Designing for Improvement

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quality by design

"everything is designed...
few things are designed well."

- Brian Reed



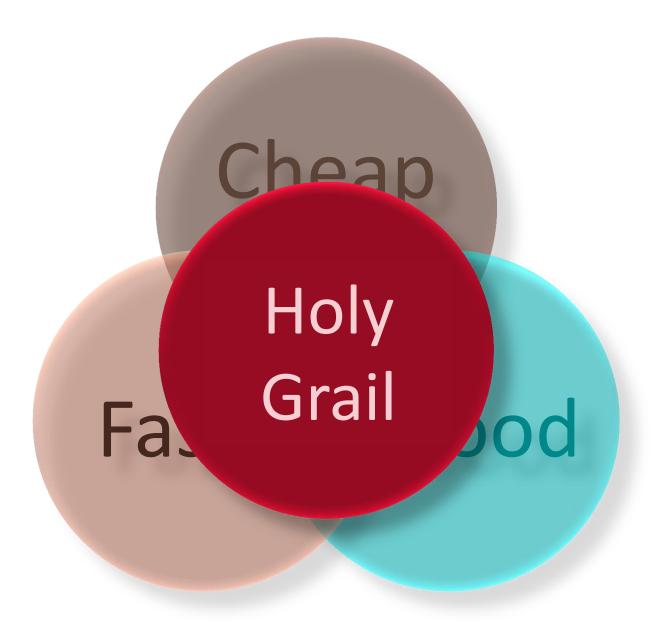
essential demands

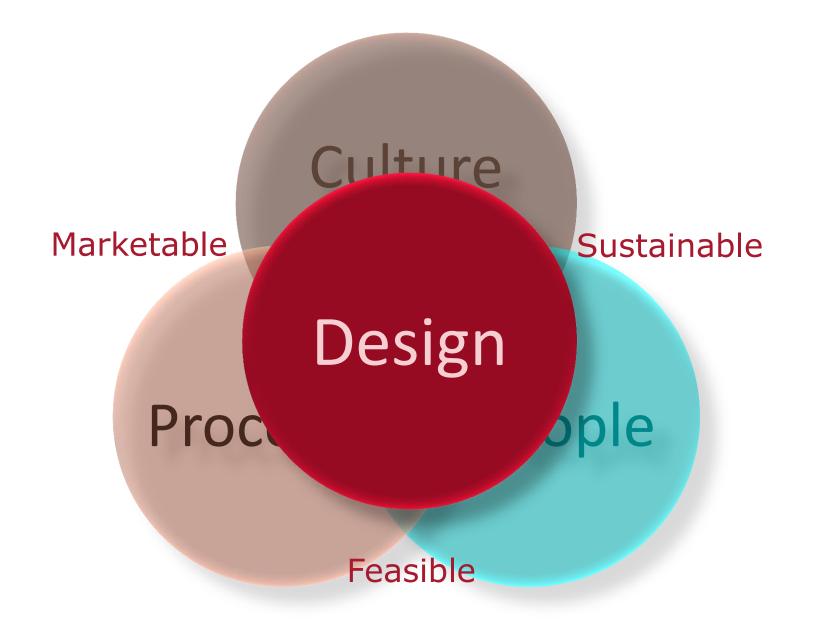
cost-effective fast and flexible continually improving





"We have low cost, fast turn-around time and high quality. Which do you prefer?"

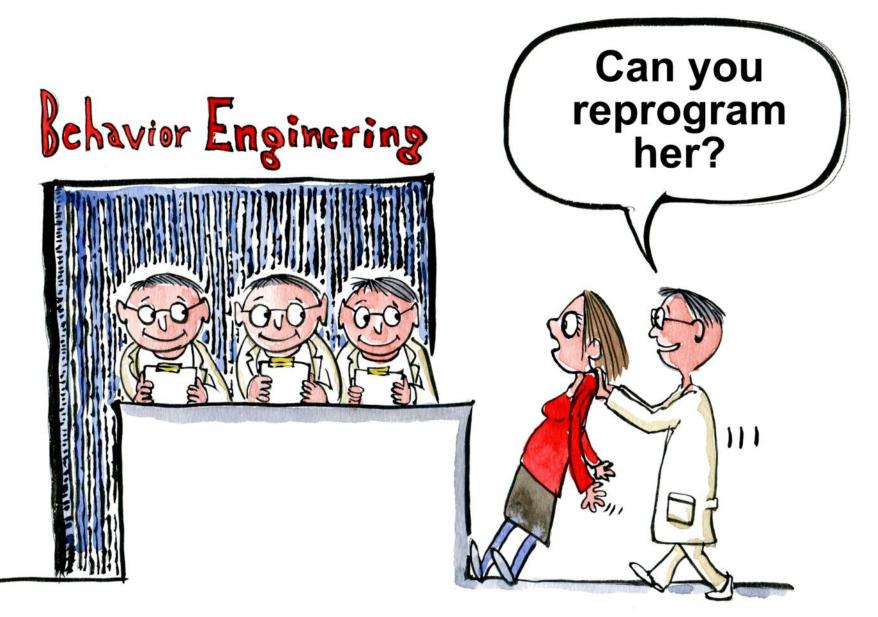




design targets

- behaviors sustainable
- work feasible
- value marketable





By HikingArtist.com

What's wrong with this picture?





visual workplace



visual workplace

translates information into behavior



traditional

- classes
- OJT
- manuals
- procedures
- meetings
- questions

visual workplace

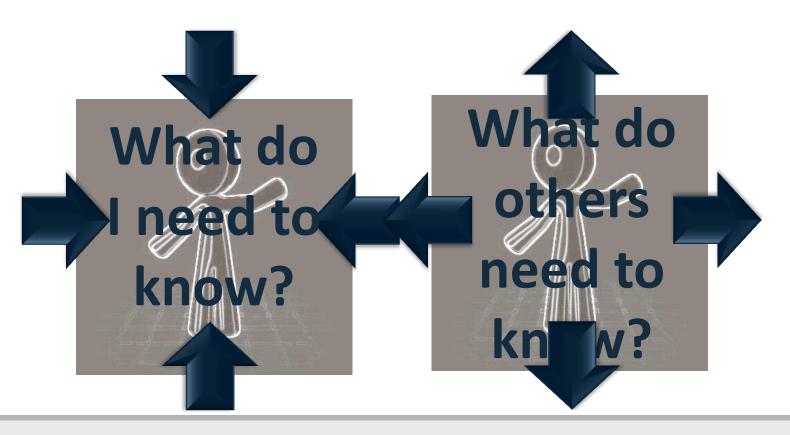
visual devices



- 1. understand *I-Driven Visuality*
- 2. establish standards
- 3. ask the "6 Core Questions"
- 4. discover information deficits
- 5. learn to "see" motion
- 6. define work
- 7. locate the value field
- 8. collect and evaluate motion metrics
- 9. optimize



i-driven visuality





14

standards

technical

- distance
- volume
- weight
- time
- pressure

procedural

- how to...
- sequence of steps
- shared measures
- outcome focused

6 core questions



where?



how?



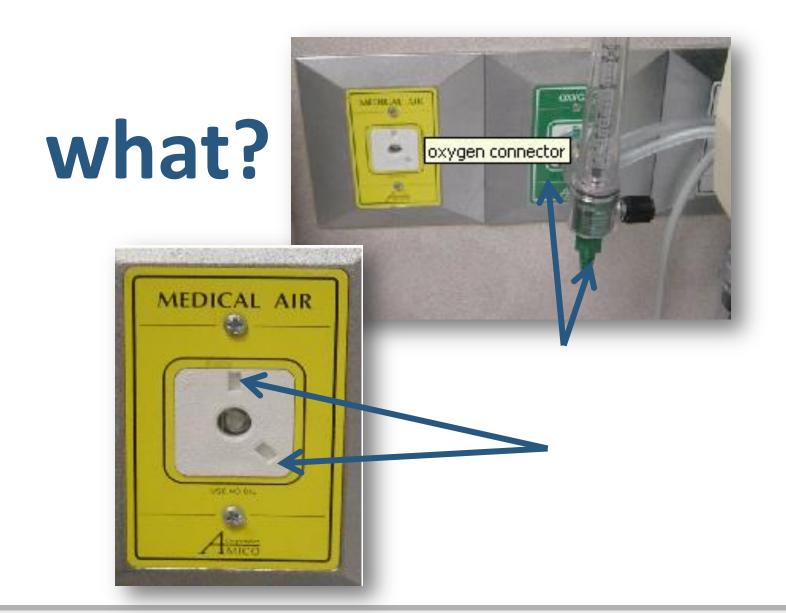
when?



Reorder at 500 sheets 750

1,000





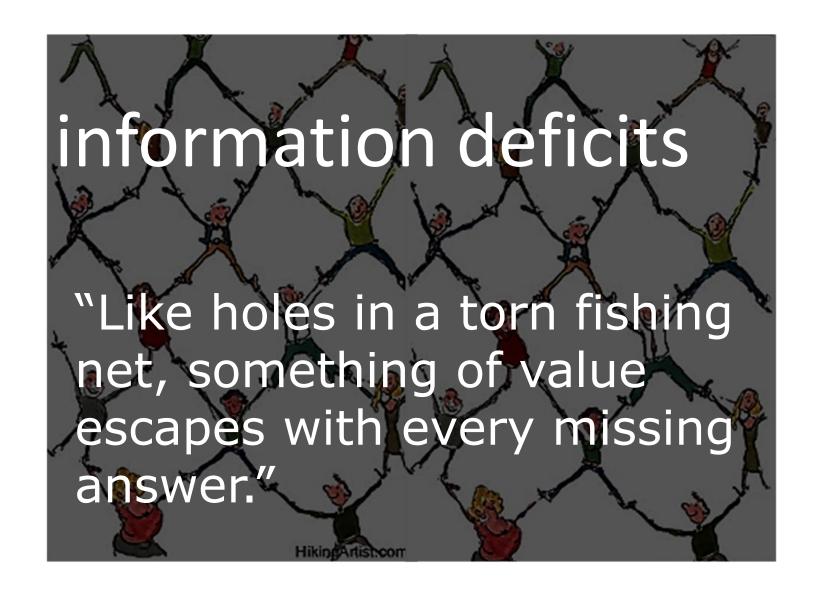


who?



how much?







the visual workplace

motion

moving

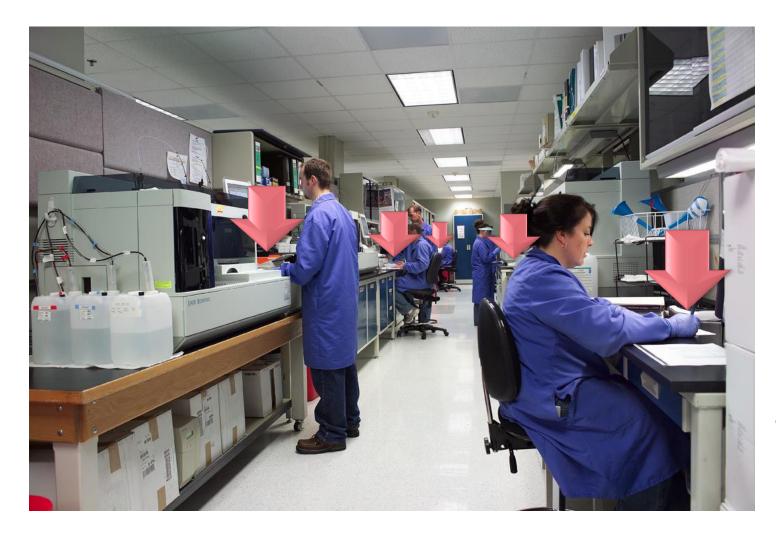
- without adding value
- not in the value field
- waste
- due to information deficits

work

moving

- and adding value
- in the value field
- value
- the result of having the information needed to complete the task







forms of motion

- searching
- looking for
- wandering
- wondering
- guessing
- checking
- re-checking
- handling
- handling again
- moving again

- counting
- counting again
- asking
- answering
- interrupting
- waiting
- doing again
- re-working
- re-testing
- stopping

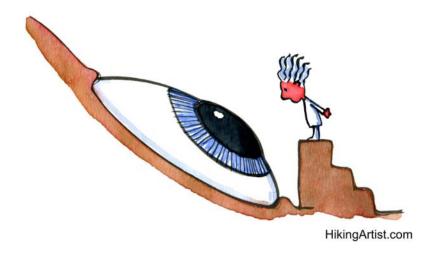












Go Look Go See

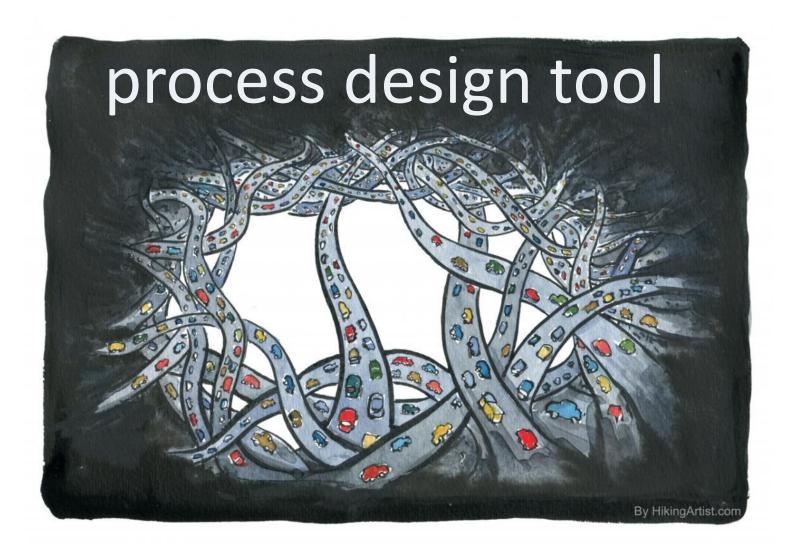
the place where work happens is the place where innovation happens



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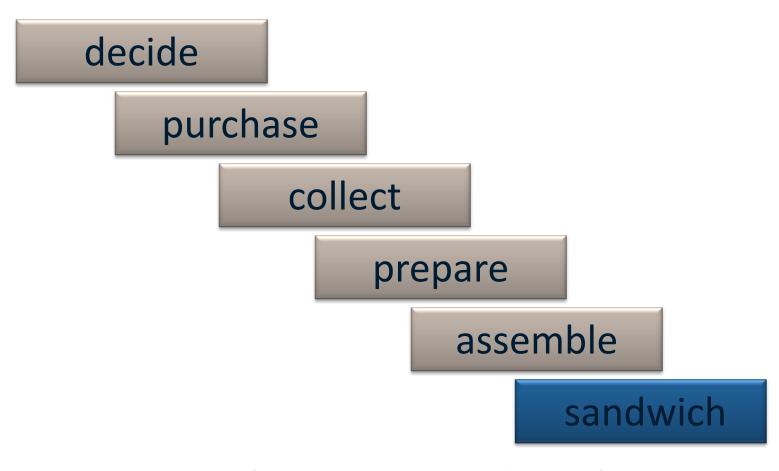




step 1

- start with the final product or service.
- describe each major step required to achieve the final product or service backward.
- do not include decision steps.
- agree when to stop





making a sandwich

step 2

- identify the variables associated with each step.
- don't record the same variable more than once.



an element or cause

independent

dependent —

controlled -

extraneous

variable



making a sandwich

decide

condiments

side dishes

prepare

chopped

cold

purchase

cost

availability

assemble

grilled

formal dinnerware

collect

on hand

how many sandwiches

eat

where to eat

alone



- o evaluate each variable
- o determine if it must be
 - eliminated
 - controlled
 - accepted
- cross out those that can be eliminated
- circle those that will be accepted





error-proofing



establish and enforce standards





facilitate early detection

making a sandwich

decide

condiments

side dishes

prepare

chopped

cold

purchase

COSL

availability

assemble

grilled

formal

dinnerware

collect

on hand

how many sandwiches

eat

where to est

alone



- make a list of the variables to be controlled
- identify the earliest step where each variable can be controlled.
- list the variable under that step



making a sandwich

decide

alone?

how many?

condiments?

on hand?

chopped?

cold?

grilled?

purchase

collect

prepare

assemble

eat



- make a list of the variables to be accepted
- identify the earliest step where each variable will be encountered.
- list the variable under that step
- as you design the rest of the process, look for a natural spot for a second check step



making a sandwich

decide

alone?

how many?

condiments?

on hand?

chopped?

cold?

grilled?

purchase

available?

collect

available?

prepare

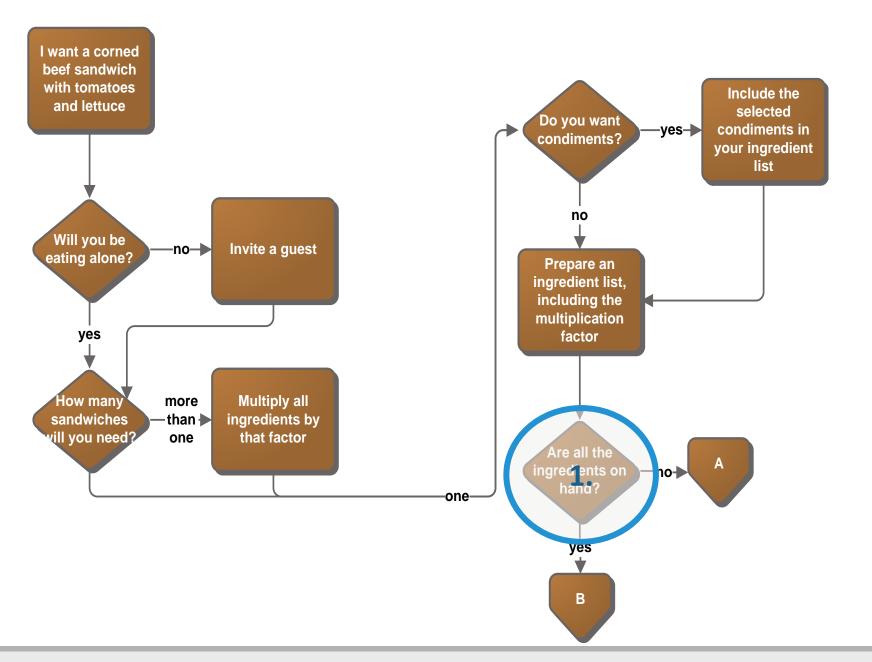
assemble

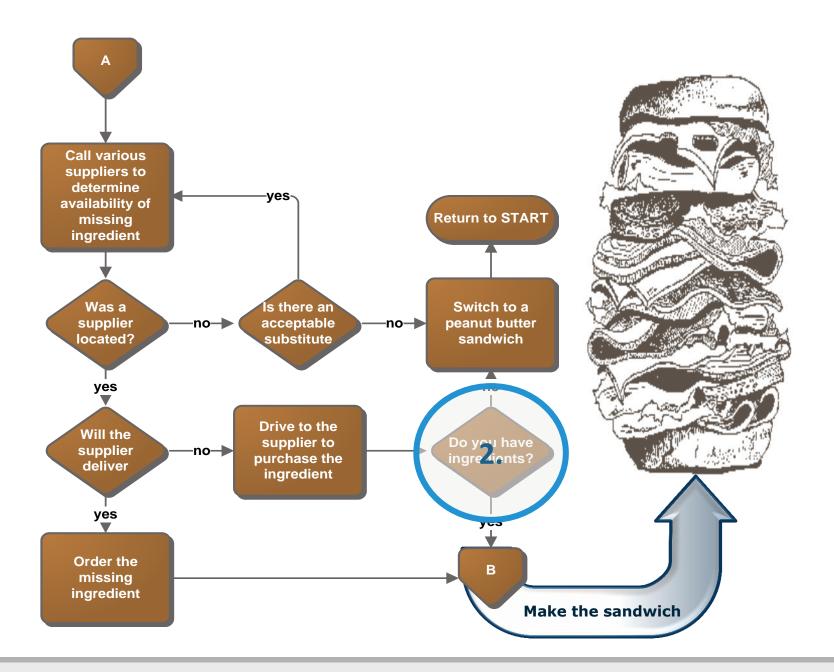
eat



- create a detail flow chart
- controlled variables are decisions
- for accepted variables, build at least two inspection points
- describe the best response to each variable
- include supporting activities







For each step, account for

- resources needed (equipment, supplies, applications, space, etc.)
- ostaff required
- step duration--minimum and maximum times
- step dependencies



- otest the process
- make changes
- oimplement
- make changes
- otest the process



creativity vs. innovation

coming up with new ideas

putting those
ideas into
 practice

creative thinking

linear techniques





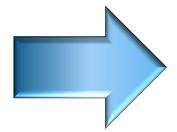






intuitive techniques







creative thinking

- 1. identify assumptions
- 2. deny the constraints
- 3. study what happens



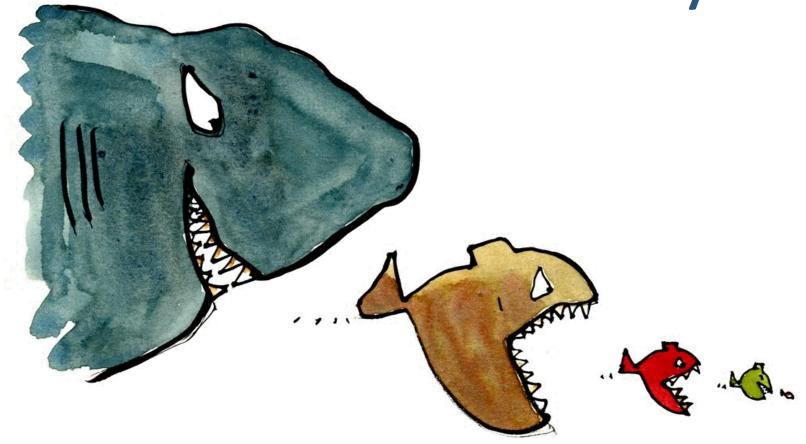
problems



innovation arises from resolving contradictions



the five "why?"s





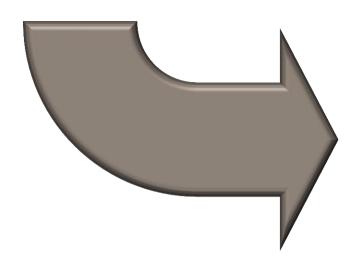
question the status quo

to best in class

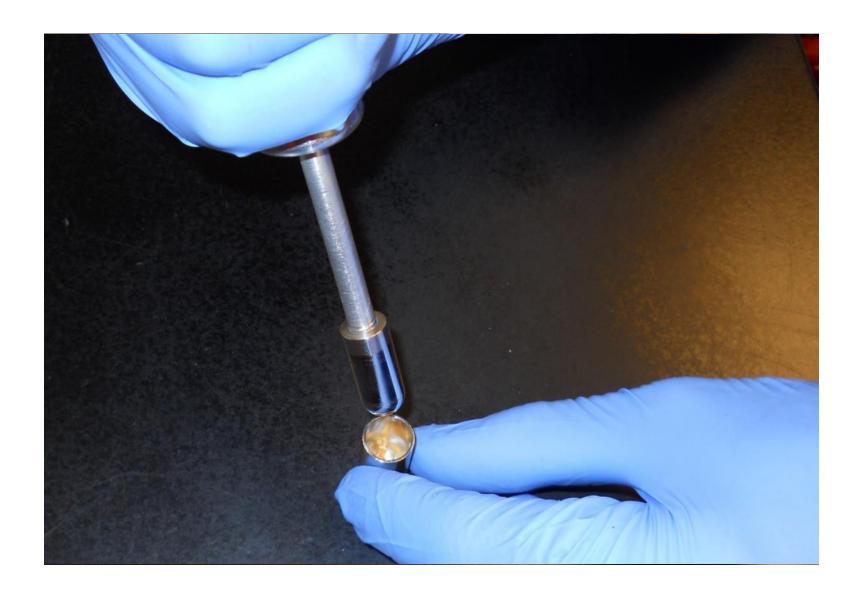
from good enough



excuses



preemptive surrender





A designer knows he has achieved perfection not when there is nothing left to add, but when there is nothing left to take away.

Antoine de Saint-Exupery

design targets

- behaviors sustainable
- work feasible
- value marketable



Subjective Theory of Value

- value resides in the mind
- value is a function of time
- we select the value that we perceive to rank highest at the moment of exchange

Objective Theory of Value

- value is an outcome of action
- value is both an end and a means
- a value-for-value exchange is a condition of survival

The best way to predict the future is to invent it, not prevent it.



(Alan Kay)

organizational system is...

social system, not a biological system

- ownership is irrelevant
- member development is an obligation
- "lower-archy" selects leaders



designing a system

a culture design that recognizes the organization as a social system

"creates the conditions under which a good outcome is not only possible, but probable."



A person having a nightmare can do many things in his dream—run, hide, fight, scream, jump off a cliff, etc.—but no change from any of these behaviors to another would ever terminate that nightmare...

The only way out of a dream involves a change from dreaming to waking.

(Paul Watzlawick)

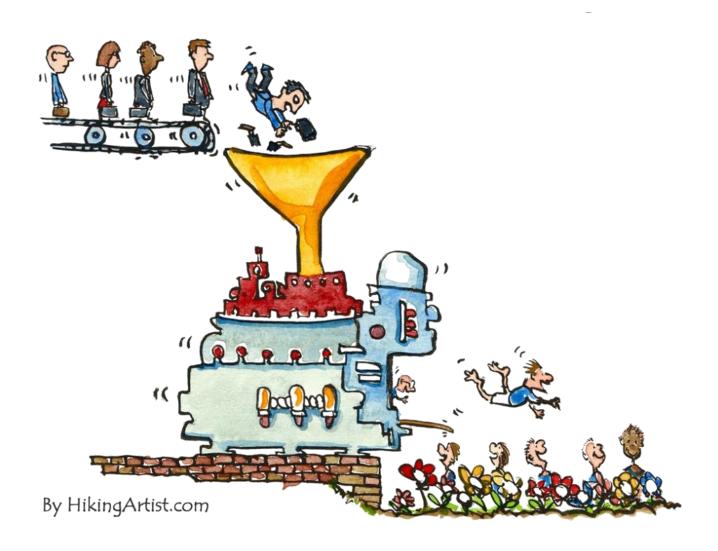
The first step in creating a culture of innovation requires overcoming paradigm paralysis



design key



- context
- limitations
- goals





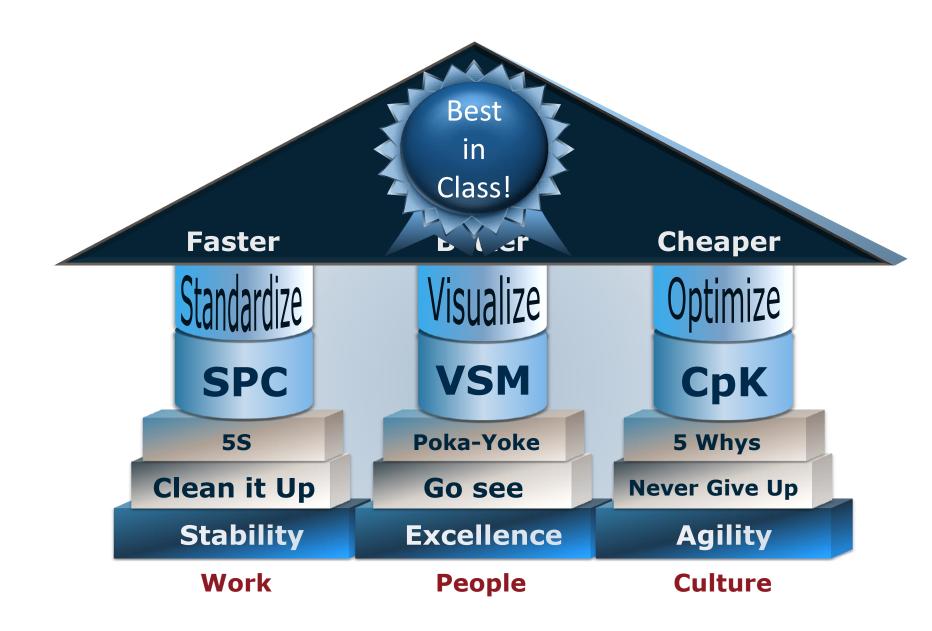
value drives design design creates culture culture shapes values

values determine the future



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References

Ackoff, Russell L., iconoclastic management authority, advocates a "systemic" approach to innovation. Interview with Robert J. Allio http://www.acasa.upenn.edu/p19.pdf

Babbitt, Tripp. "Redux: Rethinking Lean (Six Sigma) Service." Quality Digest Daily, November 9, 2009.

---. "Systems Thinking Saves Service." Quality Digest Daily, August 5, 2010.

Benson, Heidi. "Chaos and Complexity: Applications for Healthcare Quality and Patient Safety." *Journal for Healthcare Quality* Sept/Oct 2005.

Cadsby, Ted. "Why Being Certain Means Being Wrong." HBR Blog Network, July 25, 2011

Carr, Susan. "Evidence and Criteria." Patient Safety & Quality Healthcare, Sept/Oct 2008.

Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academy Press, 2001.

Diamond, Jared. Collapse: How Societies Choose to Fail or Succeed. The Penguin Group, New York, NY. 2005

Fraser, Sarah W. and Trish Greenlaugh. "Complexity Science: Coping With Complexity: Educating for Capability." *British Medical Journals* Vol.323; pp. 799-803, Oct. 6, 2001.

Frndak, Diane C. "Developing and Implementing a Practical Model of Real-Time Redesign and Problem Solving For Frontline Healthcare Professionals." (Doctoral dissertation). Retrieved from http://etd.library.pitt.edu/ETD/available/etd-12022008-091139/unrestricted/frndakdc_etd2008.pdf.

Godfrey, A. Blanton, et. al. "Application of Healthcare-Focused Error Proofing: Principles and Solution Directions for Reducing Human Error." ASQ World Conference on Quality and Improvement Proceedings, Seattle, WA, Vol. 0, No. 0, May 2005, pp. 19-28.

Galsworth, Gwendolyn D. Visual Systems: Harnessing the Power of a Visual Workplace. AMACOM. USA. 1997.

Keating, Elizabeth. "Overcoming the Improvement Paradox." European Management Journal; Vol. 17. No. 2 (1999) pp. 120-134.

Kenagy, John W. M.D., M.P.A., Interview with Patrick Mullen, Senior Contributing Editor. "Time To Roll Out 'Disruptive Innovation'." *Managed Care*, March 2001

Matthew E. May, "Let Discipline and Patience Enable Innovation," Quality Digest Daily, 4/18/13

McKinnon, Todd. How To Build a Great Company Culture, Forbes, Oct 4, 2013

Merrill, Peter. Innovation Generation: Creating an Innovation Process and an Innovative Culture. Milwaukee, WI: ASQ Quality, 2008

Sedon, John. "Cultural Change is Free." Human Givens Institute. 2009 (http://www.vimeo.com/4670102>

Shingo, Shigeo. *Kaizen and the Art of Creative Thinking-The Scientific Thinking Mechanism*. Bellingham, WA: Enna Products Corporation. 2007 (English Translation).

Wilson, Tim, Tim Holt and Trisha Greenlaugh. "Complexity Science: Complexity and Clinical Care." *British Medical Journals* Vol.323; pp. 685-688, Sept 22, 2001.





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