

# Healthcare Performance Improvement

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# Agenda

- ❖ My journey into healthcare
- ❖ A brief overview of my healthcare work
- ❖ Connection b/w mind & heart, body & soul
- ❖ Some practical examples
- ❖ What can I do today

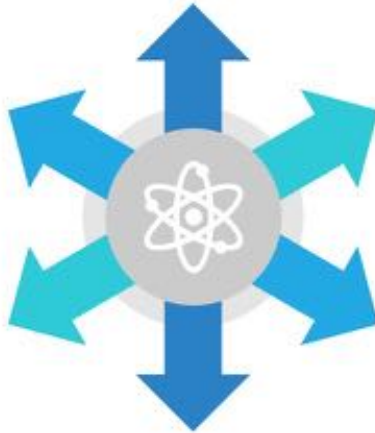


# Crossroad



Spojená škola Tvrdošín

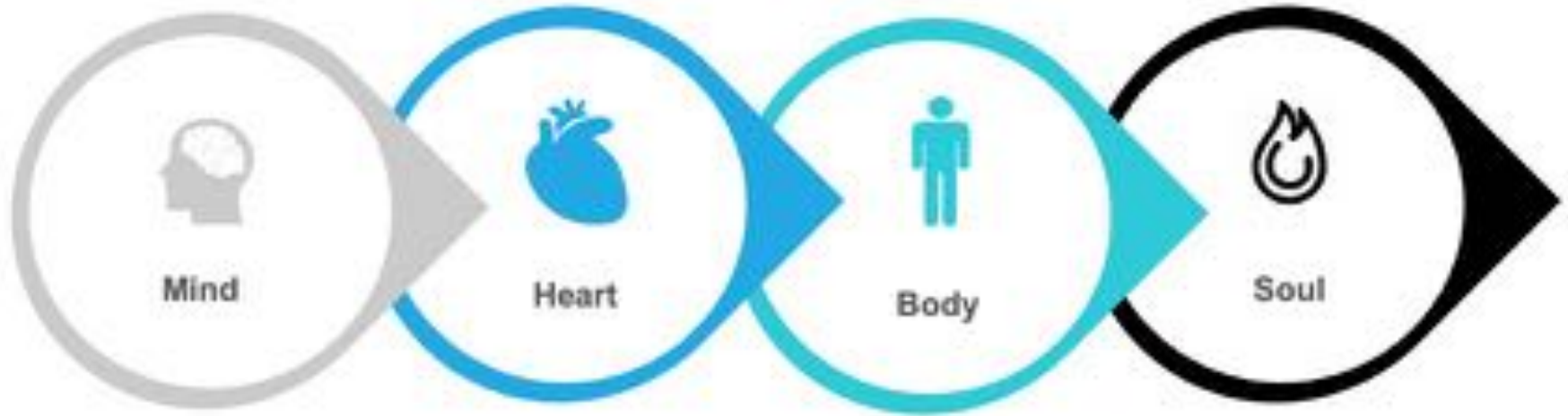
"Neučíme sa pre školu, ale pre život."



# Timeline



# Holistic Approach





# Reactive work assignments | 1/2

**Supplier Quality - Nonconformance Communication**

Microtec  
Nonconformance Report  
NCR No. 11-1393

Item No.	Description	Quantity	Disposition	Disposition Date	Disposition By
1	Part #100-580-4 Rev. B edge and face of defects	100	Scrap	11/15/07	Chris Fussell

**NCR 11-1393**

Conforming sample



Non-conforming sample



Description: Part #100-580-4 Rev. B edge and face of defects

Description: Part #100-580-4 Rev. B with nonconformities on surface

**Supplier Quality - Nonconformance Report**

Microtec  
Nonconformance Report  
NCR No. 11-1372

Item No.	Description	Quantity	Disposition	Disposition Date	Disposition By
1	Part #100-580-4 Rev. B edge and face of defects	100	Scrap	11/15/07	Chris Fussell

**NCR 11-1372**

Conforming sample



Non-conforming sample



Description: Part #100-580-4 Rev. B edge and face of defects

Description: Part #100-580-4 Rev. B edge and face of defects

**CORRECTIVE ACTION REPORT (CAR) FORM**

Microtec

CAR No.: CAR 06-0092

☒ CA ☐ PA

**Initiation/Background Information (CAPA Coordinator/Owner)**

Product Description / Quality System: Microtec Process Capability (Length Dimension) for Part #100-580-4

CAR Source: CAPA System Review Investigation (Inv. No. 3) Department Management Other:

Initial Risk Assessment: RAW #: NA (check copy of risk assessment)

Root or Probable Cause: (CAPA exists is not an investigation)

CAR #06-0092 was issued to Microtec after MPSS received two lots of Part #100-580-4 and one lot failed incoming inspection because the overall length on 17 parts fell below the lower specification limit of .314". The initial implementation plan to perform 100% inspection on all subsequent parts for this dimension was not successful. The capability of Microtec's manufacturing process to provide parts with a proper length has not been determined or required by Microtec.

CAR Owner: Chris Fussell Responsible Department: Quality Assurance

**CAR Implementation Plan (Owner)**

Description of Corrective/Preventive Action to be implemented: Microtec will begin capturing the data that is currently obtained during their in-process inspection procedures for the length dimension on the 100-580-4 part. The capability of the process will be determined from the data and appropriate actions will be taken to improve the capability as necessary. The current MPSS inventory levels for the 100-580-4 part will be sufficient for 3 to 4 months of production. Once Microtec begins manufacturing the 100-580-4 parts again, they will be required by MPSS Supplier Quality to provide in-process inspection data and capability measures for the length dimension of the 100-580-4 part.

Implementation Due Date: 05/31/07 (Provide date to CAPA Coordinator within 14 days of CAR initiation)

Additional Team Members Requested? ☐ Yes ☒ No (The Addition of Team Members Requires QMS Approval)

Proposed Criteria to Determine CAR Effectiveness: The in-process inspection data and process capability for the length dimension must be provided by Microtec for each of the next three production lots of the 100-580-4 parts that are manufactured for MPSS. The next three production lots must not fail for a non-conforming length dimension.

**Initial Plan Approval (Owner, Owner's Supervisor, & CAPA Coordinator unless waived-MMR)**

Owner	Date
Chris Fussell	10/25/06
R&D	
Manufacturing	
Quality	10/25/06
Other	
RA *	
CAPA Coordinator	10/25/06

Provide Original to CAPA Coordinator After Approval

# Reactive work assignments | 2/2

<b>Project Charter</b> Date: 31-January-2011    Project Name/QTRAK Number: LSPR0000375		
<b>Problem Statement</b>  Diamond coating yields at diamond coater, Di-Coat Corp., are below 96% causing shortages, affecting MPSS' ability to meet customer demands	<b>Project Y</b>  Production yield (PY>97%)	<b>Path Y's (if needed)</b>  Rolled Throughput Yield
<b>Project Goal</b>  Increase diamond coating yields at Di-Coat Corp. to greater than 57 % by August 2011	<b>Scope</b>  Scope includes: Diamond coating process through receiving inspection at Medtronic  Scope excludes: Transit, stem material, Medtronic packaging  Do not harm: Dimension of the product, durability of diamond coating	
<b>Resources</b>  <b>Project Team:</b> <ul style="list-style-type: none"> <li>Julie Mouzakis</li> <li>Richard Castellanos</li> <li>Glenn Nolley</li> <li>Marek Sturek</li> </ul> <b>Support Team:</b> <ul style="list-style-type: none"> <li>Kristin Hughes (MBB)</li> <li>Ross Smith (PO, SSBB)</li> </ul> <b>Stakeholders:</b> <ul style="list-style-type: none"> <li>Tony Knight (CH)</li> <li>Dan Robinson (VSM)</li> <li>Dan Cleary (F)</li> <li>Humacao PR (C.S)</li> <li>Di-Coat Corp. (S)</li> </ul>	<b>Business Impact and Benefits</b>  <b>Schedule:</b> <ul style="list-style-type: none"> <li>Project start date: January, 2011</li> <li>Estimated project completion date: August, 2011</li> <li>Estimated date when benefits will begin: June, 2011</li> </ul> <b>Benefits:</b> <ul style="list-style-type: none"> <li>Hard savings: Estimated MPSS's scrap cost of \$41K, Di-Coat's cost \$31K, NCR scrap cost of \$5K.</li> <li>Soft savings: Reduce non-conformances, reduce rework</li> <li>Other benefits: Strengthen partnership, Documented process controls</li> </ul>	

LEAN SIGMA SOLUTIONS™ -

Lean Six Sigma Di-Coat Corp. Production Project					
I. NCR Reduction	1	January-May 2011 (Pre Improve Phase)		June - August 2011 (Current State)	
		Quantity (No.)	Cost (\$)	Quantity (No.)	Cost (\$)
		4	3405	0	0
II. Scrap Reduction	2	January-May 2011 (Pre Improve Phase)		June - August 2011 (Current State)	
		Quantity (lot)	Average Scrap (%)	Quantity (lot)	Average Scrap (%)
		1868	4.604	1305	2.087%
III. Component Quantity	3	January-May 2011 (Pre Improve Phase)		June - August 2011 (Current State)	
		Quantity (lot)	Average monthly receipts (lot)	Quantity (lot)	Average monthly receipts (lot)
		49327	9865	64284	20428
IV. Savings	4	Di-Coat Corp. Savings:		Medtronic Inc. Saving	
		400 pcs X \$6 = \$2400 per month		400 pcs X \$10 = \$4000 per month	
V. Other	5	-		-	
> MPSS inspection time	6	Receiving inspection for curve burr the same		Receiving inspection for curve burr improved (Lithotonic clearing process removed)	
> Di-Coat Corp. Rework process	7	Avg Feb-May 2011 (Completed, Scrap) 3.08%		Avg June-August 2011 (Completed, Scrap) 2.43%	
> Inspection method variation	8	No visual methods of inspection established between MPSS & Di-Coat		Visual methods of inspection established & aligned	
> Di-Coat Corp. Operational process metrics	9	Operational & process metrics the same		Weekly meetings / Data collection / Data analysis established	
What's next?		Complete drawing revisions		Drive excellence to improve Op. 40	Continue focus on OPED curve burr
				Complete transfer to Plant No. 3	

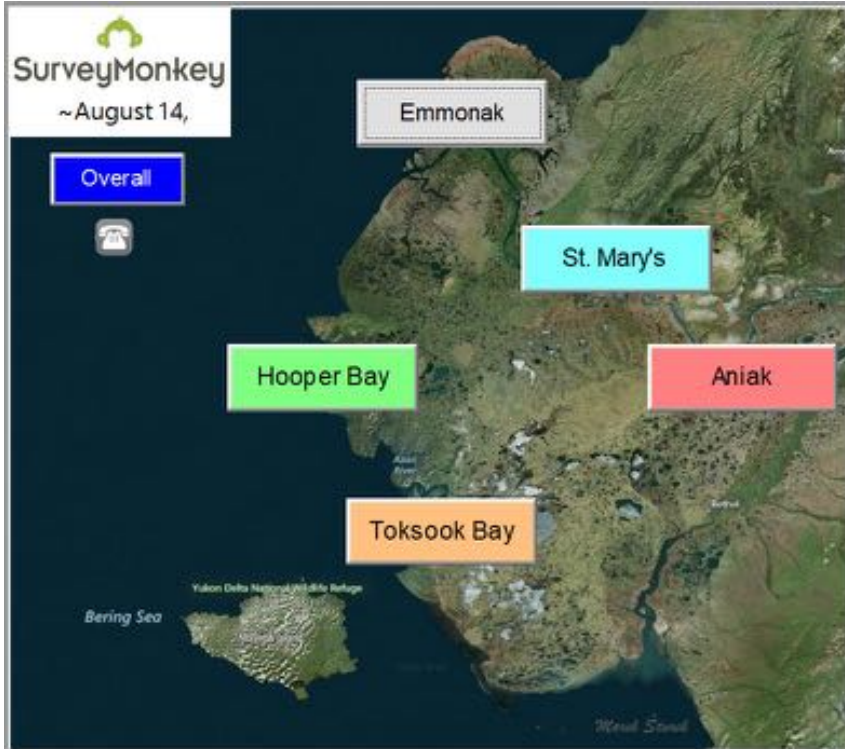
# Proactive work assignments | 1/2

<b>RISK ANALYSIS WORKSHEET</b>		Risk Analysis Worksheet No. <b>RAW07-0013</b> Rev. <b>NEW</b> NCR / COMPLAINT / OTHER: <b>07-0178</b>
Initiator: <b>JAMES ELLSWORTH</b> DATE INITIATED: <b>2/28/07</b>		
<b>Primary Event Description</b> (Include how the work was decorated, what the faulty surrounding the event.) Operator did not follow work instructions 400800-10. 1. O-Ring was not coated with Midos Plus Lubricant prior to installation. 2. Also, step 4 of work instructions, inserting collet housing into compression nut was performed in the mode of step 3 before inserting collet carrier into collet housing.		
<b>Primary Event Source: (select one)</b> <input checked="" type="checkbox"/> Internal Source <input type="checkbox"/> External Source		
<b>State Failure Effects:</b> <input type="checkbox"/> See Attached 1. O-Ring could become damaged during installation. 2. No failure effect is associated to this particular sequence.		
<b>State Potential Clinical Effects:</b> <input type="checkbox"/> See Attached There is no clinical effect of either situation 1 or 2. The risk is completely transparent to the doctor and patient.		
<b>State Potential Event Cause(s):</b> <input type="checkbox"/> See Attached Operator error - not following work instructions		
<b>SEVERITY</b> <input type="checkbox"/> 4-Critical <input type="checkbox"/> 3-Major <input type="checkbox"/> 2-Minor <input checked="" type="checkbox"/> 1-Negligible		
<b>FREQUENCY</b> <input type="checkbox"/> 4-Frequent <input type="checkbox"/> 3-Occasional <input type="checkbox"/> 2-Rare <input checked="" type="checkbox"/> 1-Infrequent		
<b>DETECTABILITY</b> <input type="checkbox"/> 3-Highly Detectable <input type="checkbox"/> 2-Medium Detectable <input checked="" type="checkbox"/> 1-Lowly Detectable		
<b>Calculate RPN</b> Severity X Frequency X Detectability = RPN 1 X 3 X 3 = <b>9</b>		
<b>Approved By:</b> (External Sources require Regulatory and/or Engineering Signatures, Internal Sources require Quality Engineering, Manufacturing Engineering, all product labeling and potential field impact requires Regulatory signature) Department: <b>Quality Engineering</b> Signature: <b>James Ellsworth</b> Date: <b>2-23-07</b> Department: <b>Manufacturing Engineering</b> Signature: <b>James Ellsworth</b> Date: <b>2-23-07</b> Department: <b>Regulatory</b> Department: <b>Product Engineer (R&amp;D)</b>		

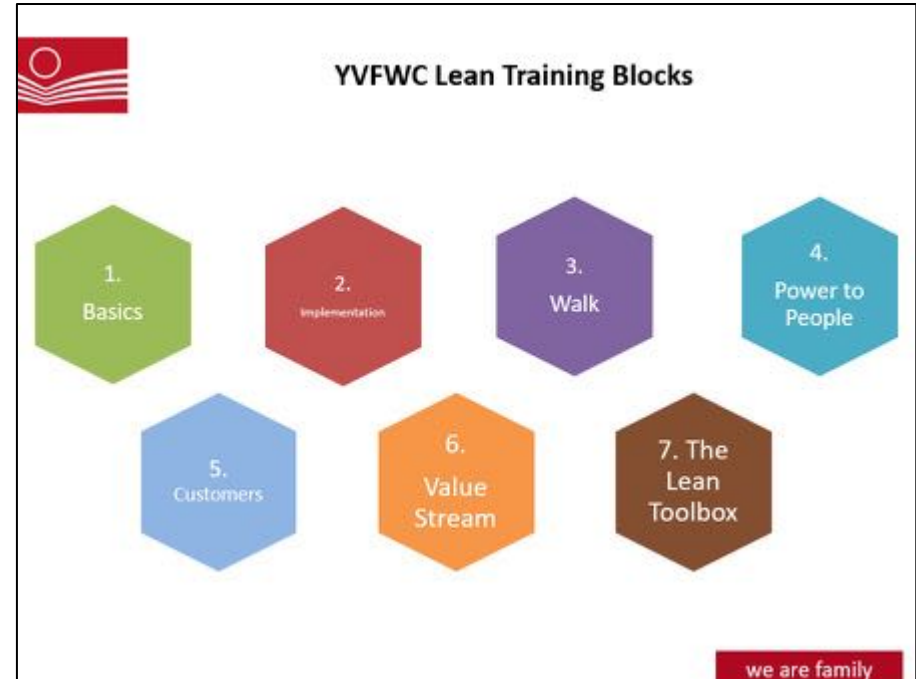




# Proactive work assignments | 2/2



# Preventive work assignments | 1/2



# Preventive work assignments | 2/2

Task	Job	Worked Work	Expected	Date
1	Acute Patient	YHSC Reception	Quality	11/04/2017

Task Elements Owner: Front Office Supervisor

Description	Key Points	Visual Cue(s)
1. Greet the patient	Ask for DOB, First and Last Name. Introduce yourself. Let patient know who they are seeing and what time is appointment.	
2. Demographics	Click on Appointment Desk Registration Registration Demographics Patient Demographics General Information	

HFMEA Subprocess Step Title and Number										
Failure Mode: First Evaluate Failure mode before determining potential causes	HFMEA Step 4 - Hazard Analysis				HFMEA Step 5 - Identifying Actions and Outcomes				Patient Responsible	Management Responsible
	Potential Causes	Severity	Frequency	Probability	Control Measure	Action Type (Control, Accept, Eliminate)	Action or Rationale for Stopping	Outcome Measure		
Bed availability (Inpatient 3 beds, ER 2 beds)		Major	Frequent	High	Y	N	Y			
	1 Gender, Age in same room	Moderate	Frequent	High	Y	N	Y	State and Joint Commission regulations		
	2 High volume of patient	Moderate	Frequent	High	Y	N	Y	Review staffing plan for North Wing and ER in order to establish more effective patient service	Effective patient service measured by Patient Satisfaction, Decreased length of stay	
	3 Staffing	Moderate	Frequent	High	Y	N	Y	Create guidelines for admission Review staffing plan on North Wing Training status		
	4 Lack of guards	Minor	Occasional	Low	N	N	N			
	5 Intoxication (High sobriety)	Major	Frequent	High	Y	N	Y			
	6 Insufficient # of room	Major	Frequent	High	Y	N	Y			
	7 Mechanical issue	Moderate	Occasional	Low	N	N	Y			
	8 Standardization	Moderate	Occasional	Low	N	N	Y			
	9 Waiting Judge, APR Response, BH clinical	Moderate	Frequent	High	Y	N	Y			

# Today not tomorrow

**8** steps  
according to  
**JOHN KOTTER**

- ❖ Urgency of change
- ❖ Coalition supporting change
- ❖ Clear vision
- ❖ Communication of vision
- ❖ Stronger employee engagement
- ❖ Short wins
- ❖ Support of next change
- ❖ Hardwiring change



Thank you & Questions

