“BETTER IS POSSIBLE”

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Clinical Educator
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LEARNING OBJECTIVES

- Define the ‘Trap of Understanding’ and recognize how it can inhibit progress in hand hygiene improvement
- Explain the importance of shifting the focus from hand hygiene behavior of healthcare workers to include the systems and processes that contribute to those behaviors
- Describe how defining and measuring action-based leading indicators can help predict hand hygiene performance results

FINANCIAL DISCLOSURE

GOJO Industries, Inc.

Clinical Educator, Healthcare

"We're doing the **very best** we can with our current resources."

Yet, we know we need to **close the gap**.

Which means we need to **do better**.

"They **know** hand hygiene is important. Why aren't they **doing** it?"

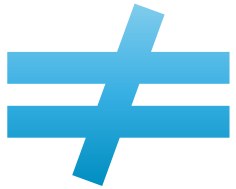
How many of you would like to lose weight or improve your physical fitness?

Now, if you have no idea what you need to do to accomplish either of those goals…

lower your hand.

CONCEPTUAL UNDERSTANDING AND BEHAVIOR

Understanding something conceptually



Following through with actions

> It's not the absence of knowing or understanding that is the problem. It is people **not doing** what they know to do.

CONCEPTUAL UNDERSTANDING AND BEHAVIOR

If I change what they know, understand, or believe

They will change their behavior

Leading to change in the organization and outcomes

General Assumption

Slide attribution: Courtesy of Jeffrey Ford PhD

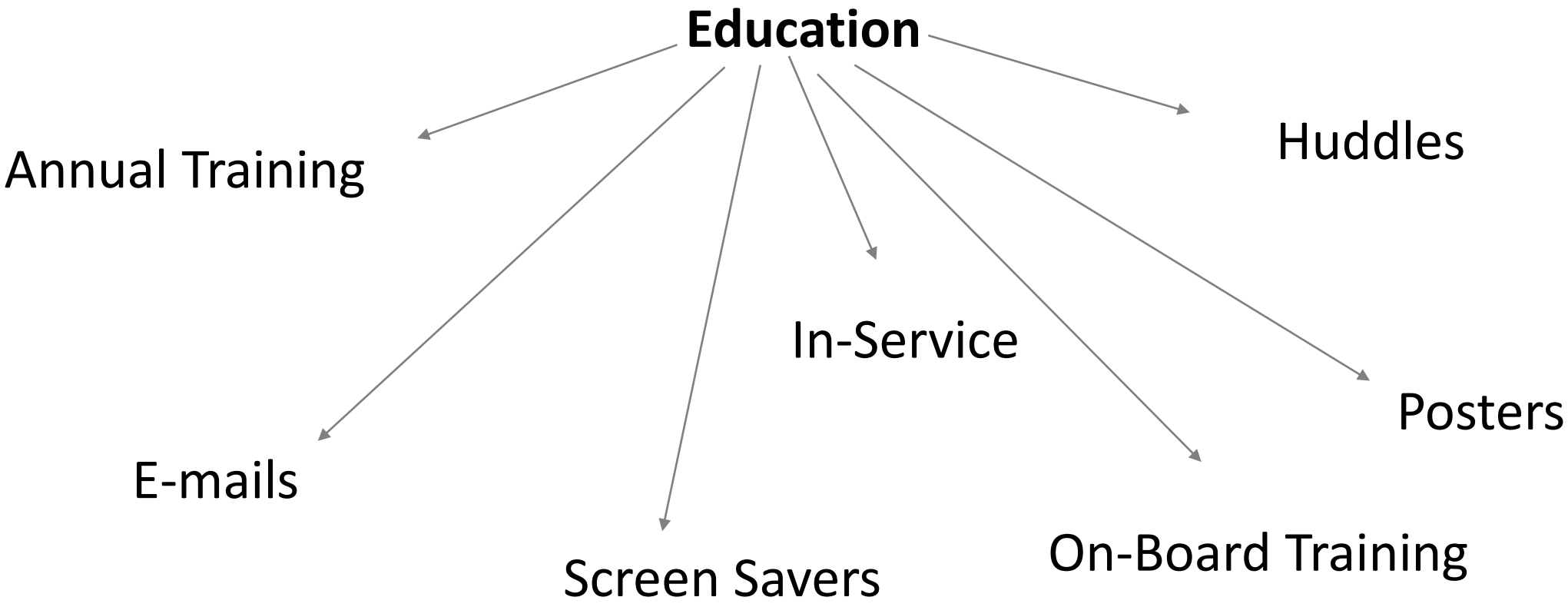
CONCEPTUAL UNDERSTANDING AND BEHAVIOR

Knowledge  **Behavior**

Changes in knowledge bring about changes in knowledge

Changes in behavior bring about changes in behavior

KNOWING DOES NOT ALWAYS LEAD TO ACTION



CONCEPTUAL UNDERSTANDING AND BEHAVIOR

Knowledge  **Action**

Changes in knowledge bring about changes in knowledge

Changes in behavior bring about changes in behavior

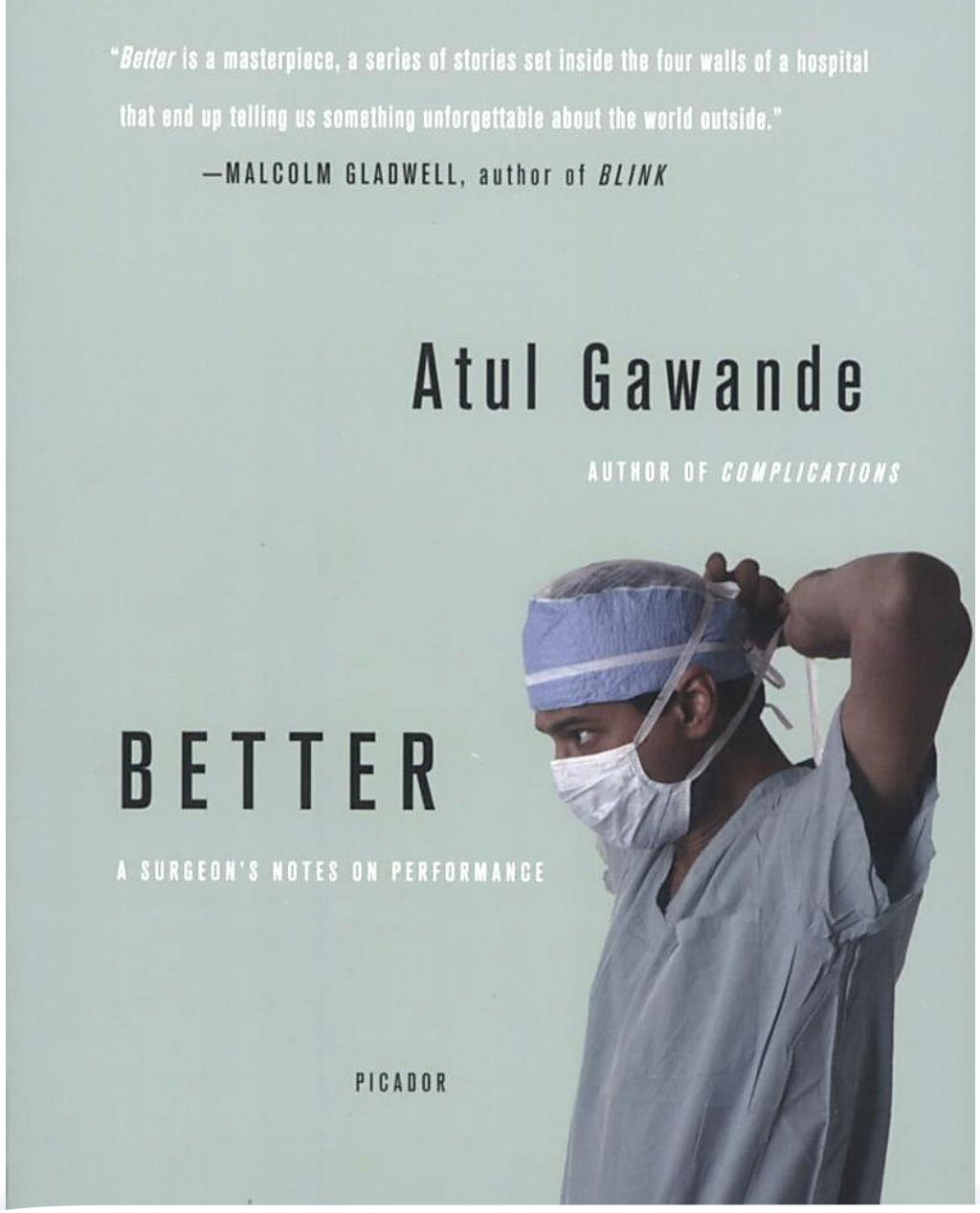
THE TRAP OF UNDERSTANDING

The belief that **when people understand (know) something, they will act appropriately** based on that understanding (knowledge).

Slide attribution: Courtesy of Jeffrey Ford PhD

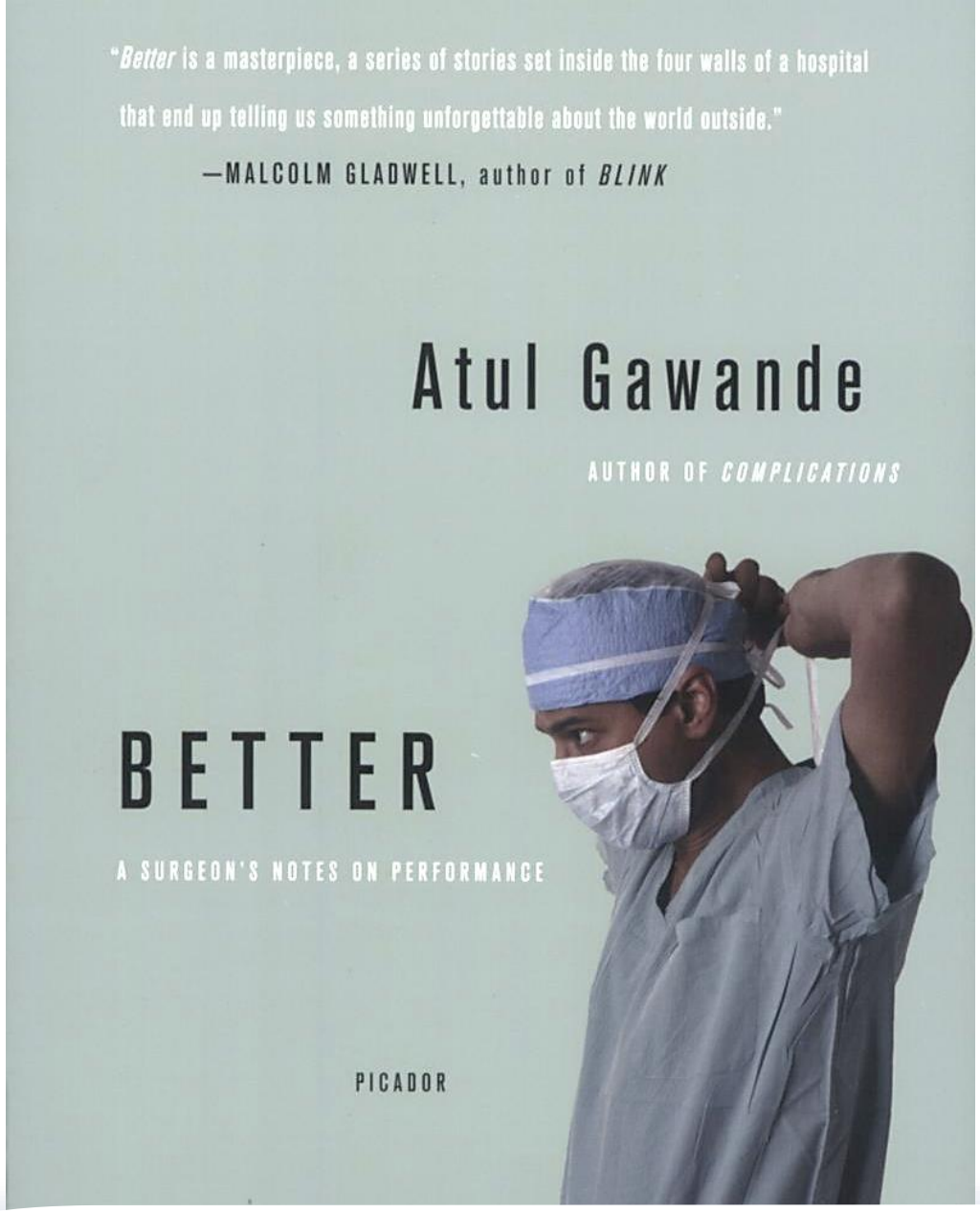
THE TRAP OF UNDERSTANDING

So where does this leave us?



"Better **is Possible**."

Gawande A. *Better: a surgeon's notes on performance*. Picador; 2007.



Chapter 1: Diligence

- The necessity of giving sufficient attention to detail to avoid error and prevail against obstacles.

  Atul Gawande

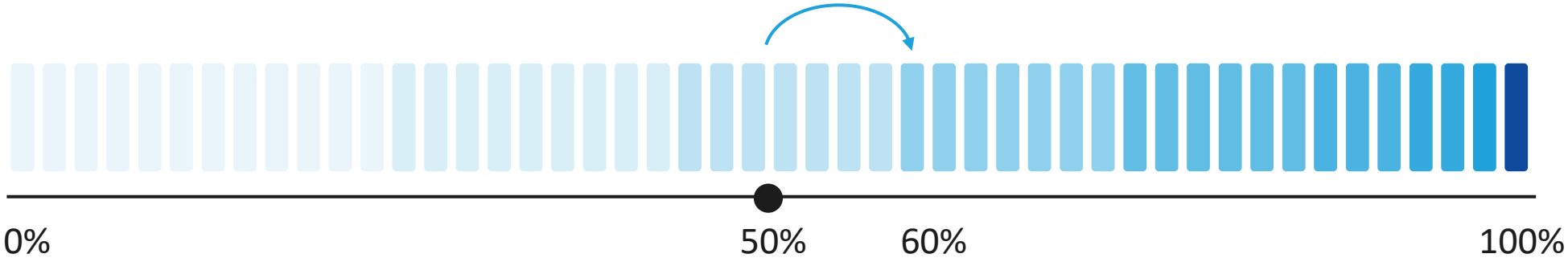
- Devoted and painstaking work and **application to accomplish an undertaking**

  Merriam-Webster

“BETTER IS POSSIBLE”

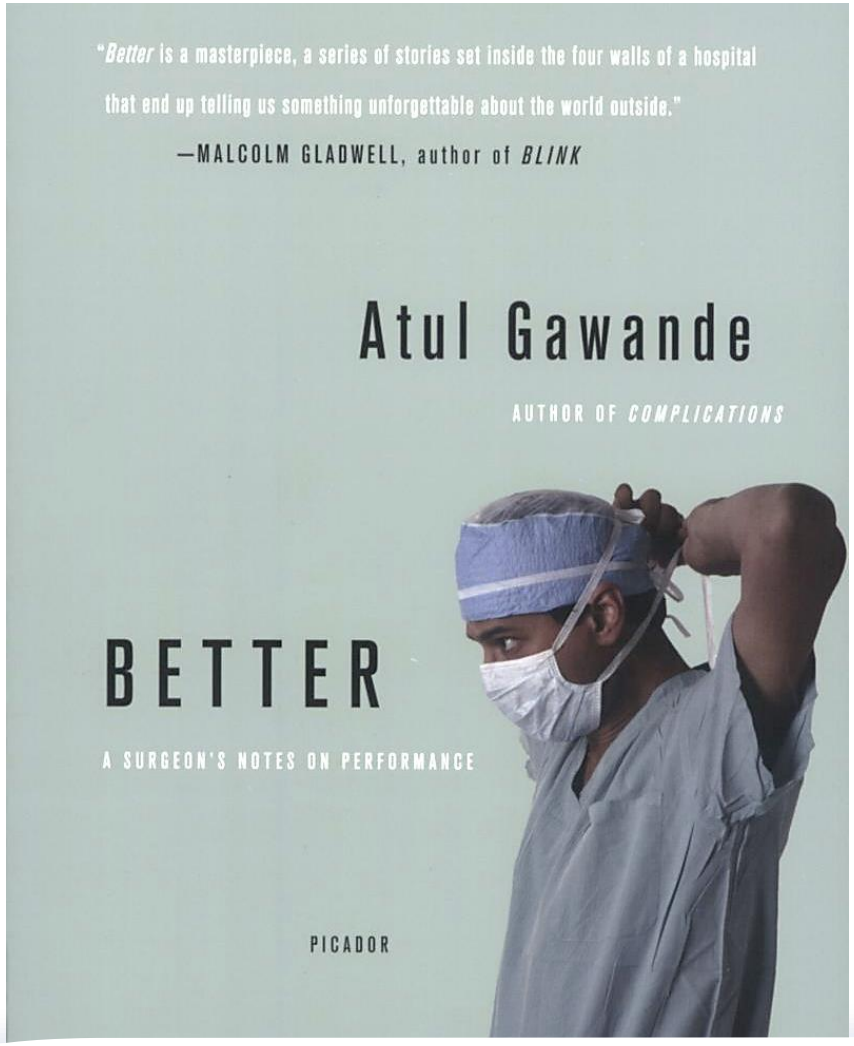
GOAL

Increase the frequency and reliability with which people will engage in behaviors that will produce the desired result



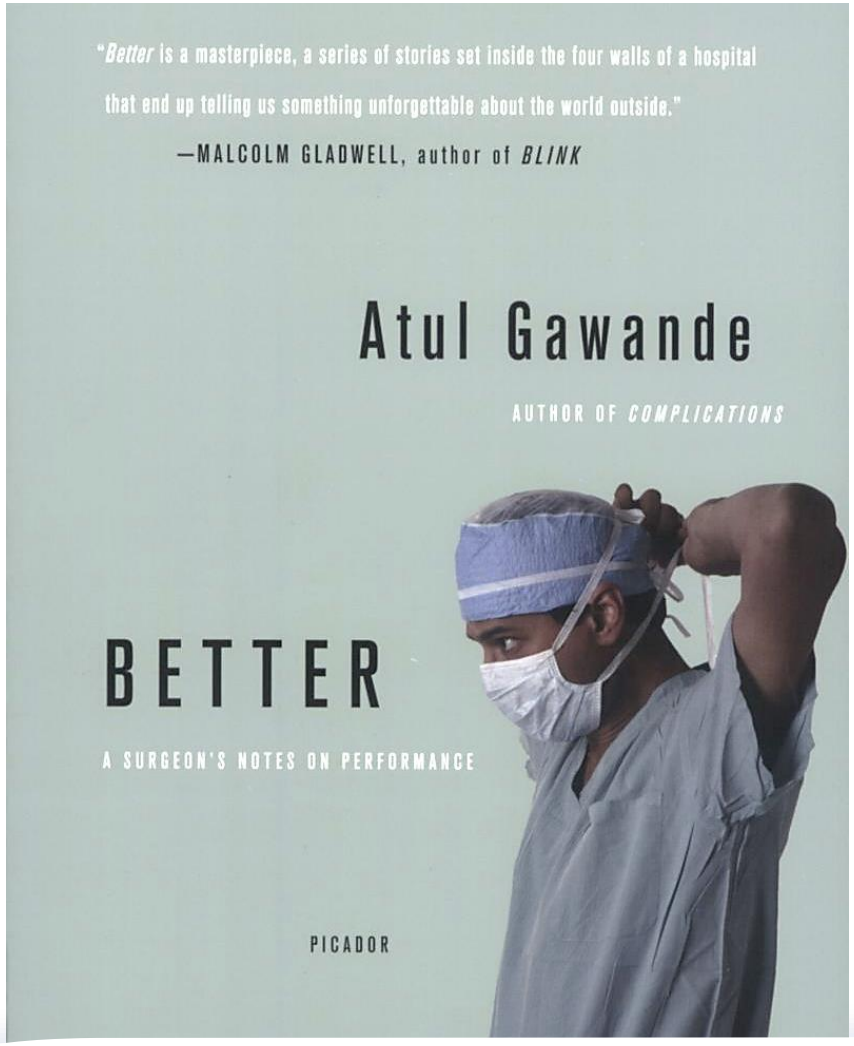
Don’t let perfect get in the way of better.

“ASK AN UNSCRIPTED QUESTION”



“Can we **do better**?”

THE IMPORTANCE OF KEEPING TRACK



"If you **count** something interesting, you will **learn** something interesting." Atul Gawande

What should **we count**?

EVENTS

COMPLIANCE RATES

What should **we count**?

OPPORTUNITIES

EVENTS

COMPLIANCE RATES

Can we improve hand hygiene by counting these things?

OPPORTUNITIES

EVENTS

COMPLIANCE RATES

Analyze past performance

Lagging Indicators

These are **outcome data**.

OPPORTUNITIES

EVENTS

COMPLIANCE RATES

Analyze past performance

Lagging Indicators

OPPORTUNITIES

Leading Indicators

Influence future performance

BEHAVIORS

ACTIONS

The **actions or processes** that drive the results we are getting….good or bad

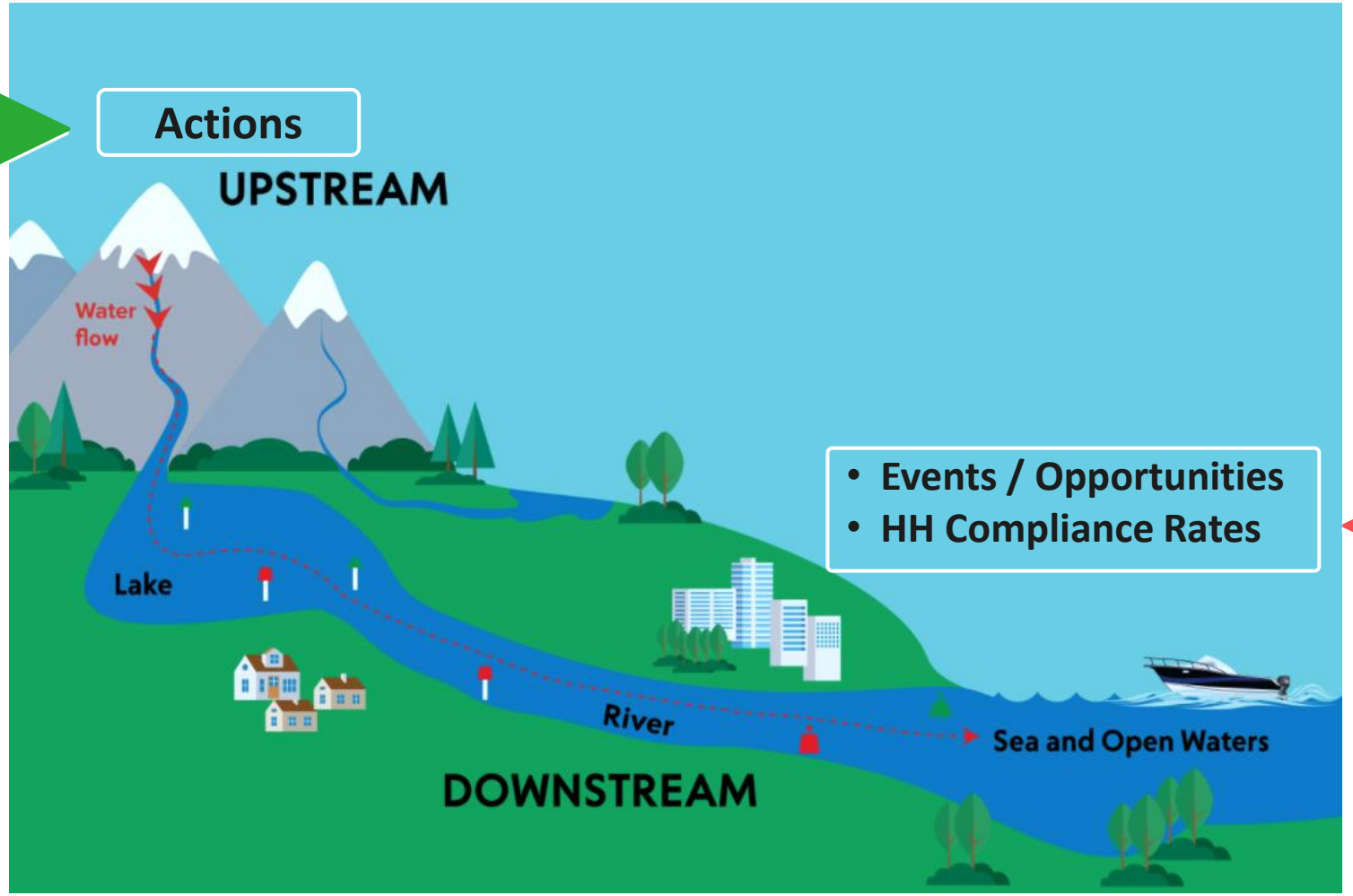
ACTIONS

BEHAVIORS

WE NEED TO "COUNT THINGS" UPSTREAM

Leading

Influence future performance



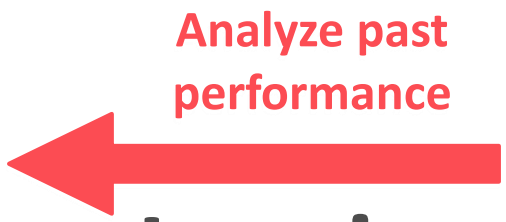
Analyze past performance

Lagging

FRONTLINE HEALTHCARE WORKERS

"They **know** hand hygiene is important. Why aren't they **doing** it?"

The focus is downstream



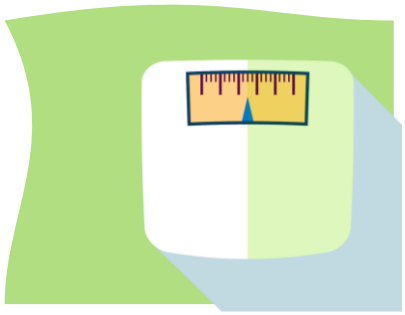
LEADERSHIP

Responsible for putting systems and structures into place that will lead to better results

The focus is upstream

Mrs. Jones

- ☑ Sets a goal weight
- ☑ Records monthly weight



No Improvement

Leading the way with leading indicators. Steve Taninecz; Vizient. October 2, 2014.

Mrs. Jones

- ☑ 2000-calorie diet
- ☑ Daily exercise
- ☑ Records daily weight

No Improvement

Leading the way with leading indicators. Steve Taninecz; Vizient. October 2, 2014

Action-Based Leading Indicators

Influence future performance

Mrs. Jones

- ☑ Records whether she **met** her calorie goal
- ☑ Records whether she **met** her daily exercise goal
- ☑ Records daily weight

TRACKING UPSTREAM
PERFORMANCE RELATIVE TO GOALS

Leading the way with leading indicators. Steve Taninecz; Vizient. October 2, 2014.

Action-Based Leading Indicators

Influence future performance

Mrs. Jones

- ☑ Records whether she **met** her calorie goal
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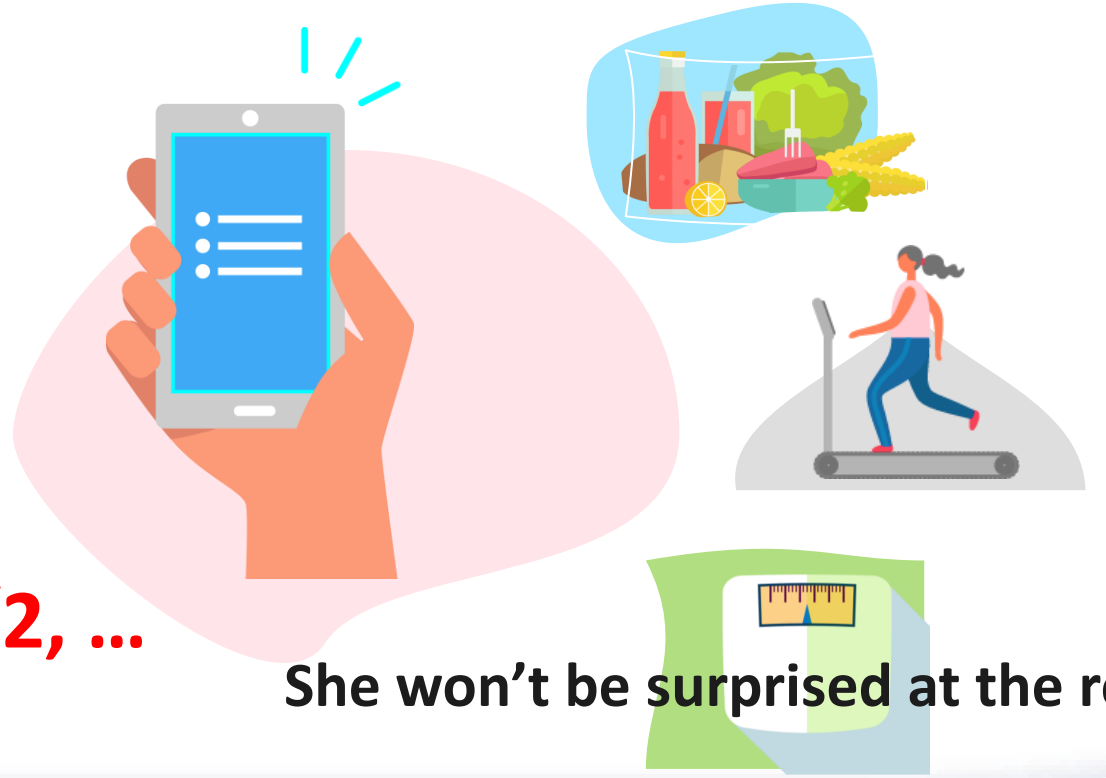


If the chart shows 0/2, 0/2, 0/2, …

She won't be surprised at the results.

Leading the way with leading indicators. Steve Taninecz; Vizient. October 2, 2014

Action-Based Leading Indicators

Influence future performance

Mrs. Jones

- ☑ Records whether she **met** her calorie goal
- ☑ Records whether she **met** her daily exercise goal

If the chart shows 2/2, 2/2, 2/2, …

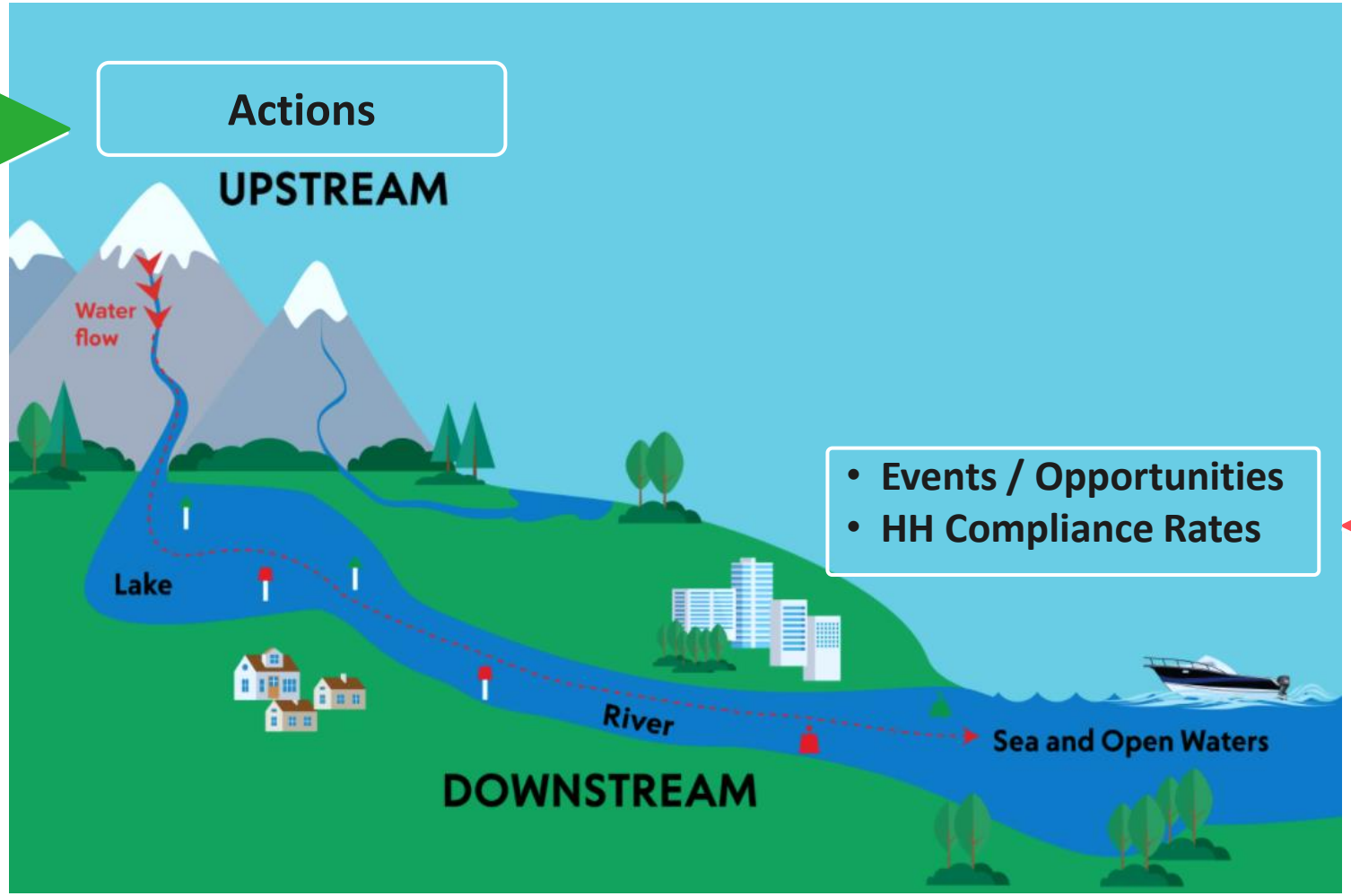
She will have confidence that her outcome will improve!

Leading the way with leading indicators. Steve Taninecz; Vizient. October 2, 2014.

WE NEED TO "COUNT THINGS" UPSTREAM

Leading

Influence future performance



Analyze past performance

Lagging

Action-Based Leading Indicators

Influence future performance

ACTIONS

BEHAVIORS

BEHAVIORS

ACTIONS

The **key**:

- Define the upstream action-based leading indicators or processes
- Measure them frequently
- Problem solve, adjust as necessary

HEALTHCARE EXAMPLE: GOAL - FALLS REDUCTION

Unit A	Unit B

Both units identified 3 actions to reduce patient falls

1. Fall risk assessment for each patient every day
2. Fall risk patient identifiers posted at the room
3. Regularly scheduled toileting of fall risk patients

- ✓ Charted process measures on visual management boards; reviewed daily at huddles
- ✓ Charted monthly fall rate

HEALTHCARE EXAMPLE: FALLS REDUCTION

Unit A

During each daily huddle:

- Charted and discussed falls that occurred the previous day
- Determined root causes for the fall
- Followed up appropriately

Downstream

Unit B

During each daily huddle:

- Charted whether the 3 **actions** were followed the previous day for each patient
- ID fall risk, Room ID, Toileting
- If not, why not?
- What can we do differently?

Upstream

Leading the way with leading indicators. Steve Taninecz; Vizient October 2, 2014

HEALTHCARE EXAMPLE: FALLS REDUCTION

Unit A	Unit B

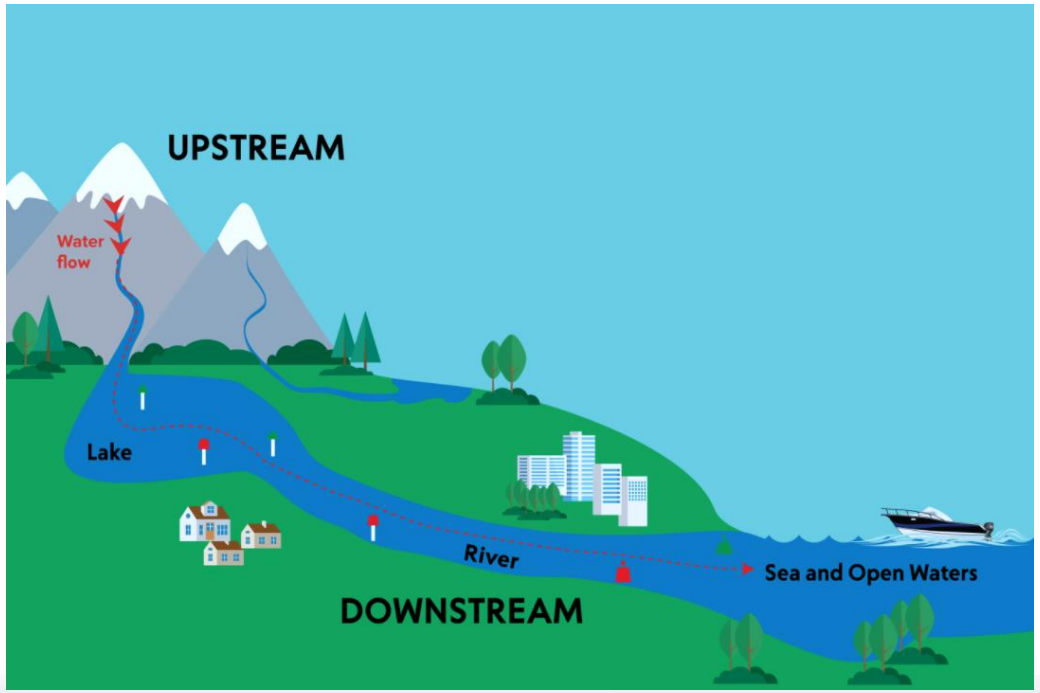
Let's Review

- **Defined the actions** that they felt would be effective in reducing and eliminating patient falls.
- **Tracked those actions** every day
- **Monitored the impact on the outcome--**monthly fall rate.

Drove accountability into the processes and ensured the actions were followed

CURRENT APPROACH TO HAND HYGIENE IMPROVEMENT

Focus is on hand hygiene behavior of healthcare workers



Focusing **only** on the hand hygiene behavior of healthcare workers is like treating the symptom **without addressing the cause**.

Graban M. *Measures of Success. React less, Lead better, Improve more*. Constancy, Inc.; 2019.National Patient Safety Foundation. Patient Safety Curriculum. *Introduction to Human Factors Engineering and Simulation*. Boston, MA. 2016.

THE SYSTEM IS THE PROBLEM

- It is unfair to ask employees to perform better than the system's design and management will allow.
- It is the responsibility of leadership to provide a system in which people can be successful.
- If you want to improve performance, you must work on the system

Graban M. *Measures of Success. React less, Lead better, Improve more*. Constancy, Inc.; 2019.National Patient Safety Foundation. Patient Safety Curriculum. *Introduction to Human Factors Engineering and Simulation*. Boston, MA. 2016.

CULTURE OF IMPROVEMENT

- The assumption is that the problem is caused by the system.
- Everyone engages in identifying problems and opportunities for improvement.
- The goal is to improve the system that is contributing to the results.

Graban M. *Measures of Success. React less, Lead better, Improve more*. Constancy, Inc.; 2019.

MOVING UPSTREAM TO IMPROVE HAND HYGIENE

How do we get started?

MOVING UPSTREAM TO IMPROVE HAND HYGIENE

Dr. Martine Caris et al.

Studied the relationship between safety culture and the ability to improve hand hygiene.

Hand hygiene performance is less about hand hygiene

and more about

other foundational issues within the unit

Upstream

Caris MG, et al. Patient safety culture and the ability to improve: A proof of concept study on hand hygiene. *Infect Control Hosp Epidemiol.* 2017;38:1277-1283

MOVING UPSTREAM TO IMPROVE HAND HYGIENE

High-Performing Units

- High levels of safety culture at the unit level
- Close collaboration and involvement of unit management /free of hierarchy
- Unit managers set standards with staff involvement (collaboration)
- Staff aware of consequences of noncompliance
- Safety issues anticipated and pre-empted
- Addressing coworkers in cases of noncompliance is common
- Implemented more HH interventions than low-performing units

Low-Performing Units

- Low levels of safety culture at the unit level
- Units with multiple medical specialties consistently showed difficulties in collaboration between medical and nursing staff
- Opposing points of view on collaboration
- Reactive approach to safety issues
- Staff focused on own performance and addressing coworker's noncompliance was not a part of the culture
- Discrepancies on improvement strategies

Caris MG, et al. Patient safety culture and the ability to improve: A proof of concept study on hand hygiene. *Infect Control Hosp Epidemiol.* 2017;38:1277-1283

MOVING UPSTREAM TO IMPROVE HAND HYGIENE

A.K.A. “Speaking Up”

Unit-Led

MOVING UPSTREAM TO IMPROVE HAND HYGIENE

Transtheoretical Model and the Stages of Change

Precontemplation	Contemplation	Preparation	Action	Maintenance
No recognition of need or interest in change	Thinking about changing	Planning for change	Adopting new habits	Ongoing practice for new behaviors

High performing units
vs
Low performing units

Long-term follow-up
and
relationship building

NURSE MANAGER READINESS ASSESSMENT

Caris MG, et al. Patient safety culture and the ability to improve: A proof of concept study on hand hygiene. *Infect Control Hosp Epidemiol.* 2017;38:1277-1283
Glanz K, Rimer BK, Lewis FM. Health Behavior and Health Education: Theory, Research, Practice, 3rd ed. San Francisco, CA: Jossey-Bass
Apisarnthanarak A., et al. Behavior-based interventions to improve hand hygiene adherence among intensive care unit healthcare workers in Thailand. Infect Control Hosp Epidemiol. 2015;36:517-521

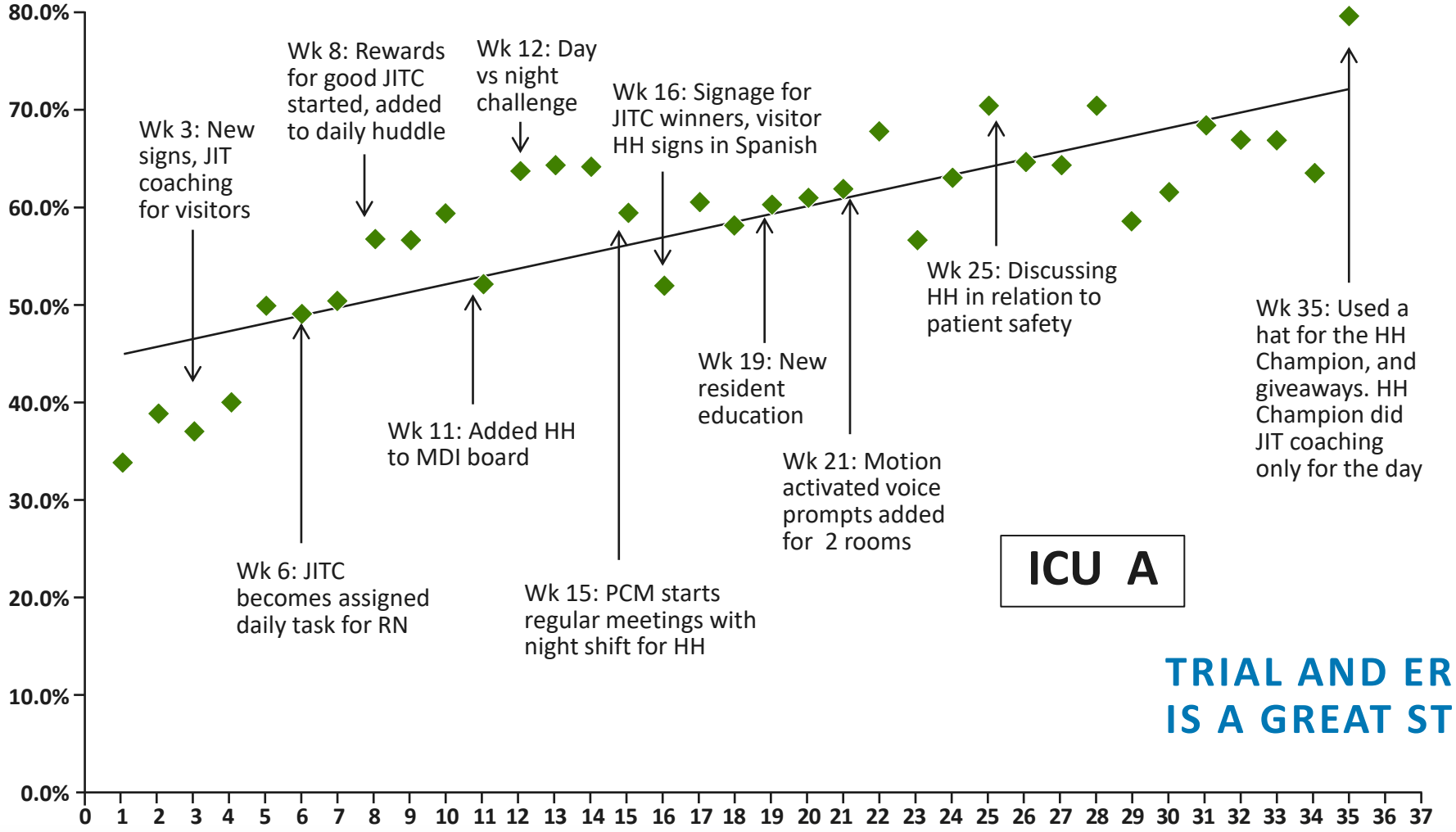
MOVING UPSTREAM TO IMPROVE HAND HYGIENE

Large Academic Hospital – 38 units with ECM – 2014 to present

Action-Based Leading Indicators:

- A nursing leader from each unit joins a 15-minute weekly call to discuss hand hygiene.
  - Report their rates, report out on their promised initiatives, what worked/ didn't work, their next steps, commitments for the next week
  - Report barriers/ problems, report solutions or ask for help
  - Every intervention is documented, categorized and tracked

MOVING UPSTREAM TO IMPROVE HAND HYGIENE



TRIAL AND ERROR IS A GREAT STRATEGY

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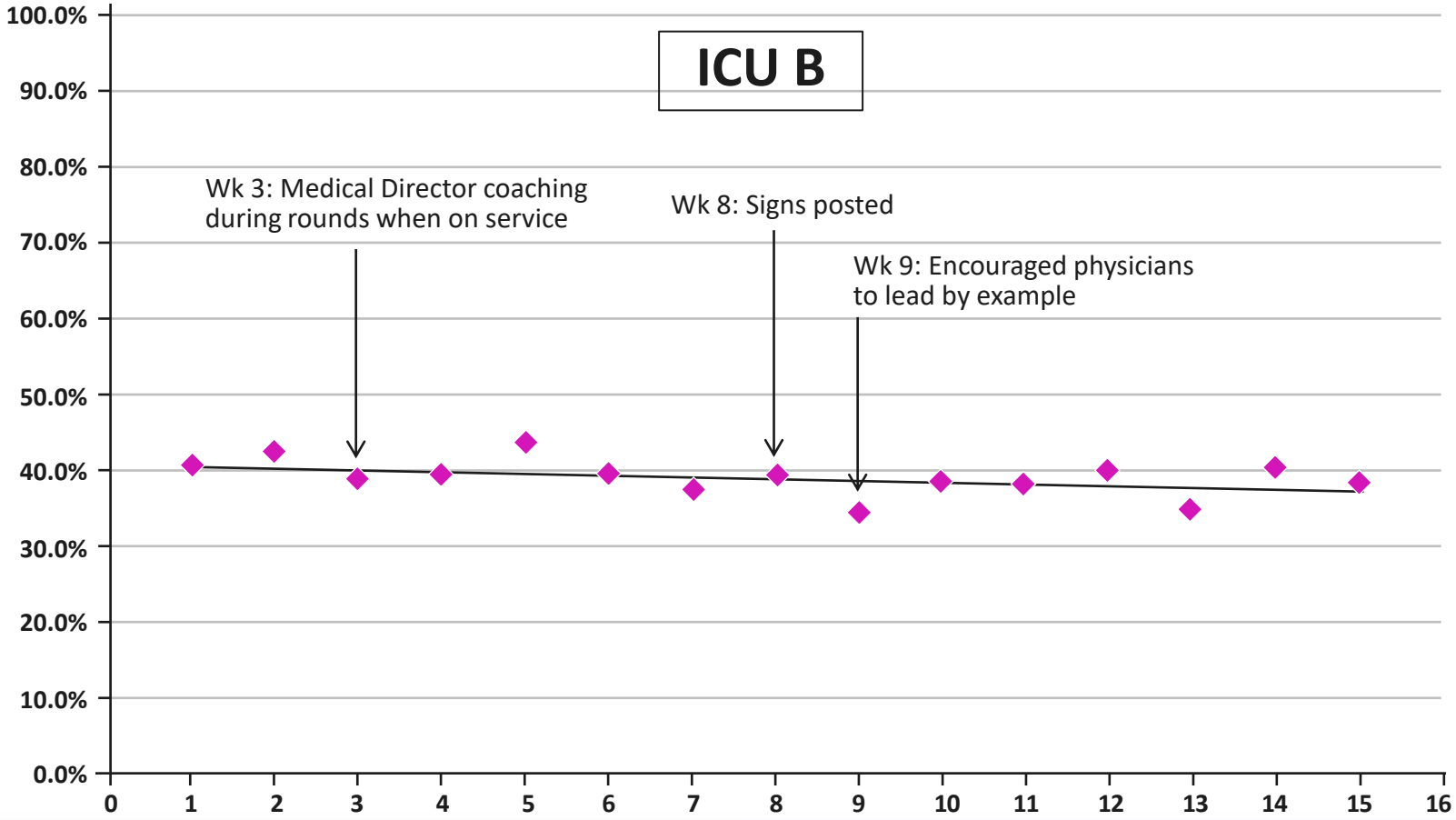
LITTLE ACTION = LITTLE IMPROVEMENT



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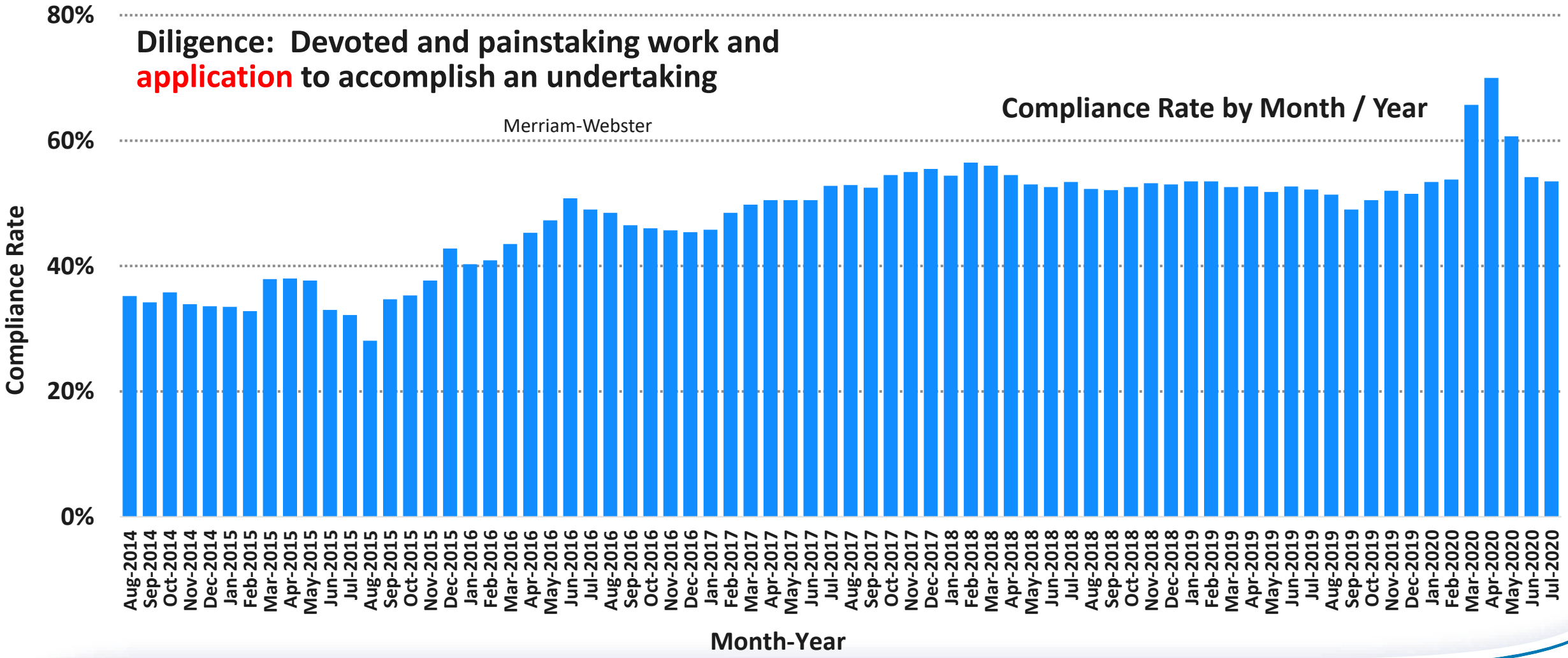
BETTER IS POSSIBLE

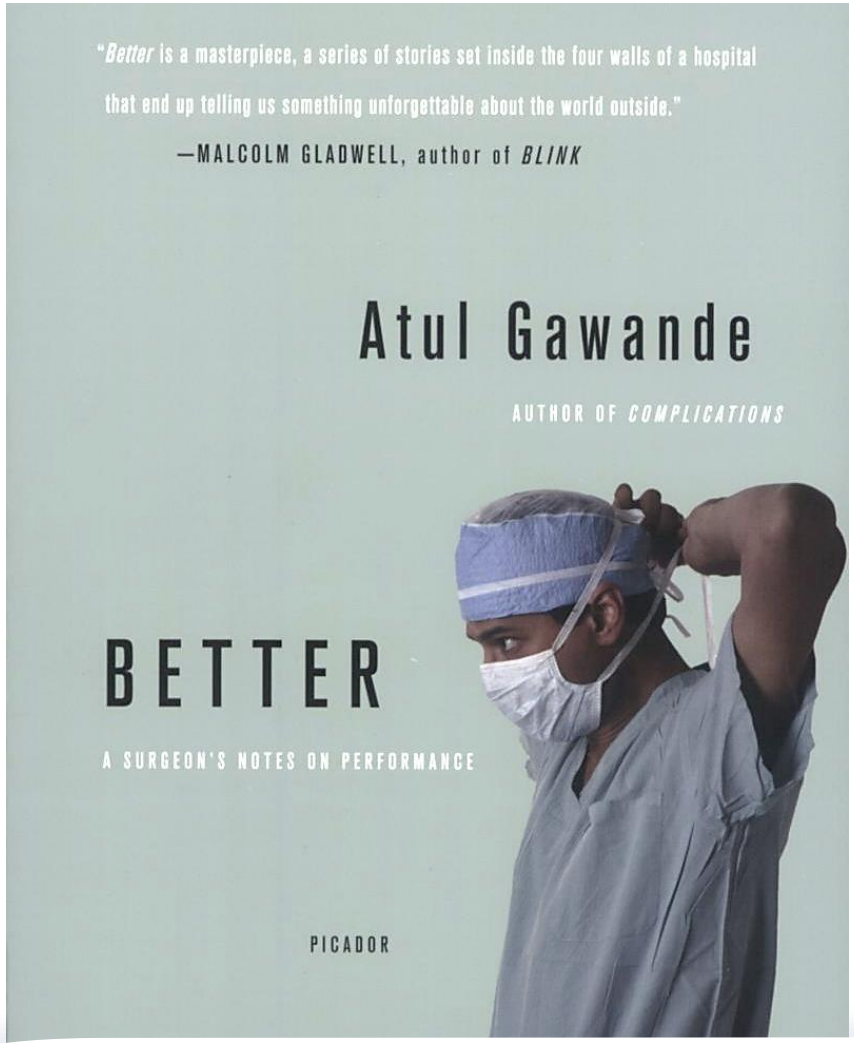
AUGUST 2014 – JULY 2020

Diligence: Devoted and painstaking work and application to accomplish an undertaking

Merriam-Webster

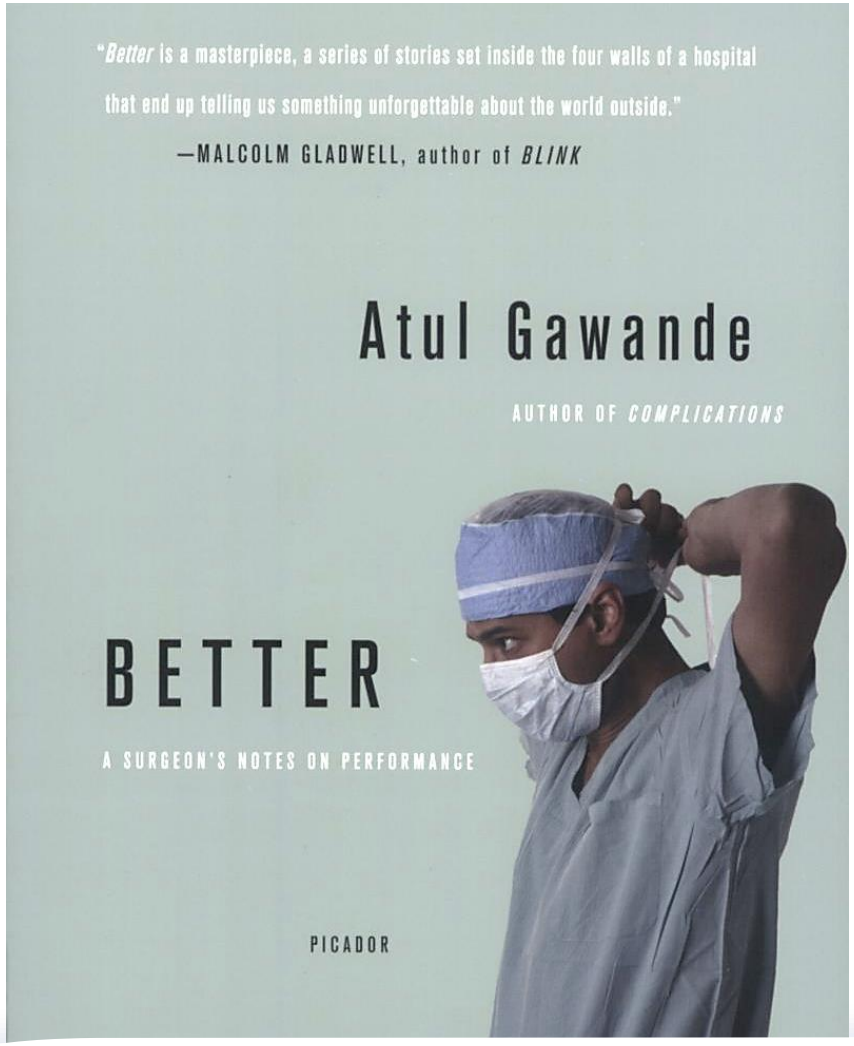


“ASK AN UNSCRIPTED QUESTION”



“Can we **do better**?”

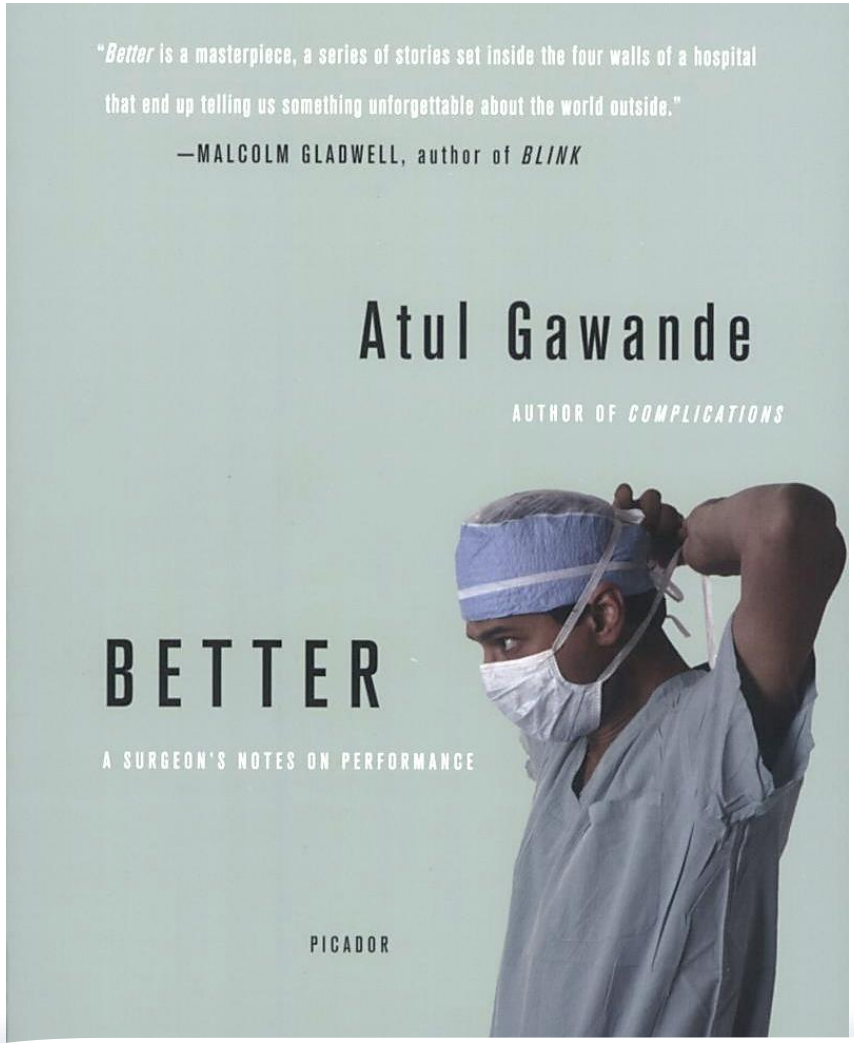
MANAGEMENT OF HAND HYGIENE



Define the actions upstream that you think will be effective at improving hand hygiene.

Track them frequently.

Monitor for improvement downstream, **problem solve** and **adjust** as needed.



"Better **is Possible**."

THANK YOU