This strategy can help cross-departmental teams work through problems.

**ROBERTA**, an emergency department (ED) nurse, tries to call report to Cheryl, a nurse on the medical unit. She's placed on hold while Cheryl is located; frustrated, she hangs up and attends to her new patient. Her charge nurse asks if her patient is ready to move. "I couldn't give report," she replies. "They never take report on the first call. They don't know what it's like down here."

Meanwhile, on the medical unit, Cheryl has just finished dressing a central line. She doffs her protective gear, washes her hands, and rushes to the phone to take report. "They hung up before I could say hello," she laments. "They don't understand what it's like up here."

As this scenario shows, two nurses can look at the same situation and see it in starkly different ways. Both want to give their patients the best care, but fragmented processes and lack of teamwork between departments stymie their efforts.

How do you get teams to function well not only within their own departments and across professional boundaries, but also across departmental boundaries? Patient journeys don’t confine themselves to particular departments or units, and transitions are high-risk times for patients. That’s why the Culture of Safety survey from the Agency for Healthcare Research and Quality includes the dimension of teamwork across units.

At Orlando Regional Medical Center (ORMC) in Orlando, Florida, we’ve identified teamwork across units as an area of opportunity. We recognize that building this capability in our hospital has the potential to improve everything we’re trying to do: make our patients safer, improve the quality and efficiency of care, and increase both employee and patient satisfaction with the care we provide.

Since the Institute of Medicine’s 2000 report, *To Err is Human: Building a Safer Health System*, teamwork skills have garnered much attention—but efforts usually focus on teamwork within departments or service lines. But is that approach the best? Hospital departments are exceptionally dependent on one another for services and information. So teaching people about teamwork only within their own work groups may reinforce silos at a time when we need to tear them down.

**Journey to the gemba**

The literature doesn’t provide much guidance on building interdepartmental teamwork, so at ORMC we decided to start in the *gemba*. A Japanese word, *gemba* means “the actual place”—the place where the work happens.

*Gemba* has its roots in the Toyota Production System, birthplace of lean methods. For ORMC, this is a natural connection; we’re in year 3 of a lean transformation journey. To work together well, teams must do more than just talk about their differences and conflicts. The only way to learn what’s really happening on the front lines is to go to the gemba and see for yourself. So let’s return to Roberta and Cheryl.

Realizing that challenges like Roberta’s and Cheryl’s occur all over the hospital, an administrator schedules a rapid-improvement workshop to tackle the problem. During the workshop, frontline nurses from the ED and...
two inpatient units, a housekeeping supervisor, a transporter, a house supervisor, and an ED secretary spend 2 full days examining the current process, identifying waste, and crafting a new process to test together. Lean transformation consultants facilitate the process, providing tools and structure to the workshop.

To examine the process firsthand, workshop members go to the gemba, where they’re instructed to view what they see through a patient’s eyes. The patient’s journey begins in the ED, so they start there. On this day, they find more than 45 patients sitting in the ED waiting room. ED nurses explain that patient volumes like this are old hat to them. But the inpatient nurses are visibly uncomfortable and concerned for the waiting patients.

The group presses onward to the ED treatment area. On the wall, 10 patients are listed because they need immediate care and all treatment rooms are full. Again, this situation is common; in fact, the ED team has numbered wall stretchers and a staffing plan to accommodate the overflow. Again, the inpatient nurses are shaken; they can’t imagine practicing like this and certainly don’t want their families to be treated this way. Going to the gemba has helped them see things in a new way.

The group moves upstairs to the orthopedics unit, which is split geographically on two wings. They learn that the curved walls, designed to keep the patient environment quiet, prevent unit nurses from hearing the desk phone ring. They see no nurses at the station; all of them are in patient rooms or scurrying down the halls trying to do several tasks at once. The gemba group walks the distance between the two wings along with the charge nurse. The ED nurses start to understand the barriers the orthopedic nurses face. Next, the group heads to a medical unit, where a similar scene unfolds.

By the end of the workshop, the group has crafted a process that’s acceptable to both the ED and inpatient nurses and fully supported by the house supervisor and housekeeping and transportation departments. As part of the new process, all charge nurses will shadow ED nurses on the floor and floor nurses will shadow ED nurses. Based on this experience, they realize gemba visits are essential to continued interdepartmental teamwork.

### Gemba board: A vital communication hub

Progress of a rapid-improvement initiative can be tracked at gemba boards—visual management boards that boost engagement by displaying improvement data and the unit’s contributions to hospital strategy. In our scenario, the board is situated in a hallway in both the ED and the medical unit, fully visible to all who pass by. All data are visible on the board, and meaningful conversations about next steps take place several times a week. At the board, everyone is welcome. Those

### Problems and countermeasures identified

The problems and countermeasures listed below were identified collaboratively during the gemba workshop at Orlando Regional Medical Center and shared with unit staff at gemba board meetings. Performance with countermeasures was tracked at the gemba board, and problems were shared between units.

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<tr>
<th>Problem (or waste)</th>
<th>Countermeasure</th>
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<td>Extremely variable handoff report, with nurses requesting or offering different types of information based on their practice area and experience level</td>
<td>• Nurses now use a standard report template that includes critical information for safe handoff.</td>
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| Multiple phone calls required for emergency department (ED) and inpatient nurses to make contact | • ED bed assignment slip now includes a mobile phone number for receiving nurse. If receiving nurse can’t answer, phone call rolls to backup or charge nurse, who takes report.  
• If report isn’t taken, ED nurse delivers patient to unit with handoff documented on handoff template, and provides mobile phone number for questions. |
| Room cleaning delayed due to equipment in patient rooms                           | • Transportation department now activates call light when picking up patient for discharge to alert nursing assistant to remove equipment.     |
| Lack of understanding between departments                                          | • Charge nurses now shadow nurses in other units’ gemba.                                                                                     |
with a major stake in a particular process and the merely curious have equal footing here. Great ideas have come from “fresh eyes.” Those new to a project might see things others can’t. Representatives from other departments are invited to visit the board so they can learn about the project and the team can learn from them. This continued exchange keeps the project visible and holds all team members accountable. (See Problems and countermeasures identified.)

Progress and challenges
ORMC has seen significant changes since cross-departmental teams began going to the gemba to work through problems. Gemba boards on each nursing unit are bearing fruit, but the system isn’t perfect. We continue to experience challenges in sustaining initial gains from improvement work. Here are some lessons we’ve learned:
• Recognize that nurses are well positioned to identify all of the appropriate players in a process because they come into contact with most of them. But that doesn’t mean nurses can represent those players. Valuing participation from all involved departments can remove or prevent barriers.
• Go small at first. Iterative small tests of change provide needed opportunities to make small-scale mistakes.
• Embrace failure. Tests of change that fail teach us what not to do and are just as valuable as successful experiments.
• Take the time to determine appropriate metrics, gather baseline data, and set specific targets. For us, failure to accomplish one or more of these things has led to poor sustainment of change.
• Spell out the “how” of a change. Document new processes thoroughly and monitor their performance. You can’t measure efficacy if everyone is doing it differently.
• Meet in the gemba at least weekly to update project progress and troubleshoot.

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Selected references