the Capital Region, you have to know the rules laid down for our work in the MHS of the Capital Region:

1. We work with lean and improvements to the benefit of patients, their families, staff members and the hospital as a whole.
2. We improve work processes based on the knowledge and proposals of managers, staff members, patients and their families.
3. We work smarter – not harder
4. We set goals, we take action and we do follow-up
5. The resources thus released are re-invested in more and better treatment.

The decision to go with lean in the MHS of the Capital Region means that all staff members and all leaders and managers at all levels must supplement and replace existing work processes and methods with new ones. In addition, we who are leaders and managers at all levels, must get out of the meeting rooms and away from our desks to meet patients and staff members, to help solve the many complex tasks at hand in the daily running of a state-of-the-art psychiatric hospital.

As leaders, we must understand the everyday work of our staff members; we must guide and coach them in the new methods for improving treatment, and our focus must be that the only purpose of our function is to ensure good, safe patient treatment in a good, effective and efficient framework which undergoes continuous, systematic improvement.

The next chapter will tell you more about the deliberations which helped to speed up the development of improvement work in the MHS of the Capital Region during the first years of this work.

“It is nice to be able to lean back and look at your whole unit and to be able to say out loud that we have an improvement culture”
PIA HUSUM FREDERIKSEN, NURSING HEAD OF UNIT
Why work with improvements?

VALUE FOR THE PATIENT

QUALITY OF TREATMENT

COMPETENCE OF STAFF

THE PATIENT'S WISHES & NEEDS

EFFECTIVE AND EFFICIENT WORK PROCESSES
What is to be improved?

- Poor/dissimilar professional procedures
- Poor work processes
- Unstructured work organisation
- Inadequate competency development
- Poor working environment
- ...and many other things

How are things to be improved?

- New leadership behaviour and new leadership action
- Lean methods and tools
- Professional competence development in psychiatry
2

The story behind and the first results
Following the establishment of the Mental Health Services of the Capital Region as one, joint, psychiatric hospital in the structural reform of 2007, we were in a situation leading up to 2010, in which new ways had to be found. New structures had been created, centres had been merged, and we had rationalised and relocated. Joint treatment standards and procedure guidelines had been prepared in connection with a number of accreditation processes which had gone extremely well.

However, the big organisational changes that were introduced were not enough to deliver more value for money in terms of quality. We were basically working in the same way that we had been working for years, despite the big organisational, technological and societal changes and many new, major, professional initiatives.

So why was it not enough for each staff member to be competent and conscientious in the performance of their work and to work as directed in guidelines and instructions?

The whole hospital – not least its leaders – was very busy in an everyday life characterised by fire-fighting, financial challenges and external requirements. It was difficult to change the use of coercive measures and the newspapers wrote about patients with eating disorders who did not receive any treatment because of shortage of capacity; there were long waiting lists for treatment and discussions of dissimilar treatment services at different centres, patient overflows and many other issues.

In 2007-09, a decision gradually shaped to the effect that lean would be interesting to pursue as a model for an improvement culture. Other hospitals in the world had converted the lean methods from manufacturing industry into lean thinking in healthcare. This was a way of working in which leaders and their staff members together created continuous, systematic improvement of patient safety, treatment and work processes, so as to make the given hospital more effective and efficient to the benefit of patients and staff alike. The MHS of the Capital Region needed a thorough, systematic change in its overall, complex treatment system. A system and new way of working were required to link up staff members throughout a given patient’s pathway.

The Executive Hospital Management decided that the core principles which had benefited others were to be introduced as the ruling principles in the MHS of the Capital Region.

Inspired by ThedaCare – a US hospital with a distinct lean culture – the work of the MHS of the Capital Region was to be carried out on the basis of three clearly defined principles:

- **Focus on the patient (not the hospital or the staff).** All treatment work to be redesigned to match the patient pathway
- **Identify what creates value for patients and stop everything else (waste)**
- **Minimise the time until treatment starts and optimise time throughout the process.**
In 2009 and 2010, the decision to go lean and introduce the improvement process was supported organisationally and politically, when the Capital Region prepared a report entitled Lean in the Capital Region. The report contained a number of recommendations to develop lean work in the Region. In 2010, the Capital Region Council decided that the hospitals were to intensify their work with improving work processes. Lean was to contribute towards enhancing treatment quality and patient safety. This work was commenced centrally in the Region and was subsequently to be rooted at the different hospitals.

The joint, regional strategy entitled Focus and Simplification, adopted by the politicians in 2014, also supported our decision to work with continuous, systematic improvements. With this strategy, the focus was now on “going for initiatives that have real value for patients” and on “looking at how we can work in the most appropriate way”. With this strategy, it was also decided to employ performance goal management.

In the years from 2010-2017, we have taken many initiatives and launched ambitious development initiatives in the MHS of the Capital Region. New patient rights have been introduced and new requirements have been made by the politicians, both regionally and nationally, such as a requirement to reduce the use of coercive measures and to introduce a right to assessment and treatment. All of this has contributed towards making the MHS of the Capital Region – the country’s largest psychiatric hospital – develop, so that we now have a new, better foundation for our work.
THE FIRST LEAN PROJECTS – AND A NEW STRATEGY

At the beginning of 2010, the first two lean pilot projects were launched. In the Executive Hospital Management, we decided to work with a joint improvement model; as mentioned, lean was chosen as the method to be applied, since good results from lean work had been recorded in health services elsewhere. The lean method was to help us improve our focus on activities that create value for patients, thereby giving hospital managers and staff members much demanded extra time for patients.

At an interval of some months, the next three units started – and then three units more. All in all, the lean methods were thus pilot-tested at eight different centres. At first, we used external consultants, but our strategy was for units to have the assistance of internally employed consultants, who were in charge of the training of managers and facilitated the first lean projects at the centres.

In the course of the summer of 2011, we had thus gleaned experience with testing lean in our clinical work. At that time, two things had become clear to us: Firstly, lean was a thoroughly tested improvement model which involved both managers and staff members and the pilot units reported satisfaction and were able to see the first results of this work. The second thing that became clear to us was that it was not appropriate for individual units at a centre to work with lean, unless the rest of the units of the centre knew about this way of working. No patient pathway can be seen in isolation in just one unit. There are always others involved, and with the new way of working with patient pathways, we had to cover the whole patient pathway across units, centres and sectors.

In 2010, the National Board of Health offered funding for mental health departments in Denmark to be able to develop “The good psychiatric department”. This project had four main objectives:

- Better patient satisfaction and patient involvement
- Reduction of the use of coercive measures
- Fewer readmissions
- Higher staff satisfaction

It was decided that the Amager Mental Health Centre was to apply for funding and use the funds to develop a model for how lean health thinking could be developed at a whole centre with a view to achieving results on the four objectives listed above, and how the model could subsequently be disseminated to the rest of the hospital centres. The Amager Center was able to engage a Lean Process Manager and a Facilitator; they supported and guided the Centre Management and all units in one combined lean process. Working in this new way was difficult and there were many challenges; overall, however, things went well and the results were evaluated by the National Board of Health. One of the main conclusions was that the number of belt restraint cases fell by 44%, while patient satisfaction increased by 3% and staff satisfaction rose by 29%. There was no effect on the readmission percentage.

With experience from units at eight centres and one whole centre which had now made good progress, we changed our strategy. Lean was not to be a project; it was to be the way in which we in the MHS of the Capital Region were going to work. This decision was all-important. A project has a starting date and an end date. We did not want an end date. The goal was to improve quality,
patient safety, satisfaction, effectiveness and efficiency – all at the same time. We wanted continuous focus at the whole hospital on the four factors identified.

Consequently, we decided that from 2012 onwards, lean was to be implemented at all centres with continuous implementation at one to three centres per year. In 2015, all centres had to be up and running lean. We wanted to use our own internal experts and only use external experts to a limited extent. We wanted to keep the expertise at the hospital and disseminate it to all those involved. That was why we built up a small, central staff of lean specialists who had the job of supporting developments at the hospital, and at each centre a small team of lean specialists was engaged with the job of supporting developments at the individual centre.

NEW RIGHTS, PATHWAY DESCRIPTIONS AND CENTRAL TRIAGE

On 1 January 2010, psychiatric patients obtained new rights in Denmark. This treatment right meant that patients had to be offered treatment within two months. Because of the introduction of this expanded treatment right, we in the MHS of the Capital Region decided to start the work of developing treatment packages. This work was inspired by the so-called cancer packages, which described the diagnostics, treatment, post-treatment and work processes related to cancer treatment.

The preparation of patient pathway descriptions – “the package pathways” of the MHS of the Capital Region involved a large group of clinicians, and pathway descriptions were developed for nine outpatient groups at main function level (ADHD, depression (single episode), and depression (periodic), anxiety and social phobia, bipolar disorder, personality disorder, OCD, adaptation and load reactions, and eating disorders).

Upon our initiative, the mental health executives of the Danish Regions organisation launched a process in mid-2010 which involved a description of national package pathways. These became a reality in 2011, when all centres in the MHS of the Capital Region were in the process of reorganising their outpatient treatment processes into the new package pathways.

With the introduction of package pathways, treatment was unified at all the centres based on the principle that patients with the same problem/disease should be treated the same. Until then, that had not been the case, since it had been up to the individual centre and the individual therapist to decide on the service to be provided.

The decision to have common treatment pathways created a need for joint, central triage. This was going to ensure easy, flexible referrals from GPs, and it was going to provide an overview of referred patients, as well as a better basis for good utilisation of the overall outpatient capacity of the MHS of the Capital Region. Mid-2011 saw the opening of the Central Triage, which meant there was just one entry point into the mental health services and equal access for all patients.
ACCREDITATION
Standards, guidelines and instructions became well-known tools in mental health services, when all hospitals in the Capital Region underwent accreditation. The Mental Health Services of the Capital Region were accredited by Joint Commission International in 2011 and by the Danish Quality Model in 2011 and 2015. In connection with these three accreditations, the cornerstones were laid for the many professional and organisational standards, guidelines and instructions which are taken forward in today’s work.

The accreditation process involved a professional and interdisciplinary discussion of what was important in treatment and in work processes. The MHS of the Capital Region had merged in 2007 and the psychiatric centres in the previous Copenhagen Hospital System and the two counties basically had very different professional standards, different guidelines in three different IT systems, different priorities and different financial settings.

The intensive cooperation carried out to create a joint, uniform mental health service provision at the centres prior to a coming joint accreditation involved a huge effort. The new, joint common stance for the hospital meant that the foundation had been laid for improvement work.

RECOVERY
For a number of years now, recovery has been on the agenda in mental health services. The focus is on the significance of involving patients and their families in treatment. The patient’s hopes and aspirations for the future are essential to the possibility of recovery.

The whole recovery thinking began to merge with our lean work in the course of 2013. If you want to work with lean in the health services, you always base yourself on the patient’s wishes and needs, and patients and their families must be actively involved in the treatment. That was why, in subsequent years, we started up a number of initiatives to support this development – including such features as continuous patient satisfaction measurements with the use of tablets, annual patient feedback meetings and establishment of a number of paid positions as recovery mentors at the centres in 2013.

“My participation in the patient feedback meeting was a very positive experience. It all seemed very professional, well-considered and ambitious. Staff members from the department seemed very interested and grateful to get our input, opinions and points of view on the different topics. I got a clear sense that a number of the improvements we discussed were taken straight back to the department for further discussion and implementation. It was great to see your former therapists and other staff members in a forum, where all of a sudden we were all equal. Where patients as well as staff members and management had great interest in getting the best possible results out of the meeting. I felt a sincere wish to involve us patients with the purpose of jointly making the treatment provided even better.

As a former patient, it was really nice to be able to contribute with perspectives and proposals for how to improve a treatment which was very significant to my own life. I felt appreciated as a valuable contributor and I was able to give back a little bit to the place that helped me move forward in my life.

BETTINA BERG THOMSEN, FORMER PATIENT"
In 2014, we adopted a strategy for user involvement; one of the initiatives was patient-managed beds at three centres. In 2015, we invited patients and their family members to become members of central councils and committees, thereby giving patients and their family members direct influence on central development initiatives and decisions.

Patients also became more and more involved in improvement work at the centres, and unit improvement measures were developed and tested with patients and their families. In 2015 we opened our Recovery School, where patients, family members and staff members go back to school together.

DEVELOPMENT OF CENTRAL DATA
When our lean work started, there was no good availability of data – particularly at centre and unit level, where leaders found it difficult to develop a broad overview of the running of their units. The data concerned was both clinical data and data for use in work processes, flows, staff-related matters, etc. The heavy IT systems, such as GS, the payroll system and the patient record system, required manually collated data, which made it difficult to have correct, real-time data available as a basis for making decisions.

At that time, we had a management information system which had not been extended and which was only used by a few people. Consequently, we decided to speed up the development of the Psychiatry Leadership Information System; within a couple of years, this system has become the central data source for data-driven management and the work of continuous, systematic improvements. However, audits are still an important part of the data overview required in clinical work; not until the Health Platform is implemented in psychiatry in 2017 will a large part of the manual data collation be replaced by electronically generated data.

PATIENT-SAFE MEDICATION
In 2012, we introduced a completely new system for medicine monitoring, in which all physicians can monitor their medication orders for each patient and we can monitor developments in the use of medication at the hospital in great detail. This system was introduced following criticism from the National Board of Health, which said that, in the mental health services, medication was given in doses much higher than those recommended. The monitoring system now provides each physician with an overview of all medication orders to patients whose treatment is the responsibility of the given physician. Furthermore, the system provides aggregated data at all organisational levels.

In 2013, the first clinical pharmacists were engaged to work in emergency rooms. Today, pharmacists write the medication history, write medication notes, provide advice and guidance on both somatic and psychiatric medication, and discuss compliance with patients and staff at all centres. In 2014, the Joint Medication Card was introduced throughout the Region; this guarantees a significant overview of the medication ordered to the patient concerned. These three initiatives have provided a much better foundation for patient-safe medication in the MHS of the Capital Region.

"This is a very significant step in the right direction. It shows me that this is a developing organisation. Much knowledge from patients and family members is now integrated in the development work that will secure future improvements of treatment. Things may go even further. We patients and family members sitting on the overall committees would also like to be involved all the way into the ‘engine room’, when problems are noted and improvements are discussed at the clinical level.

ERIK FRANDSEN, FAMILY MEMBER"
USA – THEDACARE AS AN INSPIRATIONAL HOSPITAL

In 2012, we began cooperating with ThedaCare in Wisconsin; since then, executive leaders and key personnel have paid study visits. ThedaCare is one of the hospitals in the US which is at the very forefront on all parameters as regards clinical quality, patient satisfaction, effectiveness and efficiency. ThedaCare is a medium-sized hospital with emergency services and offering all medical specialities, including mental health services. The hospital is characterised by having worked for 15 years with improvement work, using lean as a driver; all managers and staff members at the hospital work with continuous, systematic improvement. ThedaCare and the US Lean in Healthcare Organization provide a model for how an effective and efficient, top-notch hospital can create added value for patients on a continuous basis by taking a targeted approach to the principles of lean.

OUR AMBITION – VALUE FOR THE PATIENT

Inspired by ThedaCare’s clear beacon (True North), our Executive Hospital Management had continual discussions of how our ambition to create value for the patient could be disseminated in a simple way. Experience from a number of lean workplaces in the US indicated that one joint, simple indication of direction (a true north) was important and made sense to everyone involved. In 2014, our V became a reality.
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PROGRESS REPORT ON DEVELOPMENTS, EARLY 2017

Based on these many priorities and changes and also based on our decision that improvement work and the lean methods are the way forward for us, the situation now in early 2017 is that we in the Executive Hospital Management, all the centres and all staff now work with continuous, systematic improvements. Some have made much progress; for some it is still early days; others again are still hesitant, waiting at the starting line. However, the foundation has been laid and the road is clear, so we can move forward.

The assessment of our maturity can be based on a simple model, as illustrated above. This model describes the extent to which an organisation has developed a culture in which continuous, systematic improvements are the foundation for the work carried out.

All in all, the MHS of the Capital Region have reached level two to three in developing an improvement culture. At a number of facilities, some units are already at level four, but there are also units which have only just started. Our ambition is that, by the end of 2018, the whole hospital will have developed and reached level four. This is an ambitious goal, but it is not until everyone is on board and learning from each other, focusing on both the professional psychiatry competences and our work processes, that we will systematically and on a continuous basis create improvements in patient treatment and thus more value for patients.
THE RESULTS SO FAR

The results of the first years of improvement work speak for themselves. At hospital level and at each centre, we take stock of our results on an annual basis and compare them with the goals we set for ourselves. Experience is exchanged, ideas are shared, and the units or centres that found good solutions to joint issues share them with the others.

We also know which goals we did not reach. This is at least equally important. Most results show that developments are going in the right direction. Many goals have not been reached yet, but we are getting there. Improvement work is not a quick fix. We are in it for the long haul and everyone has a role to play and a responsibility for improving our work – and to maintain the improvements made.

The examples of major results shown below have been achieved in the last couple of years. These examples are at hospital level. At the centre level, a great many improvements have been made. The last chapter of this book offers a more detailed description of some of these improvements.

Belt restraints

It is a joint goal – both nationally and in the MHS of the Capital Region – to achieve a marked reduction of the number of episodes in which belt restraints have been used on patients. We have succeeded quite well with this, and this is a goal which is still processed actively at all centres. As can be seen from the figure, it has been possible to raise the bar for our expectations, as we have seen our work bear fruit.

Combination treatment

In recent years, we have made a targeted effort to reduce the number of patients being treated with both antipsychotics and benzodiazepines (sedatives). We have based our goal on the recommendation from the National Board of Health.

The figure below shows developments since the beginning of 2013.
Number of treated patients; waiting times
A few years ago, there was a long waiting list for a number of treatments in the MHS of the Capital Region. Following an intensive effort to provide treatment for more patients, this is no longer the case. An effort has been made in the form of improved work processes, and resources have been prioritised for this area.

However, improvements, new ways of working, and good results do not spread naturally like rings in water; learning from each other can be a tough process. Learning from each other across a hospital is a process that takes time. Today, we have made much progress; staff and managers now visit each other across the hospital to learn from each other.

In addition, we now hold an annual improvement conference, so as to promote learning, exchange of experience and dissemination of good solutions; at this conference, managers and staff meet and exchange ideas. In addition, improvements and good experience are shared across the hospital continually via the intranet, films and articles – and more and more staff members are now prepared to come forward and share their experience and results.
IMPROVEMENT WORK IN THE MENTAL HEALTH SERVICES OF THE CAPITAL REGION OF DENMARK
Value for the patient - what does that mean?
VALUE FOR THE PATIENT

QUALITY
OF TREATMENT

COMPETENCE
OF STAFF

THE PATIENT’S
WISHES
& NEEDS

EFFECTIVE
AND EFFICIENT
WORK PROCESSES
OPERATIONAL OBJECTIVES 2017

THE PATIENT’S WISHES AND NEEDS
- Overall patient satisfaction is min. 90%
- The share of patients who have taken part in preparing their own treatment plan through participation in the treatment conference/relevant meetings where treatment was determined is 90%

QUALITY OF TREATMENT
- The share of outpatients being treated with antipsychotics and at the same time receiving benzodiazepines is max. 20%
- Acute readmissions within 30 days amount to max. 19%
- Compared with the baseline (2011-2013), we want to avoid 997 belt restrain episodes per year, corresponding to a 57% reduction. Consequently, in 2017 we will have a maximum of 767 episodes

COMPETENT STAFF
- Total absenteeism due to illness max. 4%
- The number of work injuries resulting in absenteeism due to illness is to be reduced by 10% compared to the goal for 2016; consequently, there are to be a maximum of 126 work injuries in 2017.

EFFECTIVE AND EFFICIENT WORK PROCESSES
- The share of relevant patients who have been assessed within 30 days or have received an assessment plan within 30 days – goal 90%
- The share of relevant patients who have waited 30 days or less for their treatment to start – goal 95%
- Week plans have been prepared for all outpatient clinics – goal 100%
- Compliance with payroll budget – budget compliance max. 100%

In 2014, we laid down the main principles for the improvement work of the MHS of the Capital Region, using our V. The V is our True North and our go-to model, when we prioritise our efforts. We must create value for the patient. We always do that on the basis of the patient’s wishes and needs and by improving the quality of our treatment, making our work processes more effective and efficient, and by having an overview over and developing our competences, thereby ensuring that they support our tasks as well as possible at all times.

THE PATIENT’S WISHES AND NEEDS
Throughout the treatment process and in everything we do, we base ourselves on the patient’s wishes and needs. A basic principle of improvement work is to listen to the attitudes of the patient regarding treatment efficacy, framework and communication in the psychiatric treatment. This means we continually learn more as to whether our organisational conditions, our framework and communication or efficacy of treatment can be improved. That is why the patient is involved on a continuous basis and asked questions such as:

1. Are you feeling better – in the short term and the long term?
2. How satisfied are you with your treatment?
3. How satisfied are you with the framework, communication and service?

In regard to clinical efficacy, it is essential to have the patient’s assessment of symptoms, quality of life and level of functioning. The Patient Reported Outcome Measures (PROM) are undergoing development. This applies internationally as well as nationally, thereby making it possible to work with the treatment efficacy of the individual patient, while at the same time using data at population level. This provides a good basis for improvement processes.
Two basic questions will always form the basis of treatment:
1. Why are you here and what do you want to get out of the treatment?
2. How do you want treatment to be carried out?

The heading entitled “The patient’s wishes and needs” also includes a wish and need to involve family members in the work of improving treatment.

QUALITY OF TREATMENT
Quality of treatment is based on multi-annual studies of the outcome from different treatments. Research and development through studies of clinical databases and trials with different treatment methods form the basis for the descriptions of good treatment quality. Research and development form important cornerstones when trying to ensure that treatment creates value for the patient and that treatment services are developed and improved over the years.

However, part of psychiatric treatment services have not been examined and documented in detail, but are based on long-standing clinical practices and common sense.

Paying attention to studies, but also to good clinical practice and common sense, we in the MHS of the Capital Region describe the level of quality we want in the form of treatment standards. This requires the involvement of different professional groups as well as patients and their families. Treatment standards (guidelines and instructions) define the level of quality, thereby forming the basis of all treatment.

The treatment standards are improved continually, the same way as standards for frameworks, work processes and communication.

Patient safety is an important dimension in quality work. We must ensure that we have treatment procedures which prevent adverse events, while at the same time developing a good, safe learning environment. This is the only way we can learn from the errors which are inevitably made, so that treatment can be improved.

When we assess the quality of treatment, the following questions must be answered:

1. Does the treatment have efficacy – in the short and the long term?
2. Are we in compliance with a treatment standard? Is that standard (still) good enough?
3. Does the treatment have adverse effects? Why?
COMPETENT STAFF MEMBERS
Assessment, diagnosing and treatment of persons with mental diseases require general healthcare professional knowledge, psychiatry-specific knowledge, and good competences in communication and societal matters, just as effective and efficient operation of the hospital requires strong managerial competences and competences in logistics, finances, law and many other aspects. A complex set of skills and knowledge must thus be present in order to be able to treat persons with mental diseases with an effective outcome and, from an overall perspective, to be able to run an efficient hospital.

Consequently, the basic questions are the following:
1. Does the unit have the competences required in order for the patient’s wishes and needs to be met and for optimised treatment to be provided?
2. Does each staff member have the competences which enable the staff member to offer the quality of treatment which is required according to the standard?

The basic healthcare professional and socio-professional educational programmes form a good starting point, but competences need to be developed throughout the working life of each staff member.

Further training and competence development are necessary for improvement and for creating value for the patient. The goal is to use the competence profiles of the individual staff members and professional groups and to gather this information in a competence overview, which allows managers and staff members to ensure that the right competences are present at any given time. Competence development is an important tool for ensuring that treatment can be offered at a high professional level.

EFFECTIVE AND EFFICIENT WORK PROCESSES
Effective and efficient work processes must guarantee the patient the most treatment possible, as soon as possible, and organised in a good, appropriate way. It is also important for managers and staff that work processes are well-managed, since this makes for a calm, well-organised working day, which provides better work quality and better work satisfaction. If work processes are not well-managed, things are left to the individual staff member, which paves the way for disagreement and dispute, thereby very quickly involving a risk of errors and a poor working environment. The five lean principles help us understand the main principles of what a good work process is and how it can continually be improved.
**Value.** We must ensure that our work processes have value seen from the patient’s perspective. Through a dialogue with the patient and family members, we must ensure that we know what the patient holds to be valuable.

**Value stream.** The stream of activities and work processes required in order to offer treatment of value to the patient. Only that, which is needed, is to be done – the rest is waste. The staff members working in the process also take part in improving it.

**Flow.** There must be a flow in processes. Waiting time and document piles are waste. It is thus up to management to ensure that work is planned and clear, so that all staff members know what to do and when to do it.

**Pull, not push.** If we are to avoid creating waste (e.g. waiting time and document piles), we must only deliver to the next link in the work process, when the next link in the treatment chain is ready. This means that the next treatment link pulls in assignments. We do not push them away from us or wait for assignments to arrive. We must look at work processes from the other end. At the same time, we must have the service provision which the patient needs and we must continually adapt capacity to demand.

**Continuous improvements.** It takes time to remove waste from a process and, because of new treatment outcomes, standards change all the time. That is why we must ensure that, in a continuous and structured manner, we revert to work processes and improve them.

The five lean principles are important elements of our improvement work and it is essential that everyone understands these principles.

**THE 5 LEAN PRINCIPLES**

- Identify what has value for the patient
- Map value streams and waste
- Create a flow
- Establish pull, not push, management
- Create continuous improvements
Consequently, the main questions we must ask ourselves are the following:

1. How well, how effectively and efficiently, are our processes able to deliver value to the patient?
2. Do we know our value streams – what does a patient pathway look like from beginning to end, and where in this process are there elements which do not create value for the patient?
3. Do we ensure there is flow, e.g. do we avoid document piles, unnecessary changes of responsibility and waiting time?
4. Do we know the preparedness of the receiving therapist and do we adapt our capacity to requirements?
5. Do we create continuous improvements by continually involving staff, patients and their family members in creating improvements of patient treatment, frameworks and communication?
6. Are we using standards?

We should also pay special attention to ensuring whether tasks are carried out at the lowest possible level of cost (the LEON principle). The right competence must be present and there must be no inappropriate changes of responsibility; but when our assessment has been made, work must be organised at the lowest possible cost, while ensuring that professionals spend their time on tasks which are important to solve from the patient’s perspective.

In processes where tasks are moved from one staff group to another, however, it is essential to assess the task, so as to ensure that from an overall perspective it does not become more time-demanding. Small, simple tasks are best performed in one coherent work process with no change of responsibility.

As leaders and managers, we must always focus on the patient and take the responsibility for ensuring that what we do creates value for the patient. The summary provided in the figure on the opposite page thus shows the very necessary link between the questions we address as leaders and the goals we set for ourselves in our continuous, systematic improvement work.
Andel i % hvor undersøgelse er håndteret i KISO-ordinationsark.
Afsnit 2711
4 

Toolbox 
- methods and analytical tools
It is a job for management to help staff members identify problems continually and find durable solutions. Staff members are closest to the daily work and, more often than not, they know best how to solve problems.

This chapter describes six significant methods used in improvement work. Methods which are beneficial to the work of creating continuous improvements. This chapter will also provide a few examples of how managers and staff members have used these methods.

**METHODS:**

**MANAGEMENT BY OBJECTIVES, DATA-DRIVEN MANAGEMENT AND IMPROVEMENT MEETINGS**

In a patient record audit, we find out that our outpatient clinics do not carry out screening for medication side effects on all patients. The medication standard specifies when this screening is to be done. At an improvement event, we decided how to systematise this work and how to monitor developments on our improvement whiteboard. After three months, our data indicates that we have reduced missed screenings month-on-month from 65 to 25 patients. The goal is max. 5. We will continue monitoring developments on our improvement whiteboard.

ANITA FLEMMING, NURSING HEAD OF UNIT

Management by objectives, data-driven management and improvement meetings are becoming household words for everyone in the Mental Health Services of the Capital Region. Weekly improvement meetings have replaced other meeting structures and some units are trying to introduce several daily improvement meetings.
An improvement meeting is a short meeting, approx. 15 mins., at which the leader guides all participants through the discussions. The structure of the improvement whiteboard is such that objective graphs are shown to the left; both the overall objectives and those of the individual unit are written here. The central section of the whiteboard allows all staff members – in the course of their working day – to note important proposals and issues to be addressed, and give new ideas. The right part of the whiteboard has the improvement initiatives already taken; it is thus visible which areas are being addressed, who is responsible and what the deadline is.

The improvement meeting is dynamic, i.e. there has to be a good professional atmosphere, focus on essentials and on work processes. The meeting is normally based on the objectives and measurements which by choice are to be the subject of improvements. A progress report on new measurements is presented and compared with the progress of continuous improvement work described under “continuous measures”, so as to see whether these measures result in the expected improvement. If not, new initiatives must be launched.
We have developed the improvement card on the opposite page to help us understand problems in detail and to cover all of the P-D-S-A circle, so as to ensure that we actually carry out implementation and learn from our experience. The improvement card is used both to describe problems and ideas for solutions, and is designed to ensure that the whole work of understanding the problem and the value, which the solution will bring, in relation to our V are covered.

Long discussions are not held at the improvement meeting – the meeting is short, participants are standing and are gathered around the whiteboard, so everyone can see, and the meeting must progress with a certain speed. At a good improvement meeting, required action is discussed together with the improvement initiatives in progress and how prioritisations are to be made on the whiteboard. The performance of the work is only discussed to a limited extent, since it is up to the individual person responsible to plan the work; the person responsible must also ensure that the specific work in between meetings is actually carried out.

An increasing number of units are beginning to have patients involved in improvement meetings. Some units also encourage patients to put proposals for improvements up on the whiteboard in the course of their admission. These measures create new dynamics and provide new angles to problems as well as possible solutions.
HOW TO COMPLETE THE TEMPLATE?

To be completed as a question/challenge
How can we.....?

Overskrift:
Problemer

Is the solution to be spread/disseminated?
Who could benefit from this knowledge?

Løsningsforslag

What is the problem?
What is the scope of the problem?

Løsning af problemet:

How often does it occur?
What do the numbers say?

Effekt

What could be the reason?
What does the solution look like?

Data og signatur

What do others solve it?
Desired effect?

How do we maintain the effect?

What is the solution to look like?
Which ideas for solutions are there?

What is the problem?
Why should we address this issue?
What is the scope of the problem?
Why does it have to be now?

What is to be examined?
Which data is to be found?
What is to be implemented?

What do we want to achieve?
What value does it create?
How do we know if we have succeeded?

Which results did we achieve?
Did we do what we planned to do?
Did we reach our goal?
What happened?
What went well?
What is the reason why we did not achieve our goal?
What have we learned?

What progress has been made?
Are we running according to plan?
If not, what will it take to correct and adjust in DO?
Are things running as planned according to measurements made?
The leader of the improvement meeting must be well prepared. Typically, the leader spends 15-20 mins. making sure that data has been updated, that continuous activities are progressing, and that the relevant staff members are present, so that reporting about the improvement initiative can be done. The leader of the meeting creates a good, safe atmosphere, where everyone is aware that problems are welcome and that the focus is on processes.

The leader of the meeting is also responsible for the running of the improvement meeting. Meetings start and end on time and the leader of the meeting makes sure that what has been prepared is discussed. After the improvement meeting, the leader follows up on the decisions made. Possibly, a specific plan has to be made with participants who have tasks for coming meetings.

The leader of the meeting may be someone other than the formal head of a unit. Some units hold improvement meetings several times a week; some several times a day; and in those units the leader of the improvement meeting is chosen among staff members.

"It is a good thing that these meetings are not held behind closed doors with no access for patients. I am quite good at painting my whole life black, so I might be wondering about what is going on at the meetings if I was not allowed to sit in. What are they talking about, I might think."

PER, PATIENT

"I have been surprised that, at the improvement meetings, patients involve themselves in many different aspects of everyday life. For example, about accreditation, which we have discussed at quite many whiteboard meetings. Patients have been active and made proposals for our accreditation work. All in all, I see patient involvement as a great benefit to both parties, also in regard to whiteboard meetings."

METTE BRUUN IBSEN, NURSING HEAD OF UNIT
HOW TO CONDUCT A GOOD IMPROVEMENT MEETING

• Prepare well if you are responsible for the meeting.
• Explain (several times) the purpose of the meeting, how to read graphs, why it is important to measure x and y, etc.
• Avoid too many measurements at a time and make it easy to see if goals have been reached or not.
• Place everyone close to the whiteboard, so that everyone can see what it says and can get involved.
• Use a standard agenda; adjust if needed. Make rules for a good improvement meeting.
• The improvement boards must be visible at the workplace – also in between meetings.
• Celebrate successes in all sorts of ways.

I think it is important to have the board in a clearly visible, eye-catching place in the unit. And for the issues that are addressed to be significant and make sense to the staff group. Once the staff members find that they have real influence on how problems are solved, commitment automatically grows. So you have to allow space for improvements to come from the floor.

DARIUS MARDOSAS, ACTING HEAD OF CLINIC

We have made good progress with management by objectives and with data-driven management. In support of our work, we in the MHS of the Capital Region have developed our own measuring system, PLIS (Psychiatry Leadership Information System), which is accessible to everyone. The examples given below show how objectives and measurements can be displayed. It is essential that everyone is able to see objectives and measurements in such a way that it becomes clear to all that the initiatives launched to create improvement actually work. Easy data access also makes it possible to be curious as to how others are doing, so that we can learn from each other.
**Belt restraints – number of patients**  Objectives and measurements at MHS of CP level

**Belt restraints – number of patients**  Objectives and measurements at centre level

**Belt restraints – number of patients**  Objectives and measurements at unit
It is also important to be able to see developments in the areas focused on, and that data is available with adequate frequency, so that people can remember what happened, and so that timely follow-up can be made, which could be every day, every week or every month.

The management by objectives loop; problem escalation
Often an issue is first defined at clinical level, where staff members discuss it. If the issue cannot be solved in the unit, it is taken up to centre level. Specifically, the head of unit is given the task of writing a note to centre management explaining the problem, and the note is placed on the centre management improvement whiteboard.

At the next meeting of the centre management, the issue is discussed. If the centre management can solve the problem, it will; but if not, the problem is taken up to the hospital level. The result from this level comes back to the centre level and then to the unit that brought the problem to attention.

Issues may also be raised at the executive hospital management improvement meeting. For example, the executives want to reduce the number of patients who are readmitted. The communication then goes in the other direction, from the executive hospital management to the centre and from the centre to the unit. A shared goal is identified and this goal is broken down from hospital level to centre level and further to the relevant units.

In this way, everyone is working with shared, overall goals. This system is called the management by objectives loop and has the purpose of ensuring that identified problems can easily be escalated to a higher management level if needed, and that relevant staff members and organisational levels are involved in solving a given problem.
THE IMPROVEMENT WHEEL P-D-S-A

ANCHOR
Anchor what works (Act)

P
Plan (Plan)

S
Does it work (Study)

D
Carry out (Do)

CONTINUOUS IMPROVEMENTS

Make a standard
Practice the standard
Avoid relapses

Look at what is happening
Understand why what is happening is happening
What is the new goal?
Find a solution which can bring you to the goal

Look at what happens
Does it work as intended?
Did we reach the identified goal?

Carry out an experiment or introduce the new solution
PLAN-DO-STUDY-ACT (THE IMPROVEMENT WHEEL)

The improvement wheel has been a known method for many years in the Danish health service; we use this wheel systematically. In many ways, it offers a simple description of our entire approach to our work with continuous, systematic improvements, since it describes the work to be launched and the way to do it, when a problem is identified.

Two parts of the improvement wheel require special attention: Plan and Study. These two stages need to be elaborated. The point is that there might be a tendency to jump straight to solutions without having a proper understanding of the problem.

When a systematic process is facilitated, it often turns out that the solutions chosen did not solve the problem. There has not been adequately thorough planning and analysis – and often no attention to how communication to the whole organisation is to be carried out. Furthermore, the effects of implementation have not been studied.

The point is to understand.....problems

1. PROBLEM
What is the problem?

4. SOLUTION
What kind of solution does the analysis indicate?

2. CAUSES
What are the causes of the problem?

3. IMPACT
Which factors have the highest impact on the problem?

The analysis may consist of:
- Measurements, e.g. of the causes and frequency of errors
- 5 x Why
P = PLAN is characterised by PLANNING

**Problem & Goal**
- Identify the problem
- Establish success criteria

**Analysis of the Problem**
- Find the cause
- Look at data

**Establish Solution & Plan**
- Establish a possible solution
- Prepare an implementation plan

P = PLAN

When a PLAN is used, work is characterised by systematic planning. A number of questions are raised, such as: What is the problem? Why is it to be solved? What is the scope and frequency? What data may throw light on the problem? What value is the solution to create? It is important to pay much attention to this stage, since otherwise solutions may be taken which do not really solve the problem. A thorough analysis at the planning stage takes time.

D = DO

Before launching major changes, a trial period is a good idea. Instead of having all units, all patients or all colleagues involved in a new solution at once, it is possible to have, for example, five patients, family members or colleagues test the solution chosen. Such a trial often means that small or big improvements can be made to the planned solution, following which the end result will be better. At the DO stage, the leader monitors implementation based on the plan made by staff as part of the planning stage.

D = DO is characterised by EXECUTION

**Implementation**
- Pilot trial with the chosen solution

**Follow-Up**
- Status
- Progress

Staff members are very good at putting up notes on the whiteboard with issues to be addressed, and I think one of the things we use the P-D-S-A circle for is to leave the quick-fix model, where we would say “there is a problem; let’s solve it”, and instead make a stop and try to find what the problem is really about. We examine whether we are solving the actual problem by just taking action, or whether we need to look at other functions and other things in the department, so as to find the best solution. I think this is where P-D-S-A thinking is gaining more ground – also among staff members.

SIGRID MATTHESEN, NURSING HEAD OF UNIT
**S=STUDY**

Studying the result of an implementation of a new treatment, a new work process, or any other new initiative introduced should not be neglected. The result should be assessed on the basis of whether it created better treatment, better patient safety, more satisfaction, or whether it released resources.

In the planning stage, success criteria are established; these are compared with the result achieved. Consider whether adjustments are required, whether the solution should be disseminated or perhaps dropped completely if the expected result did not materialise. If it turns out that the problem still exists, even if the new solution has been implemented, start up the P-D-S-A wheel all over. Perhaps the problem was not described correctly. Perhaps the solution was not right, or perhaps patients and staff members see the problem completely differently? If that is the case, new analyses and new solutions must be initiated.

**A=ACT**

The last stage in the improvement wheel is the adaptation of a newly developed standard, dissemination in the organisation, and continuous follow-up on the improvement, until it has been well-anchored with everyone.

If it is found that the implemented solution has generated the right result, describe it in a standard (guideline or instruction), and if the issue is of a general nature, the solution should be disseminated and implemented more broadly across the hospital.

The gain is to be visualised, and if the result has resulted in a good gain, this is celebrated with managers and staff members. If time has been gained by making better work processes, it is decided what this extra time is to be spent on.
I remember the first time our lean facilitator told me that now is the time for a management seminar and you will be presenting some of your improvement results. And I said – improvement results? I really don’t know anything about that. But then he pointed to areas, which I had not really thought of as improvement work. You have to focus on the improvements you have made. And you need to present them to the people who actually made them. You have to go back and say – look: This was really well done! So they can feel that the change actually enhanced our standard and made a difference, instead of the old situation, when whenever you had taken a new initiative, it was gone, when it was over with.

JANNY SØRENSEN, NURSING HEAD OF UNIT

We have worked with P-D-S-A from the very start – our unit was basically planned on that basis. The unit was started up at the same time as the right to treatment and the package pathways were introduced, and we have planned our work processes to match the new requirements introduced in regard to treatment. Since then, we have worked to spend some staff days every semester to look at our practices and evaluate the things we had planned at the previous staff days. We use this to take a look at our concept and the way we have planned our packages. When changes are introduced, e.g. when we received a massive increase in our budget for initiatives in 2016, we also hold a staff day and plan how to succeed, knowing that we have to take in a much higher number of patients. Subsequently, we evaluate and make changes if needed. So we use the structure of the P-D-S-A circle.

We use much of the thinking in the P-D-S-A circle. Sometimes we are also very concrete and make an A3; but in practical and concrete terms, we are more used to working with post-it notes with activities and responsibilities and who is to follow up on the improvement whiteboard. However, the thinking behind the P-D-S-A wheel is what lies behind it all.

PIA RUBIN, SENIOR CONSULTANT, HEAD OF UNIT
STANDARDS
Standards are being used all over the Danish health system. There are treatment standards, pathway descriptions, policies, guidelines and instructions, which are developed on a continuous basis with the sole overarching objective of achieving better or more treatment for patients.

It is important to focus on how standards are prepared. In too many cases, standards that may well be fine become the subject of a lot of resistance, because the purpose of them is not clear, so the introduction of a new standard is perceived as criticism. It is thus important that the work of developing good, meaningful standards is carried out in a collaborative effort involving managers, staff members, professional specialists, patients and their families.

‘Why make standards?
- To ensure that all patients with the same symptoms and diseases receive the same treatment in the best, known quality
- Shared standards are the foundation for ensuring that you can improve together, not individually
- Standards result in less wasted time
- You can get help from colleagues in busy periods and in case of absenteeism and holidays if there are standards to be complied with
- Easier training of new colleagues
- Fewer errors and less rework. Better flow
- Improved working environment, because everyone knows his or her role

One example of standards could be the professional guidelines on medication for patients. In a group of specialists in psychopharmacology and of clinicians, a description is made of which drug that is suitable for which disease conditions, and these drugs are prioritised. Another example is the pathway description for the assessment of psychiatric patients. Here, specialists have described the diagnostic tests and deliberations to be applied in order to provide the best treatment pathway for a given mental disorder.

Work processes are also standardised, which makes it clear for staff members how treatment is organised. One case in point could be the development of week plans in the outpatient clinics.

“As a manager, you have to take things a bit relaxed – not present ready-made solution, but listen more and be more involving, so as to have more people contribute to solutions. This is how you create shared ownership of problems – and in this way things go much better than if we as managers are very proactive in presenting proposed solutions. Doing so will only generate more resistance.
DARIUS MARDOSAS, ACTING HEAD OF CLINIC”
Standardisation is carried out at all levels. A unit standardises what concerns that unit only, and a centre standardises what concerns that centre only. However, at the overall level, the hospital standardises more and more professional and organisational processes, which it makes sense to streamline for all patients. The development of standards at hospital level generates much bigger possibilities of utilising specific professional knowledge, since all of the hospital’s specialists are available.

I see a great many advantages from standardisations. I like to have patient pathway descriptions for outpatient services and to also integrate these in 24/7 facilities. I see that by standardising treatment, you help the patients as well as the staff. However, there MUST be room in the standards for individual considerations and personal goals. I do believe it is possible to have that.

LOUISE BANGSGAARD, HEAD OF DEVELOPMENT

This spring we had to engage three new staff members. One of the things I was rather worried about was how we were going to orient three new staff members all at once. The existing staff members themselves identified some of the things which the new staff members in the unit found difficult, but which were second nature to experienced staff members. Quite ordinary processes, such as “what to do when you receive a patient?” “What to do when you discharge a patient?” “Where do we place the duvet and the pillow?” “How do you get hold of housekeeping?” etc. Some of the staff members sat down and developed a checklist for receiving and discharging patients, and I think this was a very useful item to address. Because it turned out to be a bit of an eye opener for other staff members, too; some that had been here longer, but suddenly found out that there were some tasks to be performed. We took a look at guidelines concerning suicidal screening - and oops! It turned out there was something about having to call the patient’s home three days after a patient with suicidal risk during admission had been discharged. So, all of a sudden a great many staff members saw the benefit from having checklists. And of course it is very “lean-like” to have standards, but the fact that they themselves found out that they were needed, when we were to orient so many new staff members – only to find that they might actually also use such checklists in their own daily work – shows that this works.

SIGRID MATTHESEN, NURSING HEAD OF UNIT
There is no joint description or definition of what a good standard is; however, Danish Standards writes the following, which covers the concept very well:

“A document for joint, repeated use, specifying rules, guidelines or characteristic activities or desired results thereof. The document has been adopted by consensus and adapted by a recognised body. The intention is to achieve optimised order and quality in a given context.”

For a standard to be used, it must be experienced as helpful in daily work, so we are working with the description below to ensure that this happens:

A good standard is a description, picture, form or similar, which helps the person performing a given work task to carry out the right task in the right way at the right time in the right quality.

Normally, this requires that basic professional knowledge exists, so that it is possible to refer to this knowledge in the standard, e.g. about how to write a medical history.

When standards are prepared, the description should thus, as a minimum, contain an answer to the following questions:

1. Why is this task to be performed using this standard? Why is that important?
2. What is to be done?
3. In which sequence?
4. And how?
5. Who is responsible?

Example of standard for the transfer of patients between units:
GEMBA – GO OUT AND SEE WHAT IS HAPPENING
In Japanese, Gemba means: production, the real place, where value is created. Freely translated, go out to where core services are being delivered and see what is happening.

Gemba is the only Japanese word, we use in our improvement work – for a funny kind of reason. When we started up our improvement work, some staff members and managers adopted the method, so from the very start gemba became the word that was used – before anyone has been able to decide whether the method should be given a Danish name.

When you work with improvements, you must go out to where things are happening. You cannot plan improvements in distant meeting rooms. Going to the gemba means you monitor the specific work process where it is carried out, when it is carried out. Everyone can and should go to the gemba as a natural part of being curious as to whether colleagues or others have created solutions that could be copied.

Gemba is an improvement method, where you watch work being performed, you ask questions, you discuss and challenge what you see with the clear purpose of improving the framework and conditions for a given treatment or work process.

“ It is important that we get ‘away from home’ and open up our minds. We tend to walk in the same circles and frameworks. We need to meet others and find out what they are doing and thinking.

VIBEKE JØRGENSEN, NURING HEAD OF UNIT

Why go to the gemba? Most of us are present in our work every day quite naturally. The difference here is that you move around with a purpose. There is something you are curious to learn more about; this could be:

- To get an insight into how patients experience their meeting with us and with their treatment
- To get an input from staff members as to what can be done better
- Since value creation is in patient-related tasks in the units, you need to know, learn and challenge daily work processes
- To find improvement potential that can be taken forward
- To show interest and respect for the work being performed
• To obtain an insight that can help work to be based on facts, not just hunches, and so as to develop a shared picture of the daily work
• To discover which standards are being used or should be used, and subsequently to contribute actively to implementation of these standards
• To follow up on improvement initiatives that are being processed

When you go to the gemba, always comply with the three-step process outlined below:

1. Preparation
   • What are you curious about and why, and what is the link to the perspectives in the V.
   • The connection to/placement in relation to the value stream.
   • Consider how you satisfy your curiosity in a structured manner.
   • You may want to agree with the unit/person, when the gemba is to be carried out and what you are curious about and why, and possibly who will participate.

2. Implementation
   • Ask wondering and open questions
   • Ask questions not intended to check things
   • Ask process-related questions (process/transition linking activities to the value stream)
   • Possibly, use a standard
   • Take notes as you go forward

3. Evaluation and feedback
   • Give constructive feedback by telling about your observations – basically in verbal form.
   • Say what thoughts you have on the basis of your observations and what you are going to follow up on.
   • The contents of your feedback may result in an improvement card for the improvement whiteboard with the purpose of subsequent problem analysis
   • Focus on mentioning the strengths you have observed (remember – praise the good) and the challenges (help towards improvement).

We have agreed that all therapists join three other groups in the course of a year to see how they do things in these other groups. Of course we have a manual for how we work in groups, but still it is different when A and B work with a group than if C and D do it.

PIA RUBIN, SENIOR CONSULTANT, HEAD OF UNIT
Skabelon til den deduktive tilgang

**Gemba besøg – notater**

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<th>Dato:</th>
<th>Afsnit:</th>
<th>Hvem:</th>
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**FØR BEREDELSE**

1) Hvad er din hypotese? 2) Hvilken delproces, hel proces eller overgang er i fokus?

Orienter dig om relevante instrukser og vejledninger eller værdistrømsanalyser på området inden din gemba...

**Hvor i V’et ligger din nysgerrighed?**

<table>
<thead>
<tr>
<th>Værdi for patienten</th>
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<th>Kvalitet i behandlingen</th>
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<th>Kompetente medarbejdere</th>
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<tr>
<th>Effektive arbejdsgange</th>
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**PÅ GEMBA**

Hvad hører og ser jeg?

Hvad bed jeg særligt mærke i – hvad skal jeg følge op på?

**EFTER GEMBA**

Noter til tilbagemelding / hvad og hvornår?

Besvar din hypotese, blev den bekræftet eller afkræftet og hvad er videre forbedringer?

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On a number of occasions, gemba has given me a really good understanding of issues among those we cooperate with, e.g. in the receiving unit, where we feel that the problems that may exist should be solved in a given way – seen from our perspective. But when you get to know the challenges that the others are facing, you can make much more appropriate proposals for how we can move forward together. So, gemba can give you a really good understanding of why others think the way they do. This can help towards better coherence.

DARIUS MARDOSAS, ACTING HEAD OF CLINIC
IMPROVEMENT EVENT

When it is decided that a major, complex issue is to be solved, work is carried out at an improvement event. This applies to all levels at the hospital. The small, fast-acting working groups of one or two staff members, which solve minor issues taken up at an improvement meeting, cannot solve major problems. This requires more time for the retrieval of data and for analytical work, and it takes several persons and different professional groups and a facilitator to help turn analyses and proposed solutions into descriptions and communication plans.

An improvement event is a type of work, which is structured and timed in advanced, and where staff members have a good amount of time to work through a problem and a solution. It is decided which leadership level that owns the problem and which leaders that are owners of the process. The leader does not necessarily have to participate in all of the analytical work and problem-solving work, but must have a close dialogue with the working group.

Experts are appointed for issues, i.e. professionals who work with these issues in their daily work and persons closely involved – often a group of four to seven people. Depending on the scope of the problem, two to five meetings are planned, each approximately one week apart, for the preparation of the event itself. Data is retrieved, visits may be paid and patient interviews may be carried out. All of this is done to develop an in-depth understanding of the problem before the actual event takes place. Subsequently, the number of days needed to solve the problem once and for all is allocated (typically three to five days), where all strings are gathered, solutions are designed, and new standardised ways of working are prepared, together with an implementation and communication plan.

In the bed units, the challenge was often to find the time to go into detail with improvement work. When we finally found the time to meet in a working group, the meeting was often max. two hours, and then it could be several weeks before we were able to meet again. This made it very difficult to maintain work processes and our motivation. For example, we wanted to work with improvement of the implementation of cognitive behavioral therapy in the unit and broaden the cognitive treatment of the patient to cover the whole day and night. When we were given the opportunity to work at a three-day improvement event, we thus chose to work with the implementation of cognitive behavioral therapy in the unit. It is interesting how much you can benefit from two preparatory meetings and three full days spent on working with a topic in detail.

We are a small working group with representatives from the staff group and from management and we had a facilitator guide us through the three days. We were able to address everything and on the third day we had a finished product and a thorough implementation plan, which we were ready to communicate to the rest of the staff group at the next staff meeting.

It is now one year ago we had our improvement event, and there is no doubt that both the cognitive behavioral therapy in the unit and the professionalism of the staff have grown to reach a higher level.

KATRINE VELBO NIELSEN, ACTING NURSING HEAD OF UNIT
The group has a lean facilitator to facilitate the overall process, i.e. preparation meetings, the holding of the event, the follow-up on the group’s work with implementation and result creation. The work is based on a standard developed for the big events; from this standard, the relevant level can be chosen, depending on the nature and scope of the problem. The table below shows our overall standard for preparation, holding and follow-up on an improvement event.

As can be seen, this is a major piece of work that is started up, and there is a lot more material and help to be had from the Intranet and from lean facilitators.

I can still remember when our lean facilitator came and said to us that now we were going to have such an event, and I thought....An event? What on earth is that supposed to mean? Well, actually we would be spending three days talking about some tiny problem. It seemed completely absurd. I had to remove 6-7 people from their daily work and they would spend all that time going into detail with such a tiny problem. It did not make sense to me! I came from a world where quick solutions were the name of the game. There is a problem; we make this change – problem solved. And then we would inform staff. It might take half an hour. That was why I thought this new event would be a waste of a lot of time, and it was even presented to us as something that would save us time. I just did not get it. Today, I see it very differently; it really helps. I have learned to be patient. I have learned not to attack solutions, but to go much more in to the substance and unfold all details, and make sure to get all parties involved. It really does take a lot of time, but today I understand how it makes sense. So, you might say that once you learn to work with it, you appreciate the value of it more and more.

JANNY SØRENSEN, NURSING HEAD OF UNIT AND CLINICAL HEAD OF UNIT
5S
The method is called 5S, because it consists of five words all starting with an S.

5S describes five simple principles for keeping an overview and for keeping order at a workplace. This saves staff members time otherwise wasted in a busy working day with changing staff members in a unit, where three shifts work 24/7.

The principles are as follows:
**Sort:** All work remedies are sorted according to their function and any insignificant items are removed or placed in a remote storage room. Colour codes or other simple, visual methods are used to quickly have an overview, e.g. of when something might be too old. Materials must also be placed in a way that reflects the frequency of their use. One case in point is storage rooms and offices in units where a small amount of space often has to hold many different things, so the need to have things sorted is often pressing.

**Systematise:** Establish a good, visual system, which all staff members can understand, and where you mark where materials have their place, so that everything has its own place.

*Have the crash carts been filled up as they are supposed to? Are things where they are supposed to be? Are there paper piles that have been left for a long time – discard them. Do not look into them. We try to clean up our unit on a continuous basis, so that things do not pile up. Neatness and clarity are really important.*

PIA HUSUM FREDERIKSEN, NURSING HEAD OF UNIT
It is also essential that materials be placed close to where they are used. This saves staff members a lot of walking. One case in point illustrating a well-expanded system is the medication rooms, where clear markings show where medication is, so it gets easier to find it. The same systematic approach benefits offices, storage rooms, patient lounges, etc.

**Scrubbing and sweeping, that is systematic cleaning:** Hygiene is a central topic at hospitals and housekeeping needs to comply with standards. Rooms and items which are often overlooked must also be cleaned systematically. This applies to such items as toys, window blinds, computers and patient community rooms with pillows, blankets and games. Staff member clothing should also be seen in a hygiene perspective.

**Standardise:** The importance of standards has been described previously. However, also the way standards and instructions are shown clearly and where they are placed also needs to be addressed. This applies for example to the safekeeping of instructions for staff members on the maintenance of equipment such as blood glucose measuring device, ECT unit, breathalyser, etc. User instructions must be supplemented with guidelines on cleaning, calibration and maintenance.

**Sustain:** This means that the above-mentioned four points should be carried out by everyone in the organisation. Naturally, the manager has overall responsibility, but the goal is for staff members themselves to sustain the 5S principles, possibly on the improvement whiteboard.

> Our rather small office in the unit was used as a duty room, a coffee and lunch room, a documentation room, a patient record storage room, a patient board room with their data, as well as being used for conversations among therapists and as a contact point for patients and their families, for telephones, for supervising physicians arriving to the unit, and much more. The room was messy and there was paper and stuff taking up space without having been systematised.
> At an improvement event, we did the 5S. We wanted clarity, neatness, systems and the introduction of new discipline, so that the room would continue to be appropriate in its layout.
> At a three-day improvement event, we prepared the systems, wrote the instructions, and were able to change the whole office. Working in the room after that was a great satisfaction.
> **ELSEBETH BREDAHL MØLLER, NURSING HEAD OF UNIT**
ANALYTICAL TOOLS

A great many lean tools exist which are useful for analysing and improving work processes. The lean facilitators often knew which methods are suitable for which processes. In the following, a description is offered of a few, important analytical tools.

VALUE STREAM MAPPING (VSM FOR SHORT)

Most improvement initiatives start with mapping of the work processes in a patient pathway; waste in the processes is identified as improvement options. This is done through value stream mapping, where all actions are clarified on a piece of paper several metres long. On the paper, horizontal lanes are drawn, and all participants each write in their own lane. The patient (or other “customers”) is written at the top, and in the lanes below all the professional groups that have a stake in the pathway are entered. At the bottom, horizontally, time is entered – hours or days, depending on the pathway.

Typically, post-its in four colours are used:

- **Participants**
- **Short description of an action**
- **Short description of waste/poor work process**
- **Short description of suggestions for improvement**
Value stream mapping is carried out by a group of staff members who work in the process and therefore know it well.

When the value stream mapping has been completed, the staff group knows where there is waste in the work processes, and probably a number of improvements have been suggested. These are now systematised and processed in detail.

We wanted to improve and simplify our work processes regarding patients coming in for elective ECT treatment – especially, we wanted to shorten the time, which patients spent on it. Furthermore, we wanted to save physicians' hours in regard to recurring admissions as well as the ECT treatment itself.

Before, these patients were admitted – with everything this meant in terms of staff time and use of resources in general. They turned up in the emergency unit and the duty physician wrote an entry in the patient record; the patient was put to bed and transferred to the master unit. The following day, the patient was taken from the master unit to the ECT treatment and then back to the master unit, from where another physician discharged the patient, so the patient could be taken home. And this all repeated itself at weekly intervals, month after month, year after year.

We gathered a staff group to see what improvement potential there was. This group started by mapping all actions in the process for all parties involved. Both patients and staff with knowledge of ECT, as well as colleagues from anaesthesia, participated.

The value stream mapping revealed a lot of waste. Plenty of unnecessary actions, which had no value to the patient. Work processes were changed, and today things are done in a much simpler and clearer way, and with far fewer people involved. Patients for elective ECT treatment now go straight to the ECT unit and are treated as outpatients. Everything is done in a few hours with no unnecessary transitions and changes of responsibility. The actual ECT treatment is carried out by specially trained, registered nurses – the only physician involved is the one who has monitored the patient as an outpatient all the time. These patients in ECT maintenance treatment now spend much less time at the centre – and we have freed up physicians’ time previously spent on admission, treatment and discharge. All in all, this corresponds almost to one full-time position.

HENRIK SØLTOFT, HEAD OF CLINIC
WASTE – WE IDENTIFY ACTIVITIES AND PROCESSES WHICH DO NOT CREATE VALUE FOR THE PATIENT
What does not create value for the patient? Do we have activities and work processes, which do not add value? These questions are of the essence, when we want to understand how we can make our work more effective and efficient and have more time for the treatment of our patients.

Activities and work processes which do not create value exist both in the treatment environment, but also for example in unnecessarily long meetings not focusing on patient treatment, reading of unnecessary cc e-mails, preparation of long minutes, which nobody is going to read, etc. So it is not only in patient-oriented activities we must spot waste.

In lean, we look at waste in the way that your find areas, activities and processes with room for improvement. Waste thus equals improvement potential.

Remember, waste is permitted – as long as it is deliberate and necessary. There are necessary activities, which do not generate any direct value for patients, but which secure patient treatment and running of the facility. For example, blood samples must be ordered in the IT system, patient records must be written and food must be prepared. All of these are necessary activities which the patient does not see.

The nine types of waste are described below.

TYPE OF WASTE: OVER-SERVICING
Over-servicing means you deliver more to the patient than the patient needs, i.e. carry out activities which are not necessary.

The risk is that the patient is maintained in a passive role and does not fully utilise his or her own resources; furthermore, the therapist’s time could have been spent better with another patient. Over-servicing may also mean over-servicing each other, e.g. by writing minutes that will not be read.

TYPE OF WASTE: CHANGE OF RESPONSIBILITY
Unnecessary or poorly synchronised change of responsibility from one staff member to another or between units or sectors takes time and creates uncertainty in the patient. If, for example, the patient record entry has not been made, when a patient is transferred, there will be lack of clarity about the treatment and staff members spend time making calls to colleagues in the sending unit.
IMPROVEMENT WORK IN THE MENTAL HEALTH SERVICES OF THE CAPITAL REGION OF DENMARK

TYPE OF WASTE: WAITING TIME
Waiting time is about the patient waiting for the next activity that creates value. Patients wait for the first therapist, who sends the patient on to the next therapist. Then the patient waits for examinations, for the unit round and for a transfer, etc. Staff members wait, too. They wait for an IT system, a case, a task, information, an approval, a reply, a colleague, etc. Waiting time is seen at meetings, where participants do not turn up on time, and waiting time occurs if there is a lack of structure in the training of staff members. Uncoordinated work processes make staff busy and result in waiting time from one therapist to the next, as well as tiring waiting time for the patient.

TYPE OF WASTE: INTERRUPTIONS
If there is an inappropriate or unclear work rhythm or work description, staff members typically ask their colleagues. Colleagues are thus interrupted in the task they were doing. Also, if there are new staff members in a unit and their orientation has not been properly organised, so that a new colleague has to spend too much time asking an experienced colleague. Interruptions may also be a result of inappropriate layout of the workplace, e.g. if there are many people in a shared office, where everyone disturbs each other.

TYPE OF WASTE: ERROR
Errors may hurt the patient. So errors must be corrected and this takes time. Work processes must be described in standards, so that everyone knows procedures and processes. Error may relate to patient safety, e.g. if a patient got the wrong medication. Errors may also be minor ones, such as failure to prepare for a meeting or being late for meetings, which results in poor or wrong decisions, or failure to register a new staff member who thus has no password for the IT system, thereby wasting time.

TYPE OF WASTE: UNUSED HUMAN TALENT
Knowledge which is not put to use means that an organisation basically does not utilise the competences of its staff. All units must know the competences of its staff members, so that they can be put to the best possible use in solving the overall tasks for the unit. Furthermore, the many proposals for improvements from staff members should be utilised as well as possible. Waste also exists if there is a lack of knowledge-sharing and sharing of best practices across the hospital.

In 2014, all our work processes were reviewed, so as to see whether there were things that could be eliminated. I only took part at the end of the process, but we ended up with changing several different things, e.g. how to handle patient record entries. It was decided that we no longer needed to print them. A lot of time was spent, when people in one of the outpatient buildings wrote entries and printed them; then they went over to the other building and placed the entry in the patient record. When we found out that there was no requirement to have a printed patient record, we eliminated this. That gave us a lot. It also meant that we got the staff members on board. They could really feel what was happening – it was a benefit to them – and in that case lean is great!

ANN COLLEEN NIELSEN,
SPECIALISED PSYCHOLOGIST, HEAD OF UNIT
TYPE OF WASTE: SELF-MADE VARIATION
If work processes and treatment services are not standardised, disparity may exist in the treatment offered and the overall service to the patient. This may mean that too little or too much treatment is given, or even the wrong treatment, and that there is much variation in the services provided. If work processes are not based on standards, but are left up to the individual staff member, you cannot – as a staff member – be certain that the patient pathway has been dealt with appropriately in process stages and activities before and after your stage. This increases the risk of errors, waiting time, poorly synchronised change of responsibility, and unnecessary processes.

TYPE OF WASTE: INFORMATION RETRIEVAL
If information is not easy to see or retrieve, and staff members do not know where to find it, there will be waste in information retrieval.

TYPE OF WASTE: UNNECESSARY PROCESSES
Duplication of effort is one of the most frequent, unnecessary processes, e.g. where a patient is asked the same question or is presented with the same information several times, because it is unclear who has the task of asking or informing. Staff members are generally good at identifying waste. However, not all waste is visible to the individual staff member – but perhaps his or her colleague can see it. When waste is identified, there must be a good, secure atmosphere in the staff group, since there will be an assessment of activities which many staff members may have carried out in the same way for a long time, so changing an ingrained work process may lead to resistance.

“Reducing waste in work processes is essential to this thinking. Waiting time is wasted time. Where we used to have a lot of waste was because we had a great many patients coming in to be detoxified. Actually, this is about 42% of our patients. They used to sit far too long in the waiting room. This meant that their detoxification process was extended – and so was their whole treatment process. What we did was we turned a complete patient pathway upside down. We carried out value stream mapping and found out that we need to put these patients to bed immediately and start their treatment immediately. This actually meant that we reduced waiting time, which was wasted time for our patients. If we took them according to the triage level, they would often sit and wait for two or three hours. Our initiative made the process much more efficient, to the benefit of our patients.

PIA HUSUM FREDERIKSEN, NURSING HEAD OF UNIT

“
IMPROVEMENT TEMPLATE/A3
-UNDERSTAND THE PROBLEM AND DESIGN SOLUTIONS

When a major issue has to be solved, we carry out structured work using the P-D-S-A wheel on an A3 sheet. That is why this improvement template has been given the name A3, which refers only to the size of the paper. The A3 is used in the total improvement process, which begins when planning starts and which does not end until a given result has either been implemented or another P-D-S-A process has been started up. There can thus often be several months of follow-up on an A3.

The work on an A3 looks like something many people have tried before with different project management models. However, the A3 is more than that. The A3 makes it easier to get to the core of the problem to be solved and why it is to be solved. The A3 steers the process in a simple, implementation-oriented way; at the same time, the A3 clarifies the results in a broad sense. This means that follow-up on the chosen solution must be ensured, and the result must be monitored.

The A3 starts by first defining: Who is the target group, which is often patients or their families, but it can also be another unit, a municipality or other staff members. Subsequently, a description is made of who owns the A3 – i.e. which leader is the decision-maker, and a description is also made of who will participate in the improvement process.
It is very constructive for the process and for the choice of solutions to involve patients and their families in the work. This can be done through interviews before starting an A3, so as to get more detailed information about the issue. It may also be done as the process moves forward, e.g. by testing a proposed solution on the target group. Patients and their families may also participate in all or part of the work process as members of the working group. How and when such involvement is to be effected depends on the issue to be addressed; the working group will decide on this matter at the initial meetings.

**THEN THE A3 IS SPLIT INTO SECTIONS:**

1. **What is the challenge? What is the improvement about?** Which problem has been identified and what is our knowledge about the problem? It is important to have detailed knowledge about the problem and clarity as to why improvement is important. The work at this stage must be very thorough, and often the problem has to be redefined a number of times. Here, the process is in PLAN in the P-D-S-A wheel.

2. **What is the current situation?** Value stream mapping will be carried out regarding the process to be improved, and a decision is made as to where the process will start and end. Here, the process is still in PLAN in the P-D-S-A wheel.

3. **What are the wishes concerning outcome and quality goals?** When the value stream has been mapped, goals will be set for the improvement. Which outcome do we want from the future situation? And how can we measure? Work here is with SMART goals (S=specific; M=measurable; A=attractive; R=realistic, and T=time-determined). The description of the outcome is important. Is it increased patient safety, quality improvements, higher satisfaction, flow, increased efficiency or other things we want as the outcome? The process is still in PLAN in the P-D-S-A wheel.

4. **Cause analyses are carried out, and accessible data is analysed.** For example, 5 x Why is used, or other methods to find the reason/causes of the problem. We are not looking for solutions to symptoms, but to the underlying causes. All relevant data must be procured, possibly via PLIS, other IT systems or patient records. The process is still in PLAN in the P-D-S-A wheel.

5. **What is the future situation to look like?** At this stage, the working group looks at how the optimal situation could look like, and which changes this would entail. Risks of the different solutions are discussed, as are pros and cons, costs, etc. This is the first part of the DO stage.

6. **A plan is made.** The different tasks are described in a form in the A3. What is to be done? Who is to do it? When is it to be done? Furthermore, this little form contains a progress column for all the sub-tasks; these columns will be completed later in connection with the follow-up. Under this item, a communication plan is developed, which decides who to communicate with and when. Then the plan is started up and adjusted continually if needed. This is the DO stage of the P-D-S-A wheel.

7. **Results are monitored;** has the goal we set for ourselves been achieved? Other than the goal, it is also important to look at whether the outcome which the working group expected can be measured. This is done when the solution has been implemented, but the goal and the expected outcome are written specifically in the A3. It is also agreed when goals and outcomes are to be discussed and evaluated. When this evaluation is done, often weeks to months later, a decision will be made as to whether the goals should possibly be revised. In case of efficiency enhancement of a work process, it is significant for the leader to ensure that time is well re-invested. Now the process is in STUDY in the P-D-S-A wheel.
8. At the end of the improvement process, it will be evaluated what went well and what did not go that well. This item is intended as a learning exercise for future situations and for starting up another improvement process. Perhaps, a standard is to be written or amended, or other corrections have to be made. This is ACT in the P-D-S-A wheel.

9. Knowledge sharing and the dissemination of good experience are important to address. Under this item it is discussed who could benefit from knowing about the improvement, and why they would benefit from this knowledge. In the dissemination strategy, the executive hospital management has a special responsibility for ensuring that there is a system to collect and disseminate improvements. This is the last item in ACT in the P-D-S-A wheel.

By using the same simple model for problem identification, problem analysis, problem solving and communication, follow-up on results and knowledge sharing, it is easy for staff members and managers to cooperate on improvements across units and centres. The A3 model is simple to use, when disseminating the solution, and should be posted close to the improvement whiteboard, so as to provide an overview of the number of current improvement processes and the results achieved.

5 x Why: Understand the problem in detail

When a problem is to be understood in detail, it must be addressed systematically. Often, an issue will meet with a quick suggestion for a solution, and a number of the staff members who happen to be present may take action. It may end well, but it may also be that only the symptoms of the problem are addressed, while the underlying problem is not actually solved.

The 5 x Why method is simple, quick and systematic as a way to go into detail with a problem. When value stream mapping is used, this method is often used, and it may be used by everyone.

5 x Why is a tool, where you ask a problem “why”. When you have the first answer, you ask why again and you go on doing that five to seven times. The goal is to get down to the real cause, thereby removing the problem permanently.

An example:

Why 1: Why are so many people late for the whiteboard meeting?
Answer: Because it is held at the time when all patients have just gotten out of bed.

Why 2: Why is the meeting held at that time?
Answer: Because it was the time, when most people are present.

Why 3: Why are the most people present at that time?
Answer: Because patients need contact and everyone has to start sessions.

Why 4: Why have the meeting at a time, when everyone is very busy and patients need contact?
Answer: We are all a bit stressed about the time; we want to talk to patients, but we also want to be at the meeting.

Why 5: Why don’t we hold the meeting at a time, when the unit is quiet?
Action: The meeting will be held in the afternoon going forward.

As shown in the example on the next page, 5 x Why offers clear advantages, since the problem is split into elements and made more concrete in a way, so that some of the reasons why the problem exists become clear. In this way, action can be taken, which removes the problem once and for all.
I think 5 x Why is interesting. It surprises me how far you can get into the details of the issue. When you are good at using 5 x Why, this opens up for talking about something completely different than you had thought in advance. A case in point is a working group on flows in open units; I am a member of that group, and we identified a problem which meant that the flow was not high enough. It had to do with our cooperation with outpatient psychiatry. We used 5 x Why to find out why our cooperation with the outpatient clinics is not working well enough. And as we looked at the details, we found out it was not a question of lack of will to cooperate; it was something very concrete – like it might be difficult to find each other’s telephone numbers. There are staff members who find it difficult to send an e-mail, find the e-mail address in the system. Many do not know that in the outpatient clinic, they use the Outlook calendar, so you can actually just check there when you can expect them to answer the phone, i.e. when they are not in session with a patient.

SIGRID MATTHESEN, NURSING HEAD OF UNIT
Our experience is that this work is best if there is one person involved in the exercise who does not know anything about the problem. This helper can ask the entirely open questions, because the person does not have the burden of knowledge.

When a 5 x Why has been completed, the answers may often be split into different tracks. This means that there can be more than one cause and there also more than one solution to an issue.

One example of this point could be the wish of a unit to carry out all subsequent interviews following the use of coercive measures.

Why 1: Why do we not carry out all the subsequent interviews after the use of coercive measures?
Answer: Because we have no overview of who has been subjected to which coercive measure. Often, the patient has been discharged or transferred, before we have the interview. Also, some colleagues find the topic very difficult to talk about.

This will be divided into three tracks:
Track 1 is the overview of the coercive measures
Track 2 is patients being discharged or transferred
Track 3 is the fact that colleagues find it difficult

It is now possible to work with solutions within one, two or all three tracks.

PARETO ANALYSIS: 80/20
There is often more than one cause for a problem. It may be useful in order to have clarity about which causes are the most frequent ones to display the causes in a pareto analysis. In a pareto analysis, also called a 80/20 analysis, all the individual causes are listed and placed in a diagram. Typically 20% of the causes will have an influence on 80% of the errors or problems. By focusing our efforts on the 20% of causes it will thus be possible to achieve a considerable effect on the goals.

In an emergency department, the problem was that too many patients waited too long to be seen by a physician in the emergency department. The example on the next page shows an analysis of 360 patients, where 10% (36 patients) waited for more than 1 hour in the emergency waiting room. Of these, 28 patients (80%) represent 20% of the causes.
Before the above-mentioned pareto analysis was made, the standard view was that there were many different reasons why patients waited. Following the analysis it was clear that there were two main reasons why the patients waited too long, and efforts could then be made to remove these causes. Specifically, it was ensured that during peak-load periods in the emergency department there was an extra physician present, just as physicians’ conferences and training were placed at a time of the day with a smaller work load.

**Reasons for the waiting time:**
1. The physician is busy with other patient interviews (16 patients)
2. The physician is attending a conference/training (12 patients)
3. Waiting for an interpreter (1 patient)
4. Waiting for triage, since the nurse is helping in another unit (1 patient)
5. No vacant interview room (1 patient)
6. IT-breakdown (1 patient)
7. Patient has gone for a walk (1 patient)
8. The patient is eating and wants to wait (1 patient)
9. Change of shifts, and the patient was not triaged quickly (1 patient)
10. A very restless patient occupies all staff resources, so a new arrival has to wait (1 patient)

This was a review of the toolbox with methods and analytical tools. We could have chosen to present many more, but we have chosen to stick to a few tools and methods, but some very effective and efficient ones.

It takes quite a lot before you feel comfortable with using these tools and methods, and to know when to use them and for what. It is essential that, as a manager and leader, you gain your own experience working with these tools and methods. The first few times it is wise to get the assistance of more experienced leadership colleagues, lean facilitators or experienced staff members. As we gradually get to know the tools and methods, we can teach our staff members how to work with them.
IMPROVEMENT WORK IN THE MENTAL HEALTH SERVICES OF THE CAPITAL REGION OF DENMARK
Leadership actions
As leaders in a hospital focusing on continuous, systematic improvements, we have a new, challenging job. We must lead in a new way. To some, this new leadership role will be straightforward, but to many this role will require a lot of practice and will challenge existing habits, thinking and patterns of action.

Most of us involved in leadership in the Mental Health Services of the Capital Region today “grew up” within the hospital system and often became leaders with the ambition of improving patient treatment and doing things that would benefit others.

When you start as a new leader, you are quickly confronted with the many daily challenges. Difficult clinical issues, patient pathways that are not sufficiently coherent, finances that may be difficult to come to grips with, staff members who expect interesting work assignments and a good working environment, patients and family members who want more information and influence, new laws, rules, and frameworks from politicians and many other challenges.

This is the field of tension in which we must thrive as leaders, finding energy and having the courage and ability to involve everyone in continuously creating better treatment. We find this energy by seeing good results. Good treatment outcomes for patients and satisfied family members, as well as staff members who turn up for work with high professionalism and good spirits; in addition, the feedback and support you get from a committed executive makes you thrive as a leader.

We also experience difficulties about being a leader, since as leaders we often have to find out ourselves how the job is to be done in order to become a success. It is very much up to each leader to work on the performance of leadership tasks. Working in an improvement culture, we thus basically want to improve our leadership methods at all levels. In an improvement culture, we all help each other and one of the main tasks of all leaders is to help those closest to him or her, regardless of leadership level, so that they may carry out their main tasks with the best known quality and highest efficiency and effectiveness.

Leadership tasks vary, depending on your place as a leader in a hospital. However, if we work with the same perception of good leadership, supported by a shared set of methods and tools, we will be able to help each other in our daily work, while continuously improving our leadership. This is essential, since it is a precondition for being able to carry out continuous improvement of our daily patient treatment work.

This chapter introduces what we have chosen to call “leadership actions”. Leadership actions – of which there are eight – describe how we, as leaders in the Mental Health Services of the Capital Region, should act to improve work. The descriptions of leadership actions are closely linked to and refer to methods and analytical tools which are fundamental to improvement work. Leadership actions do not provide an answer to everything and do not constitute a description of “leadership virtues” or principles as such; rather, they constitute an attempt at providing inspiration for focus points in daily leadership work, when you are a leader in an improvement culture.

This chapter describes why the individual leadership action is important to carry out, and what is important to do. Furthermore, many leaders have helped by talking about their experience working with leadership actions. The intention is for leaders to be able to develop an overview of each leadership action, but hopefully also to see all eight of them as interconnected, so that it makes sense to carry out all of them. Leadership actions only make sense if they materialise as behaviour which is actually reflected in improved results in the form of better treatment efficacy, more efficient work procedures, and higher satisfaction among patients, their families and staff members alike.
We are leaders because we want to secure the best possible quality, effectiveness and efficiency in the performance of complex assignments in complex work processes solved by several persons, professional groups, units, instances, etc. It is thus quite essential that, as leaders, we have set the direction for this work in a meaningful way and that we work with meaningful goals and measurements, so that together we can see if we are on the right track.

That is why communication is a core leadership task, where we talk with our staff about direction, goals, framework and conditions, so that everyone involved understands the task and the reason why we do what we do. This is of the essence if people are to feel involved and motivated in their daily work.
KNOW YOUR VALUESTREAMS AND ELIMINATE WASTE
This first leadership action is the foundation for many of the other leadership actions, since we are here basing ourselves on the fact that our ability as an overall hospital to deliver the best possible treatment in the best possible way will always depend on the quality and coherence of the work processes we as leaders have designed and implemented.

Consequently, as leaders we must have the following questions fully under control:

1. What are our most important value streams? What do they look like, specifically? Are they visible to all?
2. What is working well and not well?
3. Why – do we know the reason?
4. Who is involved in the value streams, and who is responsible for what?

Basically, all units and departments have described and analysed their most significant value streams via the VSM method, so we can learn and understand what everyone is doing across the patient pathway. It is a precondition for being able to learn from each other that we can show each other what we work with, so it is important to make the value streams and the underlying work processes visible to allow everyone – staff, patients and their families – to understand, describe and analyse the way we work.

It is thus our responsibility as leaders to ensure that all staff members have the necessary knowledge of how their own work supports the value stream and how it is linked to the work of their colleagues – to the benefit of patients. Just as it is our responsibility to ensure involvement in the continuous, systematic improvement of the way we work.

In our experience, you – fortunately – cannot describe a value stream or a work process without also describing the waste that exists in the current way of working, so again it becomes our responsibility as leaders to ensure that we actually remove the waste, thereby solving the problems. The waste analysis, where we use the nine types of waste, is a useful way of spotting waste.

The word “ensure” is important here, because one of the ambitions with improvement work is to involve everyone in solving problems, so we have to get away from leaders and key personnel trying to solve problems on their own, since staff members are the ones closest to the problems, so they have the best conditions for solving them.

Instead, as leaders, we must ensure that there is a method for understanding the cause of the problem or the waste, so that we can actually remove it, instead of doing patchwork solutions, where the problem or waste is very likely to come back or be shifted to the next link in the chain. The problems that arise with the transfer of patients, when the necessary information has not been completed by the units, is a case in point.

It thus becomes our shared knowledge of the value streams and the significant work processes, and our leadership management work on this background, which together form the precondition for having a good working day and for improving the parts of processes which are not working, while we work to develop the necessary competences.

How we work systematically with creating continuous improvements is described in the leadership actions on the following pages.
CONDUCT MEANINGFUL, VALUE-ADDING IMPROVEMENT MEETINGS

The continual holding of improvement meetings is essential if we are to succeed in creating an everyday work situation, in which it is quite natural for staff members to try and solve problems themselves, while they are treating patients also. There are a couple of preconditions if improvement meetings are to create value and thus be good meetings:

1. All participants know why we are having the meeting
2. We all agree on the goals we are striving to achieve
3. We all know that we are focusing on value streams and work processes

Why hold frequent improvement meetings at all, at least once a week? The most important thing for us as leaders is that we know the answer to that question and make it clear to the staff. If not everyone sees the purpose clearly, the improvement meeting will be a waste of time.

So, what is it we want to achieve as leaders? What is it this unit or department is supposed to do? And how do we succeed in getting there?

These are the questions which our work on the improvement whiteboard is supposed to be able to answer every day or every week. And that is why we as leaders set goals and measure whether we are moving in the right direction. That is, where we treat our patients as well as possible, using the best known quality and using the best possible work processes.

"I think that when I show our activity numbers for the unit, I make quite a point of commenting, so the numbers are accompanied by words, telling staff that the numbers actually explain how we are doing, and so that everyone knows where we want to be and why. For example, we are actually able to have admission periods of around 30 days, as we are striving for, but it is also important to explain why we want to be there. I make a point of that. The data-driven management part has to be understandable to oneself and to the staff you show the data. Staff members need to understand why this matters. If not, the numbers will make no sense.

JONAS ASTRUP, SENIOR CONSULTANT, HEAD OF UNIT"

We learn that there is always something we can improve; the leaders who have been working with improvement work the longest have had the task of ensuring that improvement meetings are held at least once a week. Everyone who has been at it for that long will tell you it has been difficult to keep this work and the meetings at the improvement whiteboard going for that long. It is a crucially new way of working as a leader. A way of working which basically changes the interaction between management and staff, because we now make it clear what we are working with and whether or not we are on the way to succeeding. This is not an easy role to assume as a manager, because it requires, among other things, that as leaders we move away from being those that have all the answers to being those who ask involving and curious questions, so as to ensure that we are working with the right things in the right way.
However, this is a necessary thing to do if we are to succeed in creating a framework which involves all those closest to the value-creating work, so as to ensure that the work is done as well as possible. Fortunately, most experienced leaders will also tell you that, when you succeed in this, you have laid the foundation for a very positive development, where everyone feels they can contribute actively to the improvement work of the unit and help ensure that the everyday situation improves for both patients and staff. One of the ways this is achieved is that, once they have developed a certain amount of routine, many leaders let the responsibility for holding improvement meetings pass from one staff member to the next. This creates a dynamic situation and shared ownership of continuous improvement work.

One important leadership task in connection with the improvement meetings is to provide a space and an atmosphere, where participants are comfortable about asking critical questions, including questions as to whether these improvement meetings actually provide the intended value. The way of working thus also becomes essential. We must be curious as to how we can best involve people. Here, it is all important that people understand that we are focusing on the work processes. The greatest amount of waste by far comes from work processes which have not been appropriately designed, or which are not used as intended. It is very rarely one person’s actions that are the reason for the problem, so everyone can participate in improving the work processes which they form part of themselves, without things getting personal.

The centre managers and the executive hospital management hold an improvement meeting together once a week. At first, it felt a bit awkward to stand up and review data and only spend 15-20 minutes. The executive hospital management would very quickly engage in wide-ranging discussions, and as a leader of the whiteboard meeting I then had to make sure the group moved on in the process. Now, we have learned the method and we all find it much easier to quickly define the issue, analyse the data and get the further work going. Everyone in the executive hospital management participates very actively. This way of working suits us very well. I also think it is a great experience when data is reviewed in my presence at the whiteboard in a unit. Many staff members and leaders are good at interpreting data and explaining the improvement measures launched in the unit. This gives me a good picture of how and with what they are working in the unit, and which issues are repeated in many units.

MARTIN LUND, MANAGING DIRECTOR
It is our responsibility as leaders to ensure that everyone is heard, whenever relevant. This can be a difficult task, especially in the bed units with 24/7 staffing and shifts of staff members present; we are still looking for better models to deal with this.

The improvement whiteboard itself has been designed in such a way that there is only room for a limited number of tasks. There is room for five measurements and three-to-five improvement initiatives at a time. This is intended as a helping feature to ensure that the focus is on solving the most important problems, before embarking on new initiatives. This requires that we, as leaders, are also able to focus and are able to prioritise among competing improvement initiatives and problems to be solved. One guideline for this work is that it is important for tasks on the improvement whiteboards to be solved relatively quickly, so as to allow room for new improvements on a continuous basis. If a given improvement requires the work of more than three persons for three weeks, we should consider how this improvement work is to be carried out, e.g. by preparing an A3.

The work in between improvement meetings is what actually decides whether it makes sense to hold the meetings. It is thus essential that, as leaders, we assume the responsibility for making the necessary time for staff members to do both – work with patient treatment and have the necessary time to carry out improvements and remove waste in work processes. This should be incorporated in the week plans used in the units as one of the preconditions for achieving what we want to achieve.

It is thus important to solve the right problems, using the right methods and tools, so that, as leaders, we can ensure that time is being spent sensibly.

PROMOTE CONTINUOUS, SYSTEMATIC IMPROVEMENTS

Working with systematic improvement based on knowledge and facts is more difficult than it sounds, and it takes practice. As leaders, we must thus lead in asking the following questions:

1. What is the problem? What do we know about it? What is the reason why it occurs?
2. To whom is this a problem? How do we involve the right people in this improvement work?
3. What will it take to solve it?
4. What value will it create if we solve this problem?
5. Which measurements do we use to show that we are on the right track?

If we are to master this, we must be confident with the methods and the tools, since they are a precondition for being able to work systematically with measurable improvements. In other words, it is essential that, as leaders, we work all the time to use these methods and tools, so as to make us better at assessing when to do one thing and not the other. For example, when will be useful to use 5 x Why, or ask staff members to do value stream mapping before the next improvement meeting with a view to understanding the cause of the problem?

This takes experience. And, fortunately, we can be aided by facilitators, skilful colleagues and staff members, our own leaders and – hopefully – this book.
As leaders, we must be systematic in our approach to the work, and in our follow-up to ensure that the work is being done. One of the things that help us as leaders in this work is to write things down and use the tools and methods which we know will work. That is why the work at the improvement whiteboard is so important. It helps us. Also when it comes to follow-up.

Problems are welcome in an organisation, where continuous improvements drive developments forward. Everyone should feel comfortable and free to present a problem.

It is important for us as leaders to know the difference between the different types of problems so that we use the right tools and methods to solve the problems and stop ourselves from taking a musket to kill a butterfly or spending time on much too lengthy analyses, when instead we could have experimented with different possible solutions and then followed up to see if they gave the desired result.

The prioritisation matrix in the middle of the improvement whiteboard is to be used to ensure that we first look at the size of the problem.

Minor problems, which may well be very significant, should be solved in the unit, often using the improvement whiteboard.

Some problems are so small and we have so much knowledge about them that they can be solved immediately. However, here we have to pay attention, because if the same problem turns up repeatedly, it is probably because we did not solve it systematically, so we need to do things in a different way from what we have been used to.

At many improvement whiteboards today, they work with systematic improvement cards. This card help formulate the problem as precisely as possible, just as we are also forced to decide on the expected value creation even before we start. In other words, this helps us prioritise whether to work with this problem now or later.

If it is decided to start up a specific improvement task, the improvement card helps us, because of the way it is structured, to break down the task into manageable stages, to ensure there is progress from one week to the next, just as it helps us get through the P-D-S-A wheel.

When working on major problems, often intertwined with the work processes of other units or requiring more time to be solved, it is often necessary to start up an A3/improvement template together with the others involved.

Finally, it may also be necessary to work with solutions to a problem by holding an improvement event, where we as leaders assume the responsibility for solving a particularly complex issue in cooperation with staff and, possibly, patients, their families and associates. This work is also based
on the A3, which is used in the overall improvement process, starting when planning begins and not ending until a given result has either been implemented or another P-D-S-A process has been started. When an A3 is used, the amount of work involved can thus often take months.

In all improvement work, it is our task as leaders to involve staff, patients and their families closely in the improvement work, since different perspectives and views on a given problem often lead to better solutions.

The good leader ensures there is cooperation and interaction about improvement work. The good leader does not dictate solutions and cut through, but asks involving and wondering questions, so that the group together will find a joint solution and therefore also understand and accept the solution they end up with.

In all work, it is important to be able to assess the value of the time spent on a specific task. That is why improvement work at all levels must be followed by pertinent, meaningful and preferably simple measurements and data, which we can use to see whether we are on the right track and correct or celebrate, depending on the continuous results.

The entire understanding of systematic improvement work is based on being able to improve and work together. The alternative is that everyone is doing things their own way; we know that this involves a risk of poorer treatment, just as there is a higher risk of errors. Finally, we cannot cooperate on improving our work or the total patient pathway if we do not work according to joint standards.

With this understanding, it is often the case that the solution found in improvement work also involves building up a new standard which can help us do the work in accordance with the best known quality and with the higher effectiveness and efficiency. As an alternative, we may adjust an existing standard, or just ensure that the already existing standard is actually known, accepted and complied with.

This is what the next leadership action is about.

“With lean it is now ok to work on behaviour, to use a coaching approach as a leader, to dare to take a look at other people’s behaviour – and your own. To dare to ask for feedback. It has become an important part of improvement-oriented work that you dare to work with yourself and each other. Improvement work has resulted in new leader behaviour. As leaders, we need to get out there and be close to people. This has given me a different perspective on my own leadership role. It is great to get out into the units, while at the same time you are of course not to ‘take over’ the leadership of a unit. What I must do is provide the conditions for things to be vibrant – by ensuring a high degree of involvement, creating a calm, meaningful atmosphere and by setting a clear direction.

LOUISE BANGSGAARD, HEAD OF DEVELOPMENT"
REQUEST STANDARDS: WHAT DOES “GOOD” LOOK LIKE?

We have plenty of examples of standardised processes, which are working really well. Cases in point could be the medication process, ETC and DAT, and we have even developed entire treatment pathways intended to ensure that we can cooperate about patient treatment in a systematic way.

The adopted standards are a precondition for us as leaders to be able to lead a coherent, multi-disciplinary team that provides the best possible assessment and treatment of our patients. And once we have standards, we can also improve our processes together, because we have a shared understanding of the starting point.

If standards are not complied with, there is normally a reason. Either the standards are not good enough, or the people who are supposed to use them either do not agree with them or do not feel ownership of them. If we experience this as leaders, it is our job to make sure the standard makes sense, or to have it adapted. Experience from the first years of improvement work shows us that it is essential for us as leaders to:

1. Ask for the most significant standards, to make sure they are known by all and help to ensure compliance.
2. Change our own behaviour, i.e. by following standards in our own leadership work. What we ask others to do, we must also do ourselves.

Experience from the first years of work with continuous, systematic improvement is that we all see a need to do this better, and so it is important that, as a leader, you have to think carefully or perhaps even be a bit lazy, when it comes to looking for good standards. The point is that we can learn so much from each other – or steal with pride, if you like. What have other similar units or departments prepared? We must examine whether we can base ourselves on their work and internalise it, instead of reinventing the wheel.

As we get better at this, we ourselves begin to ask for standards for our own leadership work. How do I hold a good improvement meeting? How do I keep an eye on and develop my staff members’ competences? How do I myself make time for improvement work? And what are the most important questions to ask in order to help?

In the centre management at the Child and Adolescent Psychiatry Centre, we were very much inspired by our trip to ThedaCare, Wisconsin, in November 2016, and we now really wanted to work actively with changing our role as leaders. We made room in our week plan for daily morning leadership rounds, where heads of clinics and of development go visit the individual unit leaders and have a brief conversation with them based on a sheet with standard questions. This works very well – both the heads of clinic and head of development and the unit leaders are pleased with this way of working. It ensures that there is frequent contact, quick clarification of a number of questions, a possibility to follow up on implemented measures, fewer e-mails, and fewer meetings. At slightly longer intervals, our centre manager meets with us heads of clinics and heads of development in the same way – and our manager actually joins us in the leadership rounds to the units as soon as he can. We will be developing this concept on a continuous basis.

ELISABETH BILLE-BRAHE, HEAD OF DEVELOPMENT
The contents of the standards developed on the basis of the above are of course determined by the specific situation in the specific unit, but there is also a lot of help to be gained by asking management colleagues what they do and systematically allow time to discuss the leadership task in itself when we get together in different management forums.

Our experience is also that when we succeed in supporting core tasks with good standards, this becomes one of the preconditions for establishing a good, calm workplace, which delivers good patient treatment. The next leadership action will deal with this in more detail.

CREATE STABILITY AND CONTROL THE CORE TASKS

One important responsibility in leadership is to ensure there is a description of roles, responsibilities and work assignments, which creates good, coherent patient pathways. This applies at all levels in the organisation, and all leaders must focus on this. Leaders close to clinical work are often the right persons to take up issues at unit level. We do that through questions, such as: Do we have the core tasks in our unit under control? Have we ensured that the patient pathway has been described and is known? Have we supported our work processes with good standards that help staff do the work in the best possible way? Are we creating the value for patients, which we want? And are we systematically developing or work processes and our competences?

One important part of the work of managing the core tasks is that, as leaders, we must assume the responsibility for managing capacity:
1. Have we described a status and a plan for our current patients?
2. How many new patients are on the way?
3. Which pathways should they follow?
4. How much work will this entail?
5. For whom? How? For how long?

Leaders close to clinical work must be able to answer these questions on the basis of systematically obtained information or they must ensure that competent professionals are in charge of this task.

We can obtain a lot of knowledge by carrying out value stream mapping. Such mapping ends up with a description of who is working with what, when, how and for how long, and it thus forms the basis for the supporting standards which describe this in more detail.

Managers at centre and hospital level must also focus on supporting the leader who is close to the clinical work to ensure that there is a calm atmosphere and that patient pathways are well-managed. Issues should be taken to the next level in the organisation if there is a need for measures going across the organisation or special initiatives which require the involvement of leaders at the next level.

When there is a good overview of patient pathways, this often gives rise to work being done on major initiatives. Consequently, over the last few years, the hospital has worked a lot with creating good management tools or improving existing ones. At unit level, too, intensive work has been carried out to describe pathways and work processes.
In the bed units, the work has focused on creating a flow between the emergency units and the bed units, just as work as been carried out to create a flow and an overview of patient-related tasks on the patient whiteboards.

Particularly in the psychotherapy clinic and the clinics in child and adolescent psychiatry, they have worked hard for many years to manage the questions listed above. They have developed pathway programmes, flow systems, capacity management sheets and patient overview lists, so as to help leaders manage the core tasks, at the same time as the need for patient treatment was rising and requirements concerning assessment and treatment were sharpened in legislation, while only a limited amount of extra resources was added for this work.

This has been – and still is – a major effort; we have learned a lot from it and it has meant a lot to patients and therapists. Today, we do not have the waiting time for treatment that we used to have a few years ago, and the pathways are now in a much more regular framework, which has been a precondition for succeeding in treating more patients at the right time and in a more uniform way.

One way of having calm work processes is by using week plans which ensure that time is allowed for the necessary treatment work and the other necessary work assignments. This applies to the team as a whole, as well as to the individual staff member.

I create a calm atmosphere and focus on core tasks by means of capacity management. I am the one who has to ensure we actually have the required resources available in the unit. This focus on having adequate resources available goes in the direction of “pull” management. The challenge is that you also need to motivate your staff to understand that the fact that some colleagues are away on training programmes, etc., is a good investment for the unit. The point is to have an open dialogue saying that we really want this high level of training in the unit. However, we also have to look forward all the time to make sure there will be a calm period again. The whole thinking about improvement work is that it frees up time for patients. The more systematised your work is, the more your work processes will be second nature, so you do not spend so much energy on performing your tasks, and thus you can get on to actual treatment work more quickly. If we look at the general level of training and education, the point is that the better your training and education, the better you are at focusing on the work – which frees up a lot of time for treatment, for patients, and for safety and security.

PIA HUSUM FREDERIKSEN, NURSING HEAD OF UNIT
The above-mentioned work of describing the treatment work in more detail has also made it more visible that we need to develop our professional competences on a continuous basis, so as to make sure they match the patients’ needs. For example, not everyone in the outpatient clinics had been trained in the therapeutic direction now to be used, just as not all newly qualified registered nurses in the bed units were able to make the initial psychiatric assessment of the patients. The responsibility for ensuring that this targeted competence development occurs rests with the manager. The next leadership action deals precisely with this.

We created a calm atmosphere by managing the daily running of the unit well. We believe that if we have the daily running of the unit under control and deliver what we are supposed to in accordance with the activity and intake budget, then we will not be subject to constant bombardment and pressure from people interfering. That gives us a calm atmosphere. We try to pass that on to the staff, explaining that we have a shared interest in having this well-driven outpatient clinic – to the benefit of patients, who will receive treatment without having to be on a waiting list. However, in addition, we get a really good, predictable working environment which means that we can focus on treatment – not on waiting lists, etc. Waiting lists and things like that are “noisy”.

ANN COLLEEN NIELSEN, SPECIAL PSYCHOLOGIST, HEAD OF UNIT
ASSUME RESPONSIBILITY FOR INSTRUCTION, GUIDANCE AND FURTHER TRAINING

Since the quality of our efforts always depends on the competences of our staff members, there is a need for us as leaders to assume the responsibility for ensuring that continuous, systematic, measurable competence development is taking place. This applies to clinical professionalism, but also in relation to improvement work, IT, communication, economy, etc. As leaders we must ensure that our staff members work well together and that the individual person is able to fulfil the necessary roles at all times and is able to develop in that role.

The way we ensure that this happens is by working with competence overviews and competence profiles at staff member level, unit level and centre level.

Each staff member prepares his or her own competence profile based on an overview of necessary competences in the unit. Staff members assess themselves on the following, using a standard template:

1. Cannot perform the task independently – has knowledge only
2. Can perform the task independently
3. Can instruct others – is an expert in this field

Furthermore, it is also possible to specify if this competence area is not relevant to the individual staff member at all.

It can be difficult to assess oneself the first time it is to be done; we as leader must assist by explaining more specifically what the task is about, or by making a comparison with other colleagues who, for example, are obviously the experts.

Based on the overall competence overview, we as leaders together with the staff member can plan continuous, targeted competence development. As with all other work, it is important that we share this knowledge, so it can be a good idea to post the confirmed competence overview, so everyone has the opportunity to contribute to each other’s development.

“I have often experienced that a staff member came to me and wanted to attend a course in a professional subject, stating that “it sounds interesting”. Often I have thought, well, it is a good thing that a staff member wants to acquire new knowledge, but is this precisely the competence which the unit needs? For many years, I have wanted to have an overview of the competences of each staff member and to discuss with them how they can develop. Obviously, this development should go in the direction that the patients in the unit need. When we started working with competence profiles in the whole unit, it became very clear what was needed and where the individual staff member needed to develop, and which overall development initiatives the unit as a whole needed. This has given rise to very good dialogues with the individual staff members, especially when we have the annual job appraisal interview. It is a lot easier now – and more satisfying – to make professional development plans. Since the whole centre is working with competence profiles, we can now also ensure that a great many shared initiatives are taken at the centre.

ULLA DREMSTRUP, NURSING HEAD OF UNIT
At the end of the day, it is our responsibility as leaders to make the ultimate plan, showing:

1. Who can solve which tasks
2. Who should be working with whom to learn from the best
3. Where the unit as a whole needs development.

It is important that the plan has a relatively short time perspective, e.g. two or three months.

This way of working with competence development is always based on the needs we have as a group, and based on the fact that there is almost always someone in a group who is able to train others.

It is only when entirely new knowledge is required or actual certification is to be effected that we use courses. When we do, the purpose is often to ensure that the person or persons who attended the course will train the others when they come back home.

Example of competence table.
We have looked to see what competences staff members must have to be able to carry out the work of an emergency room, which sees those that are doing very poorly – and which is the entry to the whole mental health service system. That is why we have chosen that all registered nurses working in this unit must attend a training course to become triage nurses and within some years we also want them all to be emergency nurses. We have made good progress; I now have 20 triage nurses and 9 emergency nurses in this unit. These are the competences we need at the forefront in the emergency room; these are the ones that need to be available on shifts where no management is present, because they are top-gear to deal with the acute patient who is doing poorly. This also means a lot for safety and security in the unit, because staff members are systematically trained in this way, so this enhances the level of safety and security. There is always an experienced, skilful colleague on duty, so if you have some that are less experienced in this work, they always have someone they can do sparring with and rely on for assistance. This also means that I can quickly increase the level of a newly qualified registered nurse, because she always has an experienced, specially trained colleague she can use as a model. This also means a lot for recruitment and for staff maintenance, because if you work at a place where there is investment in high professional skills, registered nurses will want to work there. We work with competence profiles for each staff member. For each staff member there is a profile, which tells us where we are right now, and where the staff member is to develop more competences. We discuss these profiles once a year and also at the annual appraisal interview. Some of the training required may relate to something simple in the daily work – it does not always have to be a matter of attending a high-profile training programme. Perhaps the person just needs a bit of extra knowledge in a specific area. PIA HUSUM FREDERIKSEN, NURSING HEAD OF UNIT

The overview of competences can also be used to assess whether the right professional group is performing a given task. In an organisation, where we are working with continuous improvements in all parts of the hospital, we need to assess continually whether there needs to be improvements in the way work is organised to ensure that tasks are carried out at the lowest possible cost and without inappropriate changes of responsibility.

When it comes to improvement work, we in the Mental Health Services of the Capital Region have chosen an approach which says that leaders have to be the experts, so leaders must be the coaches that help staff members get better at using the right improvement methods targeted at the problems we need to solve. This means that, as leaders, we must always be the three’s in the competence overview, when it comes to improvement work.

As described, it is also important in the work with competence development that we are able to make the work visible.

VISUAL MANAGEMENT

When we work with continuous improvements, it is an advantage if what we work with and go for is visible in a very concrete sense, e.g. on the walls, on the improvement whiteboard, etc.

If, as leaders, we do not make visible what is important and what we are working to improve right now, this work will not be a shared effort. By making things visible in our everyday work, we involve staff members who are right in the middle of things in their everyday work.
There are four questions it is good to ask oneself in this connection:

- What is important and why this right now?
- How do we make it visible?
- How do I use this knowledge to manage both the daily treatment work and the continuous, systematic improvement work?
- How do I involve people well enough in this work?

It is important that we are able to make it visible what progress we have made on the significant key parameters and how our improvement work is going. We must make these points visible with data, so that our dialogues with each other will be based on facts.

By managing on the basis of facts and sharing facts, we will solve the causes of the problems, not just the symptoms of the problems.

Today, many leaders are working with three whiteboards, so as to have the best possible overview of what is important:

1. Patient boards, designed for each unit. This includes quality management board, like the Amager board or the QPI board.

2. A whiteboard or a wall with the most relevant measurements for the unit, the department, the centre of the entire Mental Health Services of the Capital Region.

3. Improvement whiteboards.

The Amager board
Without me taking the credit for it, because credit is due to the nursing head of unit – we have a performance board, which provides a really good overview. It has a horizontal and a vertical function. The horizontal is the individual patient pathway; what is it we are auditing? Is it being done in the patient pathway as we want? Have family members received a phone call within 24 hours; have we done fall screening; are nursing plans reassessed in a timely fashion? A lot of nursing stuff and a lot of physician’s stuff. It provides an overview. Vertically, you can then read if the individual initiative is being implemented. This provides a good overview and from a managerial point of view it provides an excellent tool to show us whether there are places where we need to make a special effort.

JONAS ASTRUP, SENIOR CONSULTANT, HEAD OF UNIT

The leadership action on visual leadership and management is also a matter of making it easy to do things right. This means that, as leaders, we must ensure that the relevant standards are available where they are to be used and not hidden away in a drawer, on the P-drive or on the Intranet. As human beings, we cannot remember all the things we are supposed to be able to do in such a complex working environment as psychiatric assessment and treatment, so we as leaders must help with this.
Consequently, visual management is very much about helping and involving our staff members. As leaders we may well tend to want to be the ones solving things; however, that is not the right strategy, when we want to create lasting, measureable, systematic improvements. Involving the right people is essential if we are to create added value.

In addition making knowledge visible and sharing it ourselves, we must also be curious about other people’s knowledge and data. That is why all data in PLIS (Psychiatry Leadership Information System) is accessible to all, so it possible to be curious about what other people are doing.

This curiosity is actually a cornerstone of improvement work and, in particular, the last leadership action, which is described here.

**GO TO THE GEMBA**

As previously described, gemba is an improvement method where we leaders observe the work being done, ask questions, discuss, coach and challenge what we see, but with the clear purpose of improving treatment or work processes. Gemba is the method where we as leaders learn a lot about how tasks are actually being solved in the organisation we lead. And where we see whether there are elements where we need to make improvements or learn from the best and be prepared to disseminate this way of working to others.

As leaders, we must see and understand the substance of the work by being out there, where value is created for the patient, where diagnostics and treatment are carried out in many complex work processes. Going to the gemba, we also learn whether standards are complied with, and we can discuss the standards with staff members. When all leaders go to the gemba, we create a hospital, where we learn from each other and from the best. We develop an overview of what is going on, where value is created, and we can help our staff solve problems that they need our help to get solved.

I was presented with a problem by our street outreach team. They had difficulties with how to register and document the treatment they provided in their outreach work with homeless people. I did a gemba walk with them to understand their challenges. The gemba clarified the legal, documentation-related and ethical issues facing our outreach staff several times every day. This has meant that the team and I first described the special issue they were facing. Then we found useable, pragmatic solutions, which have the backing of our registration experts. This means that the team can continue with its very special function – outreach work for patients who basically do not want to receive any treatment. We have also been able to establish a good dialogue about the ethical issues. As an important extra, we now have a better basis for gathering data about the results of the street outreach team, which data can be used both for improvement of treatment work and for research. It is very valuable for one’s leadership work to get out there in the frontline, when problems have to be understood and solved.

LINE DUELUND NIELSEN, HEAD OF CENTRE
Gemba is not a platform for criticising staff members and their work. As leaders, the gemba must have a purpose for us, and when the gemba is over, we give a brief feedback about what opportunities we have seen, not criticism, but questions about practices and wishes for improvements that can create value for patients.

The method is also the obvious choice if you go visit another unit or centre, where a given problem has been solved. In this situation, the gemba has the purpose of passing inspiration on to your own organisation.

As leaders in the Mental Health Services of the Capital Region, we have decided to spend two hours two to four times a week on spending time with patients and staff members, going to the gemba.

EIGHT LEADERSHIP ACTIONS – LOTS TO LEARN
In the MHS of the Capital Region, we expect managers at all levels to lead based on the eight leadership actions. However, as with everything else, we have not all made the same amount of progress and are not all at the same level. This is an important realisation, since it is only when we realise that we have something to learn that we can get better and look for new knowledge, which is a precondition for creating an improvement culture.

As leaders, our efforts are essential for the success of improvement work. We need to understand that we can learn from being curious and asking for knowledge defining what “good” looks like.

However, it is not easy and there may even be vulnerable situations, so it is perfectly natural to seek help.

IMPORTANT HELP AND GUIDANCE
In the Mental Health Services, we are used to thinking about supervision, guidance and training in regard to professional development. For many years, leadership development programmes have also been a natural part of developing all leaders.

For us to become more skilful leaders of improvement work, all leaders in the MHS of the Capital Region have a councillor. The executive hospital management has a lean manager who provides guidance; at the centres, the quality and improvement manager provides guidance; all unit managements have the local lean facilitator as their councillor. This is a new way of receiving guidance; we all need to get used to that. A councillor is a person who has detailed knowledge of the eight leadership actions and who can help others acquire knowledge of and experience with these actions, so as to achieve improvements through new leadership behaviour.

Changing leadership behaviour is not easy. Furthermore, receiving guidance as a leader is not always easy. However, it is quite essential that we, as leaders, want to and dare to enter new territory and change our habits and behaviour. This is a journey that takes a lot from us as leaders, but also from the staff members who have to be prepared to look at leadership and managers from a new perspective. As leaders, we run the risk of getting stuck in a specific behaviour, and it takes time and the right attitude from all, when we change our leadership style. The task for the councillor is to offer support throughout this process and support a development in the direction of behaviour based on the eight leadership actions.

When, in a few years time, we have made a little more progress with improvement work, the need for councillors will decrease, because, at that time, many of us will have become much more skilful at this new leadership style and will be able to guide each other.
As a manager and a staff member, you can always seek advice and guidance from the lean facilitator. Daily guidance, in the middle of the work of the clinic, is best. For example, it is obviously a good idea to spend the time just after an improvement meeting to talk with the facilitator about a given issue. In addition, facilitators often come to the units to teach.

LEAN ACADEMY
Over the last approximately five years, all managers in the MHS of the Capital Region have received training in improvement work. In 2015, we established a lean academy which has the task of ensuring that all managers and staff members are provided with training on a continuous basis.

A very special area to be strengthened is the development of our own leadership talents. There are many leadership talents in the MHS of the Capital Region and it is important to spot them and offer them training and coaching so that, when an older leader stops, there are new ones ready to take over.

The lean academy also organises an annual conference about improvement work, at which the whole organisation gets together and exchanges good experience, learning from each other. In both 2015 and 2016, the conference has been very inspirational to many participants. Furthermore, the lean academy will develop different types of events, to which representatives of other lean organisations will be invited as an inspiration for leaders and staff in their continued development.
Improvement work - the next steps
Our world does not stand still. On the contrary. We have a flow of new patients, new staff members, new leaders, new requirements and new guidelines to mention just some of the continuous changes which we need to be able to handle in the best possible way.

With the purpose of ensuring that we can continually live up to our ambition to create the best possible value for our patients and to implement the joint regional strategy entitled Focus & Simplification, we must be committed every day to improving the assessment and treatment pathways of patients in a systematic way together with patients and their families as well as other stakeholders, such as the GP and municipal bodies.

We have made quite a lot of progress and have created excellent results within a short time span. At the same time, we have gleaned a lot of experience; one lesson learned is that it is up to management to create meaning and motivation in daily work and that working with continuous improvements is a natural part of this. Where leaders themselves work with these methods and tools and engage in the work of systematically managing core tasks to ensure that everyone can contribute towards continuous improvements – that is where we see really amazing results, as demonstrated in this book.
The longer we work in this way, the more people will win this experience through their work, and the better we will get as individuals and collectively, since we can now learn from each other on a continuous basis. Therefore, the work of making us even more skilful at using the individual improvement methods and tools will continue, and it will be necessary for us to get better at teaching new staff members and managers who work here in our mental health services, so as to ensure that we can keep up the good development. This is the entire foundation.

That being said, we are able to see that we need to take things even further. Further from the previous focus on learning the tools and methods and on to a situation, in which our leadership actions can contribute to getting us closer to our ambition of having everyone contribute by creating more value for patients through improvement work. This book is a start on that journey, and in the coming years we need to work to get more skilful at using the eight leadership actions.

A set of leadership principles will help us get even better leaders of improvement, because we will have to challenge our own basic behaviour and ingrained habits as leaders to an extent we have not done before. This is probably going to be a good learning exercise, but also a challenging journey; however, there is still progress to be made and a great potential to utilise when it comes to management and leadership.

Finally, it is important to stress once again that we have made a lot of progress already, when it comes to creating an “continuous, systematic improvement culture”, which continues to deliver value to our patients, and we have achieved excellent results within a short time span and under difficult conditions. We must continue to involve patients and their families and create cooperation on current treatment and we must listen to the input we get on what we do well and where we can improve. We must continue learning from each other’s good solutions to joint issues, and as leaders we must develop our own commitment to this work, so that we can help with the above developments and continually ensure that our staff members have the competences required in order to provide the best possible quality to our patients in the most effective and efficient way.
Many centres, many units and many staff members have created improvements in recent years. This chapter highlights some examples for inspiration. The examples chosen represent both big and small improvement events, as well as little everyday improvements; all of these are important.
From feedback to action
-increased patient involvement and patient satisfaction in an intensive bed unit

The unit wanted patients to participate more frequently in concrete improvements in the unit. The unit wanted to carry this out by asking patients to answer questions about their satisfaction on the tablets of the unit.

1. THE SITUATION BEFORE THE IMPROVEMENT

A few patients were encouraged to use the tablets of the unit to reply in a questionnaire about the satisfaction with their period of admission to the unit. This resulted in a very small data volume, so no concrete patient-suggested improvements were launched. There was no red thread; there was no linkage between the improvement work in the unit and the patients' testimonies. Attention focused on quantitative data collection, not the qualitative improvement effort. This resulted in lack of motivation in the staff group.

2. PROBLEM ANALYSIS

The unit used two methods for the analysis:
• Categorisation of types of waste.
• 5 x Why.
This resulted in the following three conclusions:
1. The unit did not use the patients' knowledge and experience in its improvement work.
2. The unit did not use the scarce data, since the data was very inadequate.
3. The staff members were frustrated about the lack of understanding of the involvement process and the use of tablets for data collection. This resulted in further lack of motivation for the task. A number of staff members experienced this as "yet another task". There was no clear linkage to clinical improvement work.

3. SETTING OF GOALS

Goals were set:
• 80% of all patients give a feedback in the satisfaction survey before their discharge.
• 95% of all patients are satisfied with their treatment process.
• Feedbacks from patients lead to quality improvements.
• All staff members know and comply with the standard for patient feedback.

4. THE IMPROVEMENT – WHAT DID THE UNIT DO?

The plan outlined below was implemented:
• Shared plan of the staff group as to when patients should be motivated to reply to the questions in the questionnaire during the evening shift.
• Establishment of a process flow – a red thread in the process and systematic use of data.
• Preparation of standard: from feedback to action.
• A communication plan with four items was prepared:
  1. Discussion of patient feedback at improvement meetings.
  2. Communication with all staff members about what, why and when.
  3. Establishment of a process flow in the unit.
  4. Information to the patients at morning meetings and on the information board in the unit.
• Meeting with key persons and quality staff so as to have help for implementation and technical assistance.
RESULT AFTER EIGHT WEEKS

After approx. eight weeks, the improvement process had resulted in a very satisfactory result.
- 80% of all patients replied to the questions in the questionnaire using a tablet.
- 95% of all patients are pleased with their treatment process.
- All feedbacks from patients are discussed at the weekly improvement meeting.
- All staff members use the standard.

LEARNING FROM THE IMPROVEMENT PROCESS

Staff members took a positive and constructive approach to the task and solved it, because they saw it made sense and was important.

The high level of patient involvement results in more data, which therefore becomes interesting.

Data and patient involvement resulted in more dialogue with patients about quality and improvements in the unit and resulted in concrete improvements.

“...

It has been a super experience for everyone in the unit. Improvements are now based on the patients’ statements and wishes.

BETINA BENNIKE, NURSING HEAD OF UNIT

“...
Implementation of cognitive behavioral therapy (CBT) in the bed units

1. THE SITUATION BEFORE THE IMPROVEMENT

The unit found it difficult to make progress with the implementation of CBT. Problem target lists, interdisciplinary treatment conferences and psycho-education had been introduced, but the work was not systematic. There was not enough knowledge in the unit, and only few staff members took a systematic approach to CBT.

2. PROBLEM ANALYSIS

At a three-day improvement event, brainstorming was carried out to address the challenges regarding the introduction of CBT. The challenges were placed in an order of priority. Subsequently, a 5 x Why session was held regarding the challenges at the top of the priority list.

3. SETTING OF GOALS

- Patients who have been admitted express satisfaction with their treatment.
- Treatment is governed by the patient’s goals.
- CBT must form part of the treatment 24/7.
- Regular evening therapy and exposure exercises as a natural part of the treatment offered by the unit.
- Motivated staff, capable of working independently with CBT.

4. THE IMPROVEMENT – WHAT DID THE UNIT DO?

- Prepared a simple, visual description of the unit’s process for implementing CBT and showing what was expected from staff.
- Prepared a standard for the unit’s CBT. A simple, visual model which all staff members could understand.
- Prepared a standard for evening therapy, describing when, as well as the tasks for staff, what evening therapy is about, and what the patient’s task is.
- Prepared a brief, concrete, systematic structure with fixed agenda items for the interdisciplinary treatment conference.
- The entire staff group receives training and peer instructions.
- Everyone receives continual guidance and supervision.
CBT – NOW, IN THE NEAREST FUTURE, AND THE LONGER-TERM GOAL

Visual description of the unit’s process for implementation of CBT

- Involvement of family members
- Cognitive cooperation with other units
- The coherent patient pathway

- Everyone in the staff group works independently with CBT
- Fully integrated CBT culture in everyday work

- CBT folder for staff (placed physically at the office)
- Selection of additional cognitive tables

- Exposure exercises
- Making CBT visible in the units
- Psycho-education folder (placed physically at the office)

- Evening therapy, psycho-education, welcome folder
- Cognitive peer training, supervision, milieu reflection
- Cognitive catalogue of ideas for nursing plans

- Problem/goal list
- Interdisciplinary treatment conference
Example of symptoms:
- Isolates him-or herself
- Avoids contact with others
- Sensitive towards stimulation
- Avoids group activities
- Difficult to postpone needs

- Help him- or herself to breakfast
- The patient addresses contact person of own accord
IMPROVEMENT WORK IN THE MENTAL HEALTH SERVICES OF THE CAPITAL REGION OF DENMARK

RESULT AFTER EIGHT WEEKS

- Patient who had been admitted before express satisfaction with the changes.
- Treatment is based on the patient’s goals to an increasing extent.
- Patients are much more involved in their own treatment process.
- Staff members are motivated for working on the basis of the cognitive reference framework and speak good cognitive language to an increasing extent.
- Other units are inspired by our experience, e.g. with evening therapy and the exposure stepladder.

LEARNING FROM THE IMPROVEMENT PROCESS

- It is important to prepare very concrete solutions, which are easily accessible and preferably visual.
- Support solutions with a regular opportunity for sparring and learning, e.g. our CBT conference.
- Implementation. Leaders to keep focus, repeat messages, be patient and motivate.

In order for improvements to be sustained, it is important to:
- accommodate staff if they have challenges, through systematic supervision and training.
- maintain leadership focus, repeat messages and be patient.
- use thematic days to reach out to the whole staff group.
- have ongoing training of resource persons.
- carry out regular evaluations (P-D-S-A).

“...

For some time, we had tried to implement a problem/goal list in our treatment, which is very basic in CBT, but we had not really made much progress. After an event and follow-up thematic day, our everyday work is now much more characterised by a CBT approach. We now make plenty of problem/goal lists, week plans and mood registrations, and as regards anxiety symptoms we have a structure for gradual exposure (exposure stepladder). Naturally, we can make much more progress, but we accelerated this work over a very short time. I am fully convinced that we owe that to our event and the detailed, very concrete implementation plan which was a result of the event. The enhancement we have experienced has subsequently led to further ideas, which we have implemented – such as a weekly 30-minute CBT conference. This allows us to focus professionally and to enhance our competence further.

JONAS ASTRUP, SENIOR CONSULTANT, HEAD OF UNIT

“...
Increased quality and safety of the overall medication process at a centre

1. SITUATION PRIOR TO THE IMPROVEMENT
Mental health patients receive a lot of medication, often poly-pharmaceuticals and high-risk drugs. The centre did not have a good overview of medication, so a number of errors occurred. The Joint Medication Card had enabled an insight into all medication orders, so it could contribute towards having a better overview.

2. PROBLEM ANALYSIS
An audit of patient records was made, and a medication review was carried out by comparing the Electronic Medication Module with the Joint Medication Card. The Joint Medication Card was a new possibility, enabling a more detailed medication review. The conclusion was as follows:
- Major, inexplicable discrepancies between the Joint Medication Card and the Electronic Medication Module.
- There was a need to weed out psycho-pharmaceuticals for a number of patients; the indication for the many drugs was unclear.
- The patient records did not show any systematic medication review. In 20 out of 20 patient records, the medication review had not been carried out. Consequently, the baseline was set at 0.

3. SETTING OF GOALS
- Increased patient satisfaction, in that patients have a better understanding of their own medication.
- A good overview of the total medication status for the patient and the physician.
- An overview of poly-pharmaceuticals and the use of benzodiazepines.
- Good, uniform work processes regarding medication review.
- The medication review process focused on one sheet and was useful for implementation in the Health Platform.

4. THE IMPROVEMENT – WHAT DID THE CENTRE DO?
The items defined below were carried out:

1. Medication review using the new method.
In the systematic medication review, five questions were asked about the patient’s current medication:
- Why?
- Too much?
- Too little?
- Wrong?
- Forever?
Roll-out plan for the rest of Mental Health Centre Glostrup

<table>
<thead>
<tr>
<th>Grenne mapper på afsnit og enheder</th>
<th>Der skal oprettes mapper på alle afsnit og enheder med medicingennemgangsskemaet og andre oplysninger om projektet.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>Til alle ledermøder m.m. fortælles om nødvendigheden af projektet. Her skal der være mulighed for at svare på spørgsmål – også de kritiske.</td>
</tr>
<tr>
<td>Farmaceut i Akutmodtagelsen</td>
<td>En farmaceut ansat i Akutenheden kan lave forarbejdet til medicingennemgangen på medicingennemgangsskemaet, men det er lægen, der foretager medicingennemgangen.</td>
</tr>
<tr>
<td>Centernyt</td>
<td>Der informeres løbende i Centernyt om, hvordan arbejdet skrider frem med de gode historier og ’best practise’.</td>
</tr>
</tbody>
</table>

The documentation of the reply to the five questions took up several pages in the patient record. That was why the improvement team started testing a new medication review form, which was P-D-S-A-tested many times. A new medication review form was developed.

2. Four units carry out pilot tests
Two bed units, a district psychiatry unit and a geriatric psychiatry unit did a pilot test of the form. The four units work with a total of 1,340 patients.
At the pilot stage, weekly meetings were held, involving an interdisciplinary team of local experts, clinic management and unit managements of the four units, as well as other resource persons.
The weekly meetings ensured a sustained, systematic process, and there was an agenda and minutes from all meetings. There was commitment and good will, and a great many P-D-S-A tests were made. Also, management provided good support.

3. Broadening to the whole centre
A plan for implementation at the whole centre was made, and meetings were held about safe medication every month.

4. Quality follow-up and data improvement
There is follow-up on improvements by means of data. The measurements in the patient safety campaign are documented in an internet-based database, the Extranet, which has been developed by the US Institute for Healthcare Improvement (IHI). The Extranet is a process tool, which has been used in similar campaigns in other countries. All units participating in the campaign and registering data in the Extranet are given a homepage of their own, where they can monitor their own measurements over time and thus assess the effect of their own initiatives. The units are able to generate different reports on the basis of their own data.
RESULT AFTER 6 MONTHS

Five main effects of the improvement process have been registered:

1. There is a much better overview of medication for both the physician and the patient. The combination of the Joint Medication Card and the new form for medication overview provides an overall, updated, improved overview.
2. The medication review becomes part of the patient’s recovery process.
3. Less poly-pharmaceuticals and benzodiazepines are used.
4. There is a better understanding of the medication between somatic and psychiatric units.
5. There are no longer major errors and deficiencies in the registration of medication.

The graph on the next page shows that before the improvement there was a higher proportion of poly-pharmaceuticals in a district psychiatry unit than in the Mental Health Services of the Capital Region as a whole. Following the implementation of the new form and the new work processes, data shows that the use of poly-pharmaceuticals is reduced and is now at a lower level that in the MHS of the Capital Region as a whole.

LEARNING FROM THE IMPROVEMENT PROCESS

There are four important learning points in this process:

1. Important with active involvement of all stakeholders – patients, their families, contact person, physician, staff during admission, clinical pharmacist, the patient’s own GP and the municipal system. Everyone understands what a medication review is and why it is done, as well as how to hold on to the plan that has been prepared.
2. The medication review form is a tool that is being developed via numerous P-D-S-A, until the optimised model has been found; this model requires ongoing evaluation and adjustment, depending on the context (district psychiatry, forensic psychiatry, geriatric psychiatry, emergency unit).
3. Structure and a systematic approach in medication review provide a bigger, better overview, as well as more appropriate and safer medication.
4. Patients experience more involvement and insight into their own medical treatment, which may lead to better compliance and a better possibility of recovery.

Form for medication review
I see the medication review as psychiatry wanting to prepare optimised treatment for the patients as well as a better understanding of the interaction between somatic medication and psycho-pharmaceuticals. I understand this as increased respect for patients. Today, I feel the full backing of the mental health services, because I now have better possibilities of making demands about my treatment. With the medication review and the Joint Medication Card available, all bad errors and deficiencies can be eliminated. In my case, for example, we discovered some serious interactions between two drugs, beta-blockers and anti-depressants, which made me function poorly in my everyday life, since I was often dizzy and would fall over and hurt myself badly because of too low blood pressure. I don’t do that anymore.

SØREN LISTEL, PATIENT

Given the many persons involved in medication processes in regard to mental health patients, this improved overview is really good and helps improve patient safety.

PHUONG LE QUACH, ACTING HEAD OF CENTRE

What does the data say about the work – e.g. medication review

**P1A PCGI District Psyc, Glostrup**
Outpatients receiving treatment
Medication orders. Patients with orders for both anti-psychotic drugs and benzodiazepines
On the way to a **belt-free centre**

The Mental Health Centre at Ballerup is working to reduce the number of belt restraints, without any increase in other coercive measures, such as manual restraint or acute sedatives. At the same time, safety and security must be maintained for patients and staff alike. The ambition of the centre is to reduce the number of belt restraint episodes to a maximum of ten episodes per year in 2017. In 2015, the centre receives funding from the government’s special social initiatives pool for a three-year project period; subsequently, the efforts made are intended to function as part of the ongoing improvement work.

### 1 SITUATION PRIOR TO THE IMPROVEMENT

Like all other centres, the centre had quite many patients subjected to belt restraints as a result of violent and threatening behaviour. In 2013, the centre had 329 belt restraint episodes.

In that year, the centre started working with prevention of belt restraint episodes. This was done through the following initiatives:

- Massive management focus from both centre management and unit management, based on an ambitious, shared vision saying that the centre wanted to be one of the best in this field.
- Culture work at the individual units – how do we meet the patients? And how do we create a non-restrictive environment?
- Analysis of data to ensure that efforts are targeted at the units and patients with the highest number of belt restraint episodes.

This work resulted in the first dramatic decline in the number of belt restraint episodes at the centre. The number of belt restraint episodes was reduced from 329 in 2013 to 85 in 2014.

### 2 PROBLEM ANALYSIS

In 2014, more systematic improvement work began. In order to further reduce the number of belt restraint episodes, other initiatives had to be added. Meetings were held which involved brainstorming with unit managements and staff to find out which issues they identified.

**Conclusion of the problem analysis:**

- There was a need for new, shared, professional knowledge and a new approach to the patients.
- There was a need for staff to be able to have professional sparring and help in heated situations, so that belt restraint episodes could be avoided.
- There was a need for more activities offered to the patients.
- There was a need for staff to be more accessible to patients. Staff members spent much time in the office, so conflicts arose, because staff intervened too late.

These conclusions were linked to research results in this field which indicated that space for patients, patient involvement, competence development and evaluation of belt restraint episodes are important parameters when trying to reduce the use of coercive measures (Huckshorn, K.A. 2006 and Bak J.). This work resulted in a project description of the Belt-free Centre Project.
### Setting of Goals

The centre thus wants to reduce the use of belt restraints even further, and the three-year project is therefore a continuation of the previous work, where culture and leadership are the most important efforts made in the work to reduce belt restraint episodes. This work will be continued.

The goal for the three years:
- **2015:** Max. 50 belt restraint episodes
- **2016:** Max. 30 belt restraint episodes
- **2017:** Max. 10 belt restraint episodes

### The Improvement – What Did the Centre Do?

The centre decided on six initiatives, described below.

**1st initiative: Cognitive school**
A cognitive school is to be established at the centre, offering training programs with classes and supervision for interdisciplinary staff members. The focus is on cognitive methods for conflict prevention and de-escalation. The training program has been organised with a view to strengthening staff’s cognitive competences and reducing the use of coercive measures. The program focuses in particular on intensive units, but is also to be broadened to the other units of the centre.

**2nd initiative: Intervention teams**
An intervention team consisting of specially trained staff members is to be established; this team can be called in when situations arise which involve a risk of the use of belt restraints or other types of coercion. The purpose is for the intervention team together with the regular staff of the unit and the patient to try to avoid the use of belt restraints or other coercive measures. The intervention team always consists of two persons. Instructions have been prepared for the work of the intervention teams as well as a flowchart describing the process for calling in and using the intervention team. The flowchart is to be posted visibly in all bed units.
3rd initiative: Focus on double admissions
In 2015, the centre had a total of 32 belt restraint episodes, nine of which were belt restraint episodes occurring in a somatic unit, while the patient had a double admission in both a somatic and a mental health unit. This means that 28% of the belt restraint episodes occurred in a somatic unit. A data analysis indicates that delirium is the biggest individual factor causing the use of belt restraints in somatic units. That is why a training program focusing on prevention and treatment of delirium is being organised and will be offered to relevant somatic units.

4th initiative: Physical activity
Psychical activity helps increase the patient’s well-being and it distracts the mind from negative thoughts, anxiety and unrest. That is why the physical activities offered to inpatients in intensive units will be improved. Physical activity must form an integral part of the treatment and the everyday life during admission, not just from 9 a.m. to 3 p.m. on workdays, but also during evenings and weekends, when patients need physical activity. Physical activity is now offered four days a week from 4 p.m. to 8 p.m. as well as every weekend. There are team activities and individual activities – both for patients who are very fit and for those who are not used to getting any exercise. Furthermore, physical activities are to be offered to the most tormented patients. That is why the centre has engaged physiotherapists and trained activity consultants in all intensive units.

5th initiative: The physical framework
The three intensive units have a new layout. The nursing offices are smaller and the communal areas are bigger. A multi-functional piece of office furniture has been developed, called Front Office. This is used by patients and staff alike. Front Office allows staff to carry out their tasks in the middle of the environment together with the patients. The centre wishes to investigate various uses of Front Office and to provide a better framework for staff members to be available to patients. When it is easy for patients to get in touch with staff, it is also easier for staff to prevent conflicts and the situations which involve a risk of the use of coercive measures.

6th initiative: Safewards
The centre implements the Safewards model in three intensive units, so as to prevent the use of belt restraints and other coercive measures. Safewards is an evidence-based model for psychiatric nursing. The model contains ten different interventions preventing conflicts and coercion in intensive mental health units. These interventions are based on a high extent of patient involvement and recovery. The goal with Safewards is to improve safety and security in intensive mental health units. The means is increased cooperation between patients and therapists on the reduction of conflicts and coercive measures.
The ten Safewards interventions:
1. Clear mutual expectations
2. Soft words.
3. Communicative talk down
4. Positive words
5. Bad news mitigation
6. Know each other
7. Mutual help meeting
8. Calm-down methods
9. Reassurance
10. Discharge messages

In addition to the six initiatives, the centre also introduces differentiated triage for the three intensive units and a geriatric psychiatry unit. This means that patients are admitted to the unit where staff knows them the best and that two units are focused especially on extrovert and restless patients.

5  RESULT AFTER 2 YEARS

It is understood that belt restraints cannot be replaced by other types of coercion, e.g. sedatives and manual restraint. Each month, the centre thus prepares overviews of the use of coercive measures at centre and unit level and developments are closely monitored.

It is not possible to conclude that a specific decline in the use of coercion can be attributed to Safewards or the cognitive school. However, Safewards and the cognitive tools help create the non-restrictive culture which is aimed for and which is being anchored in units to an ever growing extent.

The use of coercive measures
In 2015, the centre had a total of 32 belt restraint episodes, while in 2016 there were 13 belt restraint episodes at the centre, one of which was in a somatic unit. On the basis of statistical calculations, the centre concludes that in 2015 and 2016 a statistically significant decline in the use of belt restraints has been registered, when comparing with the baseline (2013-2014).
Data on a monthly basis shows that in the same period there has been no statistically significant increase in the use of manual restraint or acute sedatives. The fluctuations seen in the graph on the previous page are coincidental variations.

However, it would seem that the number of episodes with belt restraints, acute sedatives and manual restraint is finding a new, lower level, just after the three central initiatives were introduced in February 2016:

- Intervention teams started up
- Differentiated triage for the intensive units
- Most staff members complete their cognitive training program

A statistically significant decline in the use of acute sedatives and manual restraint has been achieved in a few units, but the new level is to continue if a statistically significant decline in the use of acute sedatives and manual restraint is to be reported at centre level.

**Staff satisfaction**

Staff satisfaction measured as the Perceived Stress Scale (PSS-10) and the Brief Index of Affective Job Satisfaction (BIAJS), which is a golden standard for measuring stress and job satisfaction. These measurements were made before and after staff members completed the cognitive training program, i.e. April/May 2015 and again in February 2016. Stress is assessed on a scale from 0-30, where 0 is best. The result of the measurement at the centre shows a decline from 20.28 to 12.42. This means a decline of 39% across three intensive units.

Job satisfaction is measured on a scale from 1-5 (where 5 is best). The result of the measurement at the centre shows an increase from 3.15 to 3.24, i.e. an increase of 3% measured on 35 participants across the three locked units.

When the project started, there were distinct worries that fewer belt restraints would have consequences for the way staff members thrived. The results shown above do not indicate such consequences.
LEARNING FROM THE IMPROVEMENT PROCESS

The Belt-free Centre Project has been carried out using many leadership tools. In the process, new initiatives have been added as part of the ongoing improvement work, e.g. Safewards is being used, there are ongoing improvements on the improvement whiteboards of the units, and new initiatives are designed through improvement events. The centre points out that one important thing learned is that seeing the project method as part of making major improvements has been important.

It is essential for the work of reducing the use of belt restraints that there is clear leadership focus throughout the period. This applies to centre management, unit managements and project management alike. If management loses focus, this will be reflected in the results.

Working with such large cultural changes also requires continuous follow-up on the initiatives launched. What was well implemented at a certain time may crumble over time, because new initiatives are now being focused on or new staff members have joined. A few, well-chosen initiatives may thus be preferable. The results have been achieved by staff members in the units, even if they had a difficult period with change of leaders and massive pressure on the bed units. The centre has learned that major improvements in the use of coercive measures may be carried out, even under conditions that may not be optimal; however, recognition of the great effort of staff members is essential, when it comes to staying hopeful that things can be done.

Centre and unit managements have used data very systematically, thereby having a good indication of the development of the use of coercive measures. Rumours and myths have been killed several times by facts. However, the centre has learned that it may be worth it to hold your horses for a while and not respond to individual, major fluctuations in data, but instead to wait and see. However, it is important to be ready to get going, whenever unwanted, statistically significant changes are spotted, and to celebrate when things are going well.

“...We have had many things going on at the same time, so staff members have rightfully felt somewhat out of breath at times; however, we have learned that a few, well-chosen initiatives are to be preferred. It is very positive for patients that many initiatives now contribute towards avoiding the use of belt restraints, e.g. plenty of activities, new therapeutic interventions through cognitive therapy, and a new approach through the Safewards interventions.”

LOUISE BANGSGAARD, HEAD OF DEVELOPMENT

“...It does require a cultural change. You have to be open to this – and I think we are. However, this is a learning process, where you have to discontinue an evidence-based treatment culture. To me, it has been healthy to undergo a process of recognition, where I have become aware that there are things I can do better, even if I have many years’ experience.

MICHAEL URHAMMER, PSYSIOTHERAPIST
Competence development through competence profiles

Mental Health Centre North Zealand wanted to target its competence development, so as to better match patient needs of diagnostics and treatment with staff competence levels. The units of the centre wanted to always have the necessary competences available in the staff group. Finally, the individual staff member wanted to develop his or her professional competences.

1 SITUATION PRIOR TO THE IMPROVEMENT

Both the centre and the units lacked systematic knowledge of the need of competence development. In addition, there was no shared understanding of the relevant competence areas to be handled by the different professional groups. The centre and the units had not had any knowledge about the effect of the centre’s strategy for competence development. Did the many resources spent on competence development actually benefit patient treatment? There was no clear link between the annual job appraisal interview and competence development.

2 PROBLEM ANALYSIS

Mapping was carried out of how the different professional groups defined their competence area and which major questions that were raised.

Staff perspective:
- In which areas am I expected to be competent and at which level?

Unit management perspective:
- What is the actual competence level in my unit?
- Which areas of initiatives exist both for the individual staff member and for my unit as a whole?

Centre perspective:
- Which competence development initiatives does the unit need?
- What is the effect of competence development initiatives which we have launched?

WHAT WAS THE PROBLEM?

Competence mapping

Staff perspective:
In which areas am I expected to be competent and at which level?

Unit management perspective:
What is the actual competence level in my unit?
Which areas of initiatives exist both for the individual staff member and for my unit as a whole?

Centre perspective:
Which competence development initiatives does the unit need?
What is the effect of competence development initiatives which we have launched?
3  SETTING OF GOALS

The goal of competence profiles is to:

- Have shared knowledge and understanding of core competences in the different professional groups.
- Have systematic knowledge of the needs of the units for competence development.
- Establish a joint platform for staff, unit management and centre management to discuss competences and to launch development initiatives.

4  THE IMPROVEMENT – WHAT DID THE CENTRE DO?

1. Each professional group defined its competence areas.
2. A spreadsheet was prepared, in which all staff members were registered and all defined tasks/competence areas were listed.
3. All staff members scored themselves on the spreadsheet.
4. Following a pilot test in a unit, adjustments were made. Subsequently, all staff members at the centre started up.
5. Each unit accumulates data from its own unit, and the centre accumulates data from all units.
6. Each staff member registers the current competence level each year.
7. Each unit management registers the competences needed in the unit (requested number of staff with the competence concerned).
8. In a subsequent annual job appraisal interview, the competence score is discussed and possibly adjusted, and the need for competence development is discussed.
9. Current competences and wishes are summarised per professional group at both unit and centre level in regard to outpatient units and 24/7 units, respectively. The different (GAP) between current and requested competences is calculated.
10. A plan is prepared for competence development of the individual staff member, for the unit and for the centre. All development initiatives are carried out at the most appropriate level.
Before, we spent a lot of money on training programs, but we did not know whether they were entirely relevant for treatment and whether the right staff member was sent to that training program. Furthermore, it has turned out that there is a big gain from gathered initiatives across units, so that individual staff members are not sent to training programs on their own. This has given us a very good tool for planning relevant training measures at the centre, where staff members can benefit from being part of a shared development.

MARIANNA HANSEN, HEAD OF DEVELOPMENT

### Example of the calculation of lacking competences, nurses in 24/7 unit

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### Table Notes
- **Udledningsforløb** includes various aspects of patient management and treatment.
- **Laeskumental/indl. samtale og anæmianslagelse** refers to consultations and inquiries, including mental health assessments.
- **Selvmodscenning** involves self-assessment and evaluation.
- **Indenforfælde sprogfælleden** pertains to in-house language facilitation.
- **Udarbejdelse af projekplan indenfor 24 timer (ikke lægelig behandlingsplan)** focuses on the preparation and planning of treatment plans.
- **RFE** and **SCAN** are medical assessments.
- **Mark** represents a specific type of medical examination.
- **Funktionale aktiviteter** indicates functional activities.

The table is designed to calculate the lack of competences among nurses in a 24/7 unit, comparing the actual competences against desired competences and calculating the deficit.
**RESULT AFTER 2 YEARS**

- A shared platform has been provided, which staff members, unit managements and centre management can use for the discussion of competences.
- A shared understanding of core competences and the core tasks of the different professional groups has been created.
- The centre now has systematic knowledge of the unit’s need for competence development.
- A joint, annual competence plan is made at the centre, where initiatives are taken across units. This has ensured considerably better utilisation of resources.
- At this juncture, clear knowledge of the effect of the competence development initiatives on patient treatment has not yet been established. Work is continuing on this matter.

**LEARNING FROM THE IMPROVEMENT PROCESS**

- Involvement of the different professional groups in the definition of the different competence areas is time-demanding, since there are varying views of who should carry out which tasks and how.
- Each unit must work to define competences to ensure that ownership is taken of the process.
- All professional groups must have their own definitions of tasks/competences, so as to reduce the number of replies saying: not relevant.
- It has been appropriate to integrate competence mapping in the existing forums, e.g. in the annual job appraisal interviews, the competence development strategies, training plans, the local staff cooperation committees, etc.
- Inputs must be made clear. It must be shown that there is a connection between what is being demanded by patients and staff, and what is prioritised, e.g. on the improvement whiteboard in the unit, the centre management and the staff cooperation committees.
Reduction of the use of coercive measures and of absenteeism due to illness
in bed units for children and adolescents

A bed unit really wanted to improve its patient treatment by reducing the number of belt restraint episodes. Furthermore, the unit wanted to improve its working environment, since a very high rate of absenteeism due to illness was interpreted to mean that staff did not thrive well.

1 SITUATION PRIOR TO THE IMPROVEMENT

- High absenteeism due to illness, 13.1%.
- Frequent coercive measures of long duration (60 belt restraint episodes in 2014).
- The staff group needed dynamics and did not have the same professional approach to the patients.

2 PROBLEM ANALYSIS

Data analysis
- The unit management discussed data on coercive measures, especially belt restraints, and the data on absenteeism due to illness.

Inspiration from outside
- The unit contacted the adjacent unit to discuss how they worked with the same issues. The unit also contacted a unit in a different region; that unit had been praised for being exemplary when it came to reducing the use of coercive measures.

3 SETTING OF GOALS

- Reduce absenteeism due to illness to below 4%.
- Reduce belt restraints by 40%, while at the same time not seeing an increase in other coercive measures.

The reasons for the high number of coercion episodes and the high absenteeism due to illness were the following:
- Split staff group as regards the professional approach to be taken in patient treatment.
- Joint rules and straight frameworks versus individual problem-solving and conflict handling.
- No clear goals for the work.
- Indistinct, unclear patient pathways – no shared treatment standard.
WHAT DID THE UNIT DO?

- 15 minutes’ daily discussion of coercive measures and near-miss coercion episodes
- Increased staff involvement in the preparation of:
  - Clear focus areas for the unit.
  - Supplementary training/courses and team days.
  - Change of nursing via training and involvement in treatment pathways.
- Description of professional approach.
- Daily person in charge of improvement meeting.
- Cultural change with more individual approach to patients, focusing on the patient’s resources and responsibility.
  Inspiration from the “Esbjerg method”, i.e. away from rules and strict frameworks and focus on active listening, accommodating approach and individual frameworks and plans for each patient.
- Joint work culture and goals which are clear for all.
- Visible leadership in daily work, bed-side instruction and clinical sparring on a daily basis.
- Conversations following absenteeism due to illness held in accordance with the policy of the MHS of the Capital Region on absenteeism due to illness, and discussions about well-being at the workplace are often held at staff meetings and in everyday situations.

RESULT AFTER 14 MONTHS

- Absenteeism due to illness has been reduced from 13.1% to 2%.
- In 2014, there were 60 belt restraint episodes in the unit; in 2015, this had been reduced to 11 belt restraint episodes. At the same time, the number of times when sedatives have been administered was reduced from 183 to 79 and the number of manual restraints has declined from 271 to 228.

Gains

- Patients have much influence on their own pathway.
- Staff members have more influence and clear fields of responsibility.
- The organisation: We teach and share knowledge with other units.
- Much more cooperation, knowledge-sharing and supervision of group homes.
What does it take for the improvement to be sustained?

- Ongoing evaluation and improvement of measures already launched (P-D-S-A).
- Development and dynamics are all-important – the unit is not to get stuck in the old patterns and frameworks
- Continuous support for staff members, when it comes to ensuring that improvements are sustained in everyday work – very concretely.
- Holding of weekly team meetings, where issues are addressed. Daily sparing between staff group and management. The staff group must know the goals and direction, at least on a six-monthly basis.

Very few staff members are taken ill now, so we have more people in attendance on a normal workday. Furthermore, we use very few temps. Both patients and staff are more satisfied.

NINA STAAL, SENIOR CONSULTANT AND ANNIKA RASMUSSEN, NURSING HEAD OF UNIT
Compliance with the assessment and treatment right through reduction of waiting time in the outpatient clinic

The overall issue was to live up to legislation on assessment within 30 days. The outpatient clinic wanted to provide a better pathway for families and therapists through a better assessment flow and to have shorter waiting times before the first assessment interview.

1 SITUATION PRIOR TO THE IMPROVEMENT

The situation in the unit in the summer of 2015 was as follows:

- Long waiting list, many patients in the process at the same time, and a long time for the actual assessment process.
  - Average waiting time 112 days
  - 200 patients undergoing assessment
  - Average assessment time 140 days
  - 10% assessed within 30 days
- Few standards and tools for quality assurance
- Indistinct goals
- Relatively high differences in treatment provision.

2 PROBLEM ANALYSIS

A waste analysis was carried out and showed that:

- Many patients in the process at the same time required extra time for getting an overview.
- Many transitions required extra time for a new focus.
- Long pathways required extra time to read up on the patient and remember the patient.
- Inappropriate process in regard to documentation meant extra time for double documentation/unnecessary documentation.

3 SETTING OF GOALS

The follow goals were set:

- Waiting time max. 17 days.
- Better flow, fewer transitions and professional satisfaction with the new assessment process.
  - Max. five assessment processes per therapist
  - At least 2/3 of processes experienced as professionally satisfactory
- Better utilisation of competences through the use of registered nurses and social workers in the assessment processes.
- Through-time 13 days from assessment starts until it is finished.
WHAT DID THE UNIT DO?

- Described a new standard patient pathway of 13 days, focusing for example on the reduction of the number of times a patient and the parents had to come to the outpatient clinic.
- Revised the staff members’ week plans to provide appropriate processes for families and therapists.
- Facilitated the documentation task by preparing standards for assessment plans and preparing a conference document used for a revised treatment plan, statement and discharge summary.
- Prepared booking forms which automatically calculate the visit days based on the first visit.
- Described the tasks of registered nurses and social workers in the assessment process.
- An interdisciplinary working group ensured that all angles had been clarified to the extent possible.
- By and by, all staff members were introduced to the new patient pathways and week plans at staff meetings.
- Data was used at the whiteboard meetings to see if the unit developed in the right direction.

RESULT AFTER 3-4 MONTHS

Gains:

PATIENTS are helped sooner, since treatment can be started sooner.

STAFF MEMBERS have better overview of the patients.

THE ORGANISATION complies with legislation to a higher degree.

- The waiting time for assessment was reduced by 67% from 112 days to 35 days. This means that, previously, 10% of patients were asked to come in for their assessment within 30 days, while now 95% of patients are asked to come in for their assessment within 30 days.
- The throughput-time was reduced by 43% from 139 days to 80 days.
- A better flow was ensured, there were fewer transitions, and the number of patients per therapist fell from 15-18 patients to 8-10 patients.
- Working with two therapists increased; previously, 60% of patients had two therapists, while now 95% of patients have two therapists.
• 69% of therapists found they were professionally satisfied (or very satisfied) with the new assessment process.
• Previously, only physicians and psychologists participated in the assessment of patients; now, both registered nurses and social workers participate in assessment work.

12 months later...

After 12 months, a workshop was held with a new study (P-D-S-A).

The result is that:
• The assessment process has been reduced to eight days.
• Processes are much more compact (2-3 full mornings).
• Time is allowed within the eight days for a possible extension.
• A higher number of children are seen by a specialist physician.
• The plan allows back-up for first sessions, in case staff members have been taken ill.

The participants in the workshop pointed to a number of conclusions; for example, they found that the unit’s improvement work is going well:
• We find good solutions in the working groups.
• A high level of commitment is experienced.
• Many good suggestions for improvements are made.
• We have a high degree of preparedness to change – open for trying new things.
• Staff members find there is a possibility of dealing with challenges.
• We have good support from our LEAN consultant.
• The process from identification of a challenge until it is solved is experienced as being relatively short.
• Attempts are made to include all perspectives.
• The aim is for everyone to have their say.
LEARNING FROM THE IMPROVEMENT PROCESS

Initiatives to sustain the improvement:
- Continuous adjustment based on experience. A major adjustment was carried out after six months’ experience (P-D-S-A).
- Make successes clearer by looking at what patients and staff members achieve – again and again!
- Talk about the fact that this improvement has involved major changes for some staff members and their work processes which were bound by tradition. All staff members must see – and believe in – the improvement.

Learning about the process:
- Staff should have been involved more closely in the actual process of preparing specific improvements.
- The pilot project with the shorter patient pathway was not evaluated thoroughly enough.
- The goal of the improvement should have been clearer from the outset.

It is very positive when we succeed in offering more families help sooner. It is not nice to wait when your child has difficulties. Improvement work has given me a better overview of how we are doing on the goals we set, and thus we can more quickly find the causes and make adjustments if things are not going the way we expected at first.

LARS BOMANN EMANUELSEN, NURSING HEAD OF UNIT
Optimisation of rounds walked in bed unit

1. SITUATION PRIOR TO THE IMPROVEMENT

The unit found that they wasted time and did not have enough time for patient treatment. Rounds started too late, and there was often a wait for patients, physicians and contact persons. In addition, patient activities in the unit often collided with rounds; there was no shared overview or time for preparation and examination, and medication orders were missed. There were often interruptions and the writing of patient records was delayed. The unit thus had a great wish to see improvements and to have more time for patient treatment. The triage of patients was carried out at the physicians’ conference, where many people took part in making decisions, so there were many discussions and much time was spent, whereas the physicians’ conference was actually supposed to be a professional learning exercise.

2. PROBLEM ANALYSIS

An interdisciplinary design track was described, and physicians, nursing staff, secretaries and patients took part in this work.

Methods used for improvements:
1. Gemba at another centre
2. VSM
3. 5 x Why
4. Focus group interview of patients

3. SETTING OF GOALS

- 1.5 hours more for patient treatment a day in each bed unit.
- Optimisation of work processes through: Good preparation for patient sessions; replies to specimen tests to be seen systematically; ensuring that documentation has been written before rounds are walked.
- Triage of patients moved away from the physicians’ conference.

4. THE IMPROVEMENT – WHAT DID WE DO?

1. New meeting structure for the whole centre. All meetings had clarification of purpose, meeting participants and time, including lunchtime conference, conversations with family members, meetings with municipalities and other associates.
2. Establishment of a unit round board with patient names and time of rounds.
3. Record entry dictation, follow-up and writing were planned.
4. Physicians’ week plan was changed to fit the round-walking process.
5. The coordinator function was described and anchored – instructions and check-list were prepared.
6. Principles for rounds were decided and written down.
RESULT AFTER 8 WEEKS

- 1.5 hours more for rounds per unit.
- Calm work processes, known and described. Patients are always ready for rounds, since they know the time.
- After all patient sessions, the record entry is dictated and follow-up is ensured. The result is that record entries are written quicker and that all staff members can be updated.
- The coordinator function worked well, creating an overview and reliable follow-up.
- Meetings more well-prepared. All meetings were placed in the afternoon, so that 9.00 a.m. to 12.30 p.m. was reserved for rounds.
- Different professional groups (not just physicians) hold meetings with family members, municipalities and internal therapists.
- The lunchtime conference is used for professional sparring, focusing on specific topics.

LEARNING FROM THE IMPROVEMENT PROCESS

Eight months later, the solution was evaluated; it was examined whether the structure and the solutions were active and used in the individual units. Patients were also interviewed. The result was that the basic structure was good, but a few minor adjustments had to be made and a stricter approach was taken. The patient focus was still predictability and well-prepared clinicians, and patients were very pleased with these structures.

“
It is really a good thing that we now have more time for rounds and, not least, a much better structure. This has improved rounds a lot for patients and staff alike.

BOLETTE SØNDERGARD, SENIOR CONSULTANT, HEAD OF UNIT”
Change-of-shift meeting **ensures good quality and working environment**

There was a need to focus closely on follow-up in regard to many aspects of the emergency unit, and the weekly improvement meetings were not enough to achieve the ambition of improving patient treatment within the agreed focus areas.

### 1. SITUATION PRIOR TO THE IMPROVEMENT

A high patient flow with many work tasks and short deadlines meant that the unit needed to have a better overview.

It was difficult to obtain all relevant information, secure correct documentation, and provide new, improved work processes in patient treatment.

In addition, the wish was expressed that staff members’ lean competences should be used to a higher extent. Everyone wanted to participate actively, but there was a need of structure to be able to do so.

### 2. PROBLEM ANALYSIS

An A3 was carried out and an improvement event was held.

A visit to Novo Nordisk provided inspiration to take a look at daily whiteboard meetings.

**The conclusion of the analysis was the following:**

P-D-S-A did not work in a satisfactory way, and the unit did not carry out satisfactory follow-up.

The weekly improvement meetings were not frequent enough for the unit to ensure follow-up and to retain focus on the agreed improvements.

Many staff members had attended lean training programs, but they did not use these competences in their daily work.

### 3. SETTING OF GOALS

- All staff members are to take ownership of improvements – including evening and night shifts.
- Meetings are to make sense to all staff members and all participating units.
- Meetings are to be data-driven.
- Meetings are to focus on improvements following a campaign model with 1-2 topics for a brief period.

### 4. THE IMPROVEMENT – WHAT DID WE DO?

At the improvement event, the working group prepared the following:

1. Description of a 5-minute fact meeting as a supplement to the weekly 15-min. improvement meeting.
2. Preparation of a plan for fact meetings whenever shifts change – i.e. 21 fact meetings a week.
3. Information to the staff members in all units.
4. Preparation of registration overviews for the following topics:
   - patient safety – near-misses and adverse events
   - follow-up on nursing actions
   - campaign topics, e.g. allergy information
   - working environment – busy, but under control
5. Planned evaluation.
THE IMPROVEMENT – 21 meetings a week

<table>
<thead>
<tr>
<th>Tidspunkt</th>
<th>Hvem deltager</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.45-9.00</td>
<td>Alle (minus sekretærer)</td>
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</table>

Hverdage – møder i alle vagtskift

<table>
<thead>
<tr>
<th>Tidspunkt</th>
<th>Hvem deltager</th>
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<tbody>
<tr>
<td>7.00-7.05</td>
<td>Alle (minus sekretærer)</td>
</tr>
<tr>
<td>9.00-9.05</td>
<td>Alle (minus sekretærer)</td>
</tr>
<tr>
<td>15.00-15.05</td>
<td>Alle (minus sekretærer)</td>
</tr>
<tr>
<td>23.00-23.05</td>
<td>Plejepersonale</td>
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Lørdage, søndage og helligdage – møder i alle vagtskift

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<tr>
<th>Tidspunkt</th>
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<tbody>
<tr>
<td>7.00-7.05</td>
<td>Plejepersonale</td>
</tr>
<tr>
<td>15.00-15.05</td>
<td>Plejepersonale</td>
</tr>
<tr>
<td>00.15-00.20</td>
<td>Alle (minus sekretærer)</td>
</tr>
</tbody>
</table>

Overview of emergency unit improvement meetings at every new shift.

RESULT AFTER 4 MONTHS

80% of staff members are able to facilitate a fact meeting. Adverse events and near-misses are documented on an ongoing basis and discussed by staff, so as to ensure prevention.

An open culture has developed in regard to adverse events and near-misses, and learning from them.

Positive effect on control parameters in campaigns, e.g. 50% improvement of suspension and release of the Joint Medication Card and allergy information.

The working environment is discussed on the basis of facts whenever the shift changes. This includes the use and documentation of the prioritisation triangle. Registrations are used to discuss improvements.
IMPROVEMENT – Campaigns

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial assessment</td>
<td>Initial assessment</td>
<td>Initial assessment</td>
<td>Initial assessment</td>
<td>Initial assessment</td>
<td>Initial assessment</td>
<td>Initial assessment</td>
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</tbody>
</table>

Week 10
Week 11
Week 12

Example of a campaign topic and registration.

Following an additional four months and another evaluation (study), meetings have been changed to only deal with adverse events, campaign topics and working environment. Nursing processes are not reviewed for every shift, but acute tasks have been included in the table.

LEARNING FROM THE IMPROVEMENT PROCESS

Effect of the improvement:
- More openness and focus on patient safety.
- More understanding of the work load of each shift and better prioritisation of work tasks, as well as strengthening of a culture which ensures continuity in patient pathways.
- Low absenteeism due to illness – interpreted as staff member responsibility and satisfaction.

For the purpose of retaining this improvement, we must remember the following:
- Continued management focus and presence.
- It must still make sense – topics are to be evaluated on a regular basis (P-D-S-A).
- The responsibility for holding fact meetings is part of the sharing of tasks in each shift.
Example of form in which each shift registers the working environment in the priority triangle (green-yellow-red); adverse events and near-misses are registered and discussed. In addition, continuity of patient treatment is ensured and practical work assignments are placed with individual staff members.

Since we introduced the new, structured meetings for every new shift, we have improved on all the parameters that were on the whiteboard. Staff members are really good at maintaining focus.

PIA HUSUM FREDERIKSEN, NURSING HEAD OF UNIT
Reduction of the number of fully treated patients

The centre had a high number of patients admitted, whose treatment had been finalised, so they were occupying beds, which should be used by other patients, who need treatment. Both the centre and the municipality wanted to strengthen their cooperation on fully treated patients.

1 SITUATION PRIOR TO THE IMPROVEMENT

In the first half of 2015, there was an average of 9.4 fully treated patients at the centre. These patients no longer benefitted from being admitted, since their treatment had been finalised. The work processes involving the centre and the municipality were not uniform and they were unclear, so there was a lot of wasted time.

2 PROBLEM ANALYSIS

An improvement event had been held with the participation of both the centre and the municipality. Value stream mapping was carried out and waste was defined.

The conclusion of the waste analysis was as follows:

- Social problems were not always identified during outpatient treatment, so an admission could end up being extended.
- Staff members at the centre sometimes happened to promise a specific residential facility to the patient (the municipality’s competence).
- Staff members at the centre often pressed municipal staff, e.g. for a residential facility.
- The municipality’s adult assessment method is time-consuming and could thus prolong admission.
- It was not clarified where mental health patients belong in the internal, municipal organisation.
- The municipality did not know the centre’s expected time perspective for discharge.
- Patients did not want to participate in the adult assessment method or they declined a specific social service offered to them.
- There was a waiting time for the municipality to be able to participate in meetings.
- The centre did not comply with the time frame laid down for the preparation of status statements.

3 SETTING OF GOALS

The goal of the improvement:

- No fully treated patients to still be held in the unit by 1 January 2016.
- Shorter admission period in unit.
- Effective and satisfactory cooperation structure between the centre and the municipality.

4 THE IMPROVEMENT – WHAT DID WE DO?

The improvement consisted of the preparation of a joint plan. The plan contains the following:

- Early involvement of the municipality.
- Simultaneous efforts by centre and municipality.
- Close follow-up and dialogue between coordinators at
the centre and in the municipality, with review of the list of patients who were reported to be ready and where a pre-warning had been given, so that action can be agreed at weekly meetings.

- Close follow-up internally at the centre with weekly meetings with the social workers.
- Clear division of responsibility between the region and the municipality.
- Clear decision-making competence when assessing when it is not responsible to discharge a patient to a temporary facility, while the patient is waiting for a permanent municipal facility, e.g. assessment of whether the patient could stay at a hostel, until a place at a residential facility has been found.
- Management awareness and backing with quarterly meetings (both from managers in the municipality and managers at the centre).
- Targeted effort to introduce cultural changes, i.e. work to ensure that the municipality solves its tasks, even if it takes time, for example:
  - to provide a place at a hostel
  - to maintain that the preparation with the adult assessment method does not require admission
  - that it may be necessary to discharge a patient to a temporary facility, while the patient is waiting for a permanent residential facility.

5  RESULT AFTER 6 MONTHS

Patients experience that efforts are made more quickly, they have fewer admission days, and there is more coherence between the efforts of the centre and those of the municipality. Staff members experience clearer work processes, better cooperation and less waste.

The centre experiences a better financial situation and more satisfaction among staff and patients.

<table>
<thead>
<tr>
<th>Before improvement</th>
<th>Goal</th>
<th>After improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of fully treated patients still held</td>
<td>9.4</td>
<td>0</td>
</tr>
<tr>
<td>Derived effect on shorter admission time</td>
<td>23</td>
<td>Reduced admission time</td>
</tr>
</tbody>
</table>

6  LEARNING FROM THE IMPROVEMENT PROCESS

Reflections in connection with the analysis
- Intersectorial cooperation on improvements is extremely valuable.
- More waste than expected.
- More nuanced picture than expected – not just the municipality; the centre had to improve, too!
- It can be beneficial to involve a staff member from another centre with parallel experiences.
- Good tone of voice, respectful dialogue, great openness and curiosity.

How is the improvement to be sustained?
Continued great focus at staff member, local management and executive management level.
Continued close dialogue and problem-solving between centre and municipality, and a dialogue to clarify the division of tasks between the two sectors in more detail.

"The whole improvement work has been a good learning experience, providing insights for both sectors, and our cooperation has improved markedly. However, there is a long way to go, since the number of fully treated patients held in units is still too high.

MARIANNE HAAHR LUND, SOCIAL WORKER"
# Week plans as a tool

<table>
<thead>
<tr>
<th>SITUATION PRIOR TO THE IMPROVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was in a newly started outpatient clinic where we used lean methods for planning work processes, activities and patient pathways. There was a need to look at the planning of patient pathways in combination with resources and the patients referred.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROBLEM ANALYSIS</th>
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<tbody>
<tr>
<td>Value stream mapping was carried out in order to plan patient pathways.</td>
</tr>
<tr>
<td>Subsequently, capacity was calculated on the basis of the number of expected patients, the activity goal allocated to the outpatient clinic, and the staff resources of the outpatient clinic.</td>
</tr>
<tr>
<td>On this background, the outpatient clinic provided week plans for all staff members. Time was allowed for flexibility, since patients do not always go by the plan, and therapists needed to have the possibility of adjusting the week plan and developing it going forward (P-D-S-A).</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>SETTING OF GOALS</th>
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</thead>
<tbody>
<tr>
<td>The goal of the outpatient clinic was to comply with all the service goals established.</td>
</tr>
<tr>
<td>1. Compliance with activity and intake budgets 100%.</td>
</tr>
<tr>
<td>2. First interview within two months (goal at the time).</td>
</tr>
<tr>
<td>3. Time allocated in week plans has been booked. Initial interviews 100%, individual appointments 90%; an average of eight persons have been booked for groups.</td>
</tr>
<tr>
<td>4. Appointment letter sent within eight days.</td>
</tr>
<tr>
<td>5. Absenteeism due to illness below 4%.</td>
</tr>
<tr>
<td>6. Cancellation/no-show max. 15%.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>THE IMPROVEMENT – WHAT DID WE DO?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The outpatient clinic prepared a plan for both work processes and week plans.</td>
</tr>
<tr>
<td>• It was decided that the beginning of the patient pathway is planned by secretaries, and secretaries make the bookings in the staff members’ calendars.</td>
</tr>
<tr>
<td>• Tight management by leaders at the beginning and continual management commitment to sustaining the plan.</td>
</tr>
<tr>
<td>• Planned and held half-days, focusing on improvement work and involving all staff members.</td>
</tr>
<tr>
<td>• Planning of changes/improvements, holidays and course attendance very well ahead, so the clinic can experience stable running.</td>
</tr>
</tbody>
</table>
RESULT 3 YEARS LATER

We succeeded in complying with our activity and intake budget from the very start.

Because of the now ingrained working culture, where we plan, follow the plans and are reality- and future-oriented, we succeeded in increasing activities by 10%, from 5,941 visits in 2014 to 6,560 visits in 2015. See the graph below.

- The booking rate is in compliance with the goal.
- The appointment letters are sent within eight days.
- Absenteeism due to illness is below 3%.
- We have not succeeded in reducing the number of cancellations and no-shows significantly.

LEARNING FROM THE IMPROVEMENT PROCESS

What does it take for improvements to be sustained?
The outpatient clinic continues to hold half-days, where the focus is on improvement work and where all staff members are involved.
We still plan changes/improvements, holidays and course attendance very well ahead, so that we can enjoy stable running of the clinic.
There is still massive management focus on compliance with week plans, and the head of the clinic works closely with the secretaries to secure this compliance.

Mental Health Centre Stolpegaard
Outpatient clinic for anxiety and compulsive disorders – number of visits

Week plans are a good tool for managing capacity and having a good overview. The individual therapist always knows what is expected and receives valuable help from our secretaries.

PIA RUBIN, SENIOR CONSULTANT, HEAD OF UNIT
Reduction of no-shows and cancellations in the outpatient clinic

An outpatient clinic has a high number of no-shows and cancellations. This frustrates staff members, since they would rather spend their time on treatment. Each time a patient cancels or does not show up, this results in extra registration, extra work of contacting the patient for a new appointment, etc. Cancellations in a process make the pathway longer, thereby increasing the waiting time for patients not yet receiving treatment. Many cancellations make it necessary for therapists to book, for example, five patients in a day in order to see four, which puts pressure on the therapists, their calendar flexibility is reduced, and the working environment suffers.

1 SITUATION PRIOR TO THE IMPROVEMENT

Data shows that 17.7% of all patient meetings do not occur. Consequently, the unit could hold 17.7% more patient sessions if these no-shows/cancellations could be eliminated. How can we achieve that?

2 PROBLEM ANALYSIS

Cancellations and no-shows are analysed in more detail via data from the patient administration system. The 17.7% no-shows are data from January to September 2014, and can be broken down as follows:

- 11.3% of patient meetings not held represent cancellations made by patients themselves. This often happens the same day, so it is not possible to ask a “replacement patient” to come in.
- 5.9% of cancellations are no-shows, where the patient does not turn up and does not cancel, i.e. no-shows.
- 0.4% of patient meetings not held are cancellations by staff members.

The outpatient clinic interviewed 67 patients who either cancelled or did not turn up in November 2014.

The unit used a fishbone diagram for the analysis. The patients’ reasons for cancelling/not turning up could be categorised into six groups:

Somatic illness
- Prioritisation, e.g. taking care of children who were ill.
- Motivation for treatment
- Mental barriers, e.g. depression and lack of energy.
- Forgot the appointment.
- Distance.

A review of patient data has shown us the following:

- The share of no-shows and cancellations is highest at the beginning of a patient pathway.
- Younger persons – especially younger men – have a higher propensity to stay away than others.
- Distance is not very significant.
- Patients stay away from sessions with physicians to a higher extent than if they are going to talk with other professional groups.
- There is no big difference between the different diagnoses on the one hand and the share of no-shows/cancellations on the other.
The goal for 2015 was to reduce no-shows and cancellations from 17.7% to 13.3%, a reduction of 25%.

The activities outlined below were initiated:

- New approach to young men. A group was established in August 2015 for young men only.
- A patient gave a presentation at a Tuesday meeting. “Why was it difficult to turn up at first, and what motivated me to have my treatment.”
- A rolling psycho-education process with different topics was started up: Depression, anxiety, medication, personality disorders and sleep.
- Orientation classes were held for new patients.
- Contents: What is psychotherapy, why is it difficult to have psychotherapy, psycho-somatics and psychotherapy.
- The contact person books the first interview with a physician instead of a secretary doing it; this is an attempt to give the patient influence on the choice of date and time.
- Text message reminder. Therapists can now send a text message via e-mail.
- Data showed us that borderline patients were not absent more than other diagnoses (contrary to our expectations). We thus concluded that the work in DAT treatment, e.g. with commitment and crisis plans, had a positive effect on patients turning up. We prepared a new type of commitment plan, which was relevant for all patients, and integrated it in the first treatment session in the outpatient clinic. See the enclosed example, where any obstacles to a patient turning up are discussed at the start of the pathway, and a kind of crisis plan/commitment plan is prepared on this basis.
- Improved framework for psychotherapy, e.g. chairs, coffee, etc.
- Social media (used for giving appointments and sending reminders). Unfortunately, this could not be introduced, since for legal reasons it is not permitted to use for example Facebook in our communication with patients. This applies also to so-called closed groups.
- Scott Miller’s FIT (Feedback Informed Therapy) was used for selected groups. This is a method with special focus on continually adjusting the contents of therapy to match what patients experience as the most important contents. This method includes ongoing evaluation from the patient.
- Final session with physician including contact person.
There was ongoing evaluation of activities, and the activities which did not have an effect that matched the number of patients appearing were stopped. The two forms below are used to talk with patients about turning up. They are used as a commitment plan – a kind of crisis plan for turning up.

5 FOLLOW-UP AFTER TWELVE MONTHS

One of the three treatment teams did not experience the same effect of their efforts as the other teams. Another improvement event was held in January 2016. As a result of the event, there was an increased, shared understanding in the team in question of how cancellations and no-shows can be handled, just as there was increased focus on how to get patients to turn up. This seems to have resulted in the following decline in the number of cancellations/no-shows in the specific team from 16% in 2015 to 12% in 2016.
It has been inspirational to see the great importance to our working environment of being able to reduce the time wasted on cancelled patient interviews! The low number of cancellations/no-shows also helps ensure that we can have a good flow in our patient pathways, so we do not have any waiting time between the first interview and the actual treatment, just as we have a short waiting time from the referral to the first interview (approx. 14 days).

ANN COLLEEN NIELSEN, SPECIAL PSYCHOLOGIST, HEAD OF UNIT

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</thead>
<tbody>
<tr>
<td>Patient cancelled</td>
<td>12.0 %</td>
<td>11.0 %</td>
<td>10.3 %</td>
<td>9.5 %</td>
<td>9.5 %</td>
<td>8.8 %</td>
<td>7.3 %</td>
</tr>
<tr>
<td>No-show</td>
<td>6.9 %</td>
<td>4.2 %</td>
<td>4.4 %</td>
<td>5.0 %</td>
<td>4.8 %</td>
<td>3.9 %</td>
<td>3.4 %</td>
</tr>
<tr>
<td>total</td>
<td>18.9 %</td>
<td>15.2 %</td>
<td>14.7 %</td>
<td>14.5 %</td>
<td>14.3 %</td>
<td>12.7 %</td>
<td>10.7 %</td>
</tr>
<tr>
<td>Index</td>
<td>100</td>
<td>80</td>
<td>78</td>
<td>77</td>
<td>76</td>
<td>67</td>
<td>57</td>
</tr>
</tbody>
</table>

The biggest difference has probably been made by the continuous focus from both staff and management throughout the process, not by the individual activities. The process has helped change our perspective. A cancellation is not a welcome break; it is an extra work task, a delay of the patient’s treatment, increased waiting time for new patients, and a burden on the working environment. Such a process triggers many good ideas, which are tried out. Not all of them have the desired effect, so they are to be stopped. This is not an easy task; it requires focus on the purpose.
Reduction of waiting time in the outpatient clinic

The adult psychiatry outpatient clinic has a long waiting list, many unwritten patient record entries, and has difficulties finding a good way to organise and have appropriate work processes, so that no waiting times and piles of paper occur.

1. **SITUATION PRIOR TO THE IMPROVEMENT**

138 patients were waiting for an appointment (February 2016).
There were 585 unwritten patient record entries, and the secretaries were not able to keep up.
There was no overview of the connection between the activity budget and the number of patients in package pathways, so piles of paper/bottlenecks occurred all the time.

2. **PROBLEM ANALYSIS**

Different cause analyses have been necessary for the different problem areas; however, the fishbone has been an effective way of covering everything.

The waiting lists were analysed:
1. Waiting list in one team: Internal waiting list with subsequent need for follow-up sessions.
2. Waiting list in another team: Understaffing resulting in delays when starting up groups.
3. Waiting list entries (<500) result in extra work because of having to listen to the entries and because of delays of: Treatment conference, various appointments, etc.
4. Bottleneck in group rooms on some days and at specific times of the day.
5. Certain individual treatment processes require standardisation, e.g. in the form of standard letters.
6. Need to reduce the many activities from the referral by centre triage until a patient started the treatment. In addition to the initial assessment, for example, there were both orientation processes and introduction processes, second opinion on assessments, one or several interviews with physicians.
7. Staff members feel under pressure and are frustrated, and the culture or barriers are blocking change.
3 SETTING OF GOALS

1. Work processes to function effectively and efficiently in everyday work.
2. Waiting list and other related parameters for running of the unit to be met – also during periods of illness among staff.
3. Improvement focus moves to the quality of treatment and the working environment.

4 THE IMPROVEMENT – WHAT DID WE DO?

...short term...temporary solutions:
- Removing the internal waiting list by having “visiting therapists”. Twelve psychologists at the other units of the centre each helped one day every week with the first interview, individual pathways, and treatment groups.
- As part of the removal of waiting lists, voluntary overtime agreements were concluded.
- Removal of the piles of patient record entries.

...long term...lasting solutions:
- Five vacant full-time employment positions filled
- Standardisation of pathways. A number of patient pathways were simplified with fewer activities before treatment started.
- Standardisation of three diagnostic groups, so that pathways were adapted to the regional pathway description. This meant that intake budget, capacity and package pathway length now match.
- Optimisation and standardisation of many work processes, e.g. triage and standard letters.
- Measurements on the improvement whiteboard with adjustment of plan on the basis of results.
RESULT AFTER 3-4 MONTHS

Assessment and treatment right – follow-up on plan

- Prognosis for number of patients in pile
- Actively waiting over 30 days – current

Week

%
LEARNING FROM THE IMPROVEMENT PROCESS

The removal of piles of paper had a big effect on the waiting list. However, the removal of piles of paper also has “some side-effects”, such as massive pressure on the secretariat and on rooms. It was difficult for physicians to keep tabs with developments, and it was difficult to find time for some of the subsequent work, e.g. writing of discharge summaries. The time with removal of piles of paper as a method should be as short as possible.

Voluntary overtime agreements with staff members had a good effect on waiting lists, but led to a relatively high amount of time spent by administration in light of the short period of these agreements.

The unit has a democratic, discussing, reflecting culture, which has been strongly challenged by requirements to – relatively quickly – reach some goals which involved shorter treatment processes and generally a higher level of effectiveness and efficiency. The visible effect on the waiting list, however, was a motivating factor.

Many changes within a relatively short period of time have taken a lot of ongoing explaining of the purpose by management. However, when the goal was reached, it was clear that a different atmosphere had come about.

“This has been a tall order, which we all started working on in the outpatient clinic. It has taken a lot, but the result is clear, and we are very pleased with the result. Pathways and processes are under much better control and – not least – we have no patients in the waiting list. NICOLE G. K. ROSENBERG, SPECIAL PSYCHOLOGIST, HEAD OF UNIT, ADJUNCT PROFESSOR"
**Books**

**Beyond heroes. A Lean Management System fro Healthcare**  
Af Kim Barnas sammen med Emily Adams  
Udgivet af ThedaCare Center for Healthcare Value, 2014

**Den gode leanleder**  
Af Christian Balmer Hansen, Jens Stockholm Normand og Mikkel Simonsen.  
Udgivet på Børsens forlag, 2009

**Doing more with Less: Lean Thinking and Patient Safety in Health Care**  
Udgivet af The Joint Commission on Accreditation of Healthcare Organizations, 2016

**God leanledelse, i administration og service**  
Af Mikkel Eriksen, Thomas Ficher og Lasse Mønsted  
Udgivet på Børsens forlag 2015

**Lead with Respect, a novel of lean practice**  
Af Michael Ballé and Freddy Ballé  
Udgivet af Lean Enterprise Institute 2014

**Lean Behavioral Health - The Kings County Hospital Story**  
Edited by Joseph P. Merlino, Joanna Omi, and Jill Bowen  
Udgivet af Oxford University Press, 2014

**Lean Thinking**  
Af James P. Womack and Daniel T. Jones  

**Management on the mend. The Healthcare Executive Guide to System Transformation**  
af John Toussaint, MD sammen med Emily Adams  
Udgivet af ThedaCare Center for Healthcare Value, 2015

**On the mend. Revolutionizing Healthcare, to Save Lives and Transform the Industry**  
af John Toussaint, MD og Roger A. Gerard, Ph.d. sammen med Emily Adams  
Udgivet af Lean Enterprise Institute 2010

**Potent medicine. The Collaborative Cure for Healthcare**  
af John Toussaint, MD sammen med Emily Adams  
Udgivet af ThedaCare Center for Healthcare Value, 2012

**Articles**

**Akut. Kortere ventetid giver bedre behandling**  

**En introduktion til patient reported outcome measures i kvalitetsarbejdet**  

**Sundhedsstyrelsens slutevaluering af Den gode Psykiatriske afdeling**

**Danske Regioners oplæg til fremtidens sundhedsvæsen**
Glossary

A3: Problem-solving tool, which is used in case of major issues and always in improvement events. Starts by formulating the problem and ends with full implementation.

Fishbone: A diagram in which problems are sorted according to type and cause; solutions to the problems are presented.

Gemba: This is a Japanese word, which means “where value is created”. The concept of gemba means that managers go to the gemba, which is walking to the clinic – to see and understand tasks and coach staff in relation to goals and problem-solving.

Improvement event: A defined number of days (e.g. 3-4), when a group works intensively with solving an issue described in an A3.

Instruction: A description of how a given task is expected to be solved.

Kaizen: Ongoing improvements.

Lean: Means slim, trimmed. But it also means trusting. Lean is a work culture which was developed at Toyota in Japan, but which is now used by many enterprises.

Model cell: An isolated unit, where an overall, major improvement is tested, before it is broadened to the whole organisation.

Pareto: The 80/20 rule, which focuses on improving the 20% of the causes so as to ensure that 80% effect is achieved in terms of the result.

P-D-S-A: The improvement wheel, which is used in all improvement work. Plan, Do, Study, Act.

Sensei: Guide/Coach, who helps and supports the development of improvement work.

Standard: A written specification showing the level at which a given task is expected to be carried out, and indicating clearly the requirement for compliance.

Value stream mapping: Value Stream Mapping (VSM) is a visual presentation of all the players and all the actions involved in a pathway, showing also time indications. Subsequently, waste is defined and placed on the mapping document. And, finally, solutions are defined.

Visual management: An easy and simple way of understanding a process, a goal or an action – often through graphs, symbols, signs, colours or other clear marking, which means that staff members can quickly see and understand what they are supposed to do.

Waste: There are nine types of waste. Waste is all the activities, which do not generate value for the patient.

5S: A method creating an overview and system in work processes. The 5 S’s are: Sort, Systematise, Scrub and sweep, Standardise, Sustain.

5 x Why: A question method intended to find the underlying cause of a problem.

Graphics design: BOCCA
The work on this book "Improvement Work – A Handbook for Leaders in the Mental Health Services of the Capital Region of Denmark" was ended in February 2017. However, improvement work is a continuous process. Monitor its progress at PsykIntra.
This book is addressed at everyone in a leadership position in the Mental Health Services of the Capital Region of Denmark. The purpose of the book is to provide a common basis for working and leading in an improvement culture.

The book offers help for the concrete daily work with improvement methods and tools and for acting as a leader in an improvement culture.

Leaders from all over the Mental Health Services of the Capital Region have contributed to this book with their experience, hopefully as an inspiration to others.