

Section One

Getting Started



Getting Started

The first few months of the MRSA Prevention Initiative are a time for you to become familiar with the idea of Positive Deviance (PD), to practice some important facilitating skills, and to shore up your leadership and Resource Group.

We are deliberately having you start a little slow so you are ready to go faster in the spring!

Here are the activities in which you and your facility will participate:

Informational & Coaching Calls

We know that you will have lots of questions so Anne Millman, our MRSA Prevention Initiative Project Manager, will be setting up periodic *Informational Calls* to walk you through logistics and data issues.

Interactive Peer Coaching Calls will take place every two weeks. We encourage you to actively participate in these calls and feel free to include as many people from your facility as you would like. We will be joined on these calls by people like Jerry and Monique Sternin, your coaches, and others you have been using PD in healthcare. These calls are intended to give you a chance *to discuss issues* you have come across and to get guidance from your peers and our faculty.

We have also asked you to form a group of 2 or 3 facilities that we are calling *"Clusters."* We hope that you will make an effort to interact, share notes, and take initiative as a group to guide your *'cluster coaches'* towards the types of support that are most beneficial for your particular group.

Forming a Resource Group

Section Three gives you details for getting this group started. Each of you have already identified a core for this group—read and talk to each other to make sure you feel you have a **diverse mix** of departments and talent recruited to get the ball rolling.

Keeping your Leadership engaged

Section Four gives details regarding the role of leaders in Positive Deviance. This is not a top down or a bottom up approach. Everyone in the facility has a **critical role** and for everyone the role may be different from the usual. We hope you will have senior leadership on your resource group and that **you actively seek opportunities** to involve and update leadership.

Facilitating Discovery & Action Dialogues

Section Five is a refresher resource for your Discovery & Action Dialogues.

These Discovery & Action Dialogues are, **ABOVE ALL ELSE, the MOST** critical ingredient for success. Make sure that your group gets out and gets practice doing these—the sooner the better. Debrief with each other frequently afterwards, join our coaching conference calls, share and get peer feedback.

Section Six provides some excellent resources for you as you facilitate D&As. You'll find frequently asked questions and tips from facilities that have experience with the PD process.

Section Seven reviews the key tenets of Positive Deviance, in general, and D&A Dialogues, in particular.

*If You Ever Feel
That You Are “Not Getting”
Discovery & Action Dialogues -
Speak Up And Let Us Know:*

*We Will Troubleshoot This
With You!*

Cluster Site Visits For Advanced Training

As soon as you have started getting comfortable with the basics, touch base with your Cluster partners decide **where** and **when** you would like our team to come to you and spend a day doing **advanced on-site skill building**. Each Cluster should have completed its advanced training by the end of February.

Internet Portal

A dedicated site for the MRSA Prevention Initiative will be **available online** for all participants. In the portal, you will find information and reminders about upcoming events or calls, links to literature and news about MRSA, and a space to interact with other participants and record your thoughts, questions, and impressions. An **email listserve will also help** to keep you informed of news and events.

Scaling Up With Kick-Offs

Kick-offs or Kick-ups are the second most important ingredient for success. They **expand your efforts** to a much larger audience.

Ideally you will hold your kick-off **sooner rather than later**—but we want your senior leaders to be comfortable with their role and ensure that your group has enough experience with Discovery & Action Dialogues so you can use some of your own successes as illustrations during the Kick-off.

Like Discovery & Action Dialogues, **kick-offs have some critical ingredients**. You'll learn more about Kick-offs during your Cluster Site Visit.

Data

We will help you get set up to transfer OUTCOMES DATA to the CDC. These data are collected so the MPSC can evaluate the effectiveness of the initiative. We will be looking at **MRSA, VRE and C. difficile CLINICAL** isolate trend lines from 2005 to 2009. These data *already* exist in your hospital's clinical information system—they are the cultures that are ordered to evaluate patients who have symptoms of infection. Our arrangement with the CDC will make it possible for you to send raw data, which will then be analyzed using a standardized formula so we can see how we are doing as a cohort.

THE Most important thing to know this that the OUTCOMES DATA we collect is DIFFERENT from the internal data your facility staff will chose to follow on its own to monitor progress. Your internal data measures are up to you to pick - because they have to be meaningful and helpful for your staff.

Because the **nursing home** and **dialysis** facilities participating in this initiative are the first in our region to be testing PD they will only be asked to do internal measures, but we will ask them to share results with us so we have a way to judge how effective we have been in helping them use the PD approach.

1. Your Point of Contact and ICP will **need to connect** with Anne Millman, our MRSA Prevention Initiative Project Manager, who will **walk you through** the initial data submission requirements. Our Data submission goals are:

a. FOR HOSPITAL TEAMS

i.

ii. BY MARCH 2008

1. Register with NHSN
2. Complete On-line Training
3. Select your NHSN “good standing” module
4. Identify your Information System liaison

iii. BY JUNE 2008

1. Begin data transfer to CDC

b. FOR NURSING HOME TEAMS

i. BY MARCH 2008

1. Establish your data points

ii. BY JUNE 2008

1. Begin sharing submission to MPSC

c. FOR DIALYSIS TEAMS

i. BY MARCH 2008

1. Establish data submission plan

ii. BY JUNE 2008

1. Begin data submission to MPSC

Keeping It Going!

After the first four to nine months you will notice that Discovery & Action Dialogues seem to **happen on their own** and your initial facilitation role will decrease some.

During this time, your attention will **shift towards strategies** for supporting the durability of your new culture and expanding beyond your own facility.

We will begin focusing on this during our March gathering.

***MRSA is not a hospital-, nursing home-, or
dialysis-unit only problem. It affects us all, so when
we get to be experts in PD in our own facilities we should ask
ourselves “where next?!”***

Section Two

Introduction to Positive Deviance: The Power of PD



What is Positive Deviance (PD)?

The term Positive Deviance is the scientific description that Dr. Marian Zeitlan used in the late 1980s to describe a phenomenon she observed in her studies of malnutrition. Dr. Zeitlan found that in every community she studied, no matter how disadvantaged the environment, there were always a few groups or individuals whose special practices enabled them to have better outcomes (in this case better nutritional status) than their neighbors, even though they did not have access to any different or additional resources

We call the practices of these people or groups who, by doing something different, have better outcomes “POSITIVE DEVIANT” practices.

Jerry Sternin, Director of the Positive Deviance Initiative at Tufts University defines Positive Deviance this way:

“Positive deviance is a development approach that is based on the premise that solutions to community problems already exist within the community. The positive deviance approach thus differs from traditional “needs based” or problem-solving approaches in that it does not focus primarily on identification of needs and the external inputs necessary to meet those needs or solve problems. Instead it seeks to identify and optimize existing resources and solutions within the community to solve community problems.” (www.positivedeviance.org)

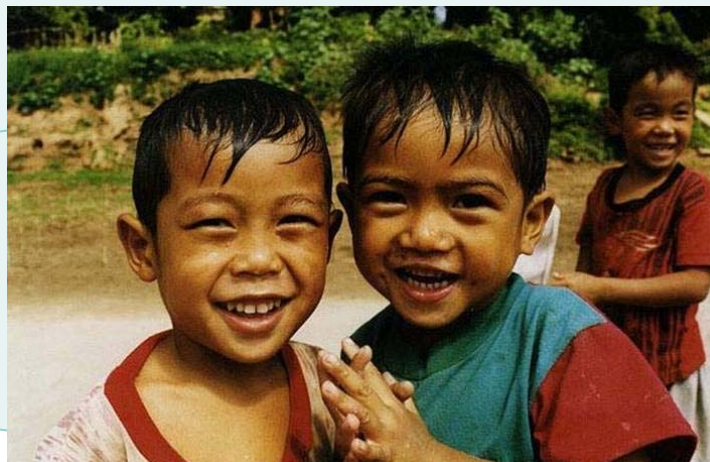
***The Positive Deviance Approach is NOT
the right the tool for every problem.
It works best when you know you need
an all-hands-on-deck response, when
the problem is perceived as serious
and meaningful to the community.***

POSITIVE DEVIANCE in PRACTICE

In Vietnam in 1990 over 60% of children under the age of five were severely malnourished. But even among a few families who were the poorest of the poor, there were kids who were well-nourished.

Observation and interaction with these families revealed that the parents and older siblings were collecting tiny shrimps and crabs from the rice fields and adding these, along with the greens from the tops of sweet potatoes, to the kids' meals. These families also had a habit of dividing their child's daily rice portion into several smaller portions that kids could eat in their entirety, and they fed the kids instead of leaving the rice bowl on a table and counting on the kids to feed themselves. Hand washing was also more common. Other families in the village recognized that they could use the same behaviors for feeding their own children and these previously "deviant" practices became the new norm.

Over the following decade, the PD approach to nutrition became a national model and today reaches a population of 2.2 million inhabitants in 250 Vietnamese communities. The program has sustainably rehabilitated an estimated 50,000 malnourished children under the age of 5.



Do We Have to Call It “Positive Deviance” at our facility?

No, not at all. The word “deviance” has a very negative connotation in our society, but we retained the name because it is based in validated scientific theory. It is not important or necessary for you to use this term at your own facilities, or even to be blatant about participating in a new initiative. If your facility has ongoing **MRSA-reduction programs**, think of the **PD as a complement** to what you are already doing!

Where has PD been used?

PD is particularly effective in working with intractable problems where other approaches, like training or communication initiatives, have already been attempted without success.

*PD has been used successfully in **international development** contexts to tackle problems as diverse as malnutrition, girl trafficking and low educational attainment.*

*In the United States, Waterbury Hospital in Connecticut used PD to address the issue of medication reconciliation. For the past two years, a dozens of hospitals participating in a projects funded by the Robert Wood Johnson Foundation, the Veterans Administration and the Maryland Patient Safety Center have been using PD to work on **reducing and preventing MRSA** transmission.*

What is the Positive Deviance Approach?

Positive Deviance as an “approach” is very helpful when you are faced with a problem that is serious, seems overwhelmingly difficult to solve, and extra resources are not readily available. ¹

The Positive Deviance APPROACH takes advantage of these EXISTING successful practices – and teaches us “HOW” to use them as the “stimulus” for getting these practices and others just waiting to emerge into widespread and lasting practice.

This Field Guide highlights some of the techniques that Jerry and Monique Sternin, the first people to turn the science of Positive Deviance into a practical

social change approach, have learned are essential ingredients for successfully taking advantage of the Positive Deviance in our midst.

What’s different about PD? Is it just Best Practices?

The PD approach differs from traditional problem-solving approaches in that it seeks to identify and optimize *existing* resources and solutions within the community. **The focus is on identifying solutions, not problems.**

One of the key points of PD is recognizing that what works in one community (which can be as small as an intensive care unit or as large as a whole nursing home) may not work in another. Only the local experts (the people who live or work in that community) can determine if a solution is right for them.

When they find that solution themselves, it already has “social proof” that it works, which helps people more confidently try a different practice. This makes Positive Deviance different from Best Practices – because it emphasizes finding the best practices within in each unit and not “importing” someone else’s best practices.

¹ Positive Deviance is a “social” or “behavioral” change approach. It is part of a bigger family of approaches that are based on “Complexity Theory.” Paul Plsek, healthcare consultant and author of “*Creativity, Innovation, and Quality*” described Complexity Theory in Appendix B of the Institute of Medicine landmark report – Crossing the Quality Chasm. We are exploring these complexity informed tools for their value as “how to” resources.

ONE CRITICAL THING TO REMEMBER in Positive Deviance is that there is a big difference between **EVIDENCE-BASED** practices - which are scientifically proven, non-negotiable actions that we want people to practice (hand washing, gowning in isolation rooms etc.) - and **BEST PRACTICES**—which are a description of **HOW** a particular group was able to successfully carry out those **EVIDENCE-BASED** practices.

What we learn from PD is that in complex systems like healthcare the “best practices” are really LOCAL, and the most efficient way to figure them out is to have the people in each local environment figure out what works best for *them*. They are the “world’s experts” on their work and their work environment; what works well in another environment might not work for them.

If you are **thinking** that could get messy—and it does not sound very efficient—you are right, to a point.

Early on, Positive Deviance is **NOT** efficient - it involves listening to **LOTS** of people - and when we involve **LOTS** of people they have **LOTS** of ideas and they start to do LOTS of stuff - and it does not feel very comfortable for those of us who are used to managing projects, meetings and timelines.

But - **IT GETS TO BE** extremely *efficient* and *potent*, because very quickly all those people that have been **ENGAGED** by the process begin acting as thousands of sets of eyes, ears and minds - actively working with you towards a **SHARED GOAL** - and because of that they are also actively mindful of their own compliance with evidence-based practices.

This is especially true when it comes to the very practical issues associated with making it easy for everyone to carry out functions to reduce the transmission of MRSA --like wearing gowns when caring for infected patients.

Everyone might agree that it's important to have signs to make it clear when they need to wear a gown - but how and where to place those signs so they are clear to the people that depend on them - can be different from unit to unit. In one hospital, a phlebotomist mentioned a unit in the hospital that had signs placed in a plastic sleeve outside the door - the signs were in her visual field and always did the trick of reminding her to gown before she entered the room. When she shared this observation with her peers - they were eager to spread the word because they had "proof" that it would work and that was meaningful to them.

When a housekeeper noted that these signs were removed before he arrived to clean the room after patient discharge, the group came up with a strategy so everyone who needed to know which were the isolation rooms.

PD offers a way to engage everyone, at all levels and from all parts of the organization, to discover "**positively deviant**" practices in their local communities, and to design collaborative approaches so everyone can adopt, adapt, or create practices that work in their unique situation.

Involving everyone is important, because groups directly involved in the **decision-making** process regarding a specific issue are much more likely to **change their attitudes and behaviors** than those who were told how to change their behavior.

Do you use the expression “BUY-IN” a lot?

It used to be part of our everyday vocabulary - now we use it as a **red flag** that reminds us we might be slipping back into some habits that make it **less likely** that the changes we are eager to nurture will be sustained.

We keep reminding ourselves that what we want to aim for is **“OWNERSHIP”** and not **“BUY-IN.”**

In the words of Henri Lipmanowicz (Founder of The Plexus Institute and former President of the Intercontinental and Japan Division of Merck Pharmaceuticals) here is why:

Buy-In Vs. Ownership

I think it is very, very important to make a clear distinction between buy-in and ownership and not present them as if they were the same or interchangeable. It is important because buy-in is what everybody talks about and it more often than not doesn't work precisely because it is the opposite of ownership.

Ownership is when you own or share the ownership of an idea, a decision, an action plan, a choice; it means that you have participated in its development, that it is your choice freely made.

Buy-in is the opposite: someone else or some group of people has done the development, the thinking, the cooking and now they have to convince you to come along and implement their idea without you having been invited at the table upfront before the goose was cooked. They decided without you but now they need your buy-in because without you their great ideas and plans can't get implemented and so are worth nothing. But since you were not part of the process this great idea is a strange one; you cannot fully understand its history or genesis. Since you were not part of the process you cannot be aware of all the other options that were considered and rejected, and of the thinking that went into these choices. You feel ignored, imposed upon, pushed around, unappreciated and your immune system naturally kicks in to reject this foreign idea. You will look like you agree eventually to this new idea because you have no choice and your masters will cheer believing that you have bought in and that you are now as convinced as they are. Your implementation will inevitably be a pale imitation of what it could have been had you been an owner instead of a “buyer-in” and be truly convinced.

Of course the immediate reaction to such a proposition is that it is ludicrous because it is obviously impossible to involve everybody upfront. Wrong!!! ***Since it is possible to involve all the people afterwards.***

Hence my message is: **ANYTIME YOU OR SOMEONE AROUND YOU THINKS OR TALKS ABOUT BUY-IN, BEWARE!** It is a danger signal telling you that your development and implementation process is missing the essential ingredient of involving all who should be. Reconsider your process before you waste a lot of time and energy or achieve mediocre results.

In **SUMMARY, POSITIVE DEVIANCE** is a scientifically-based approach that is best used to address serious problems whose resolution **DEPENDS** on people **ACTING** in different ways.

To succeed in getting people to change their actions, PD capitalizes on the fact that there will be some people or groups in every “community” that have existing solutions to problems, and their peers will be more inclined to take on actions that already work in their setting and ideas that they take part in discovering and creating.

While **on the surface this seems inefficient** - it actually leads to exponential uptake of new behaviors because **it activates hundreds and thousands of the very people** whose actions have to change.

*“Where other approaches are outside jobs,
PD is an **INSIDE JOB.**”*

--Dr. Jon Lloyd--

Section Three

Creating a Resource Group



Creating a Resource Group

We have learned that the first action for the facility's senior leader and PD point of contact is to begin convening a starter group of people who will help 'get the ball rolling' for PD.

This is **NOT** a task force or project team—it's a group of people who help get the PD process started. Early on the group has some very important facilitating and support functions, later they keep up on big accomplishments, inject "booster shots" of energy, and celebrate the successes. Eventually they seem to disappear as the changes stimulated by PD become part of business as usual.

Here are some ways your resource team is different from other project teams you might have been involved with:

PD Resource Groups

- Facilitate the process
- Engage others in doing things
- Get decisions made by the appropriate people
- Members join and leave over time
- Group leadership changes over time
- Get things started

Other Project Teams

- Drive the process
- Take responsibility for doing most things
- Make most decisions
- Membership stays the same through project completion
- The leader continues in that role until the project is done
- Plan and manage most activities

Getting the Resource Group Started

This group needs people, so the first step is to start thinking about who and how to get the invitations out.

Think about the types of activities the group orchestrates and of **the right people** to help carry out these activities. One of the first things you will do is facilitate Discovery & Action Groups, so you will need people **who will be comfortable** acting as facilitators.

- ◆ Seek out people who are good listeners and “**people**” persons-- they will be excellent facilitators
- ◆ This is a good opportunity to go **BEYOND** the usual suspects-- think about inviting people from departments you don't usual include, such as environmental services, maybe someone from your organization development group, maybe some graduate nursing students.

Think about the types of expertise you will **need to tap into** and include folks who can be a resource for that expertise

- ◆ For this project people who have **knowledge about MRSA** transmission and infection control are a must
- ◆ Look for people that are good at getting the word out. Consider a person from your communications department - or one of those natural “**connectors**” we all seem to know.

Think about the **resources and obstacles** your group might need to address and include people who will make that easier

- ◆ You will definitely want to have a senior leader or someone that has a direct line to the senior leader on this group (this is one way the senior leader “shows up”)

Keep your eyes and ears open for the passionate volunteers; these are the people who let you know they want to be involved by the interest they show when you talk about PD and MRSA or who have shown initiative on other projects.

- ◆ At a few places, folks who have completed the first wave of training visit staff meetings and share a bit of what they learned **about PD and MRSA**. As they leave, they extend an invitation to anyone interested to join the resource group--this gives people a chance to “declare” themselves

As soon as you start adding people to your group, make sure you ask, “who else should be here?” and share the responsibility for extending those invitations.

Remember, the group is *dynamic*. Some people are always involved with it and some come and go. Just keep thinking about what you need and who you need and invite them to participate. Remember that it doesn’t have to include everyone because the magic of PD is that it happens as a result of the engagement of your whole community. This group just gets things started—they definitely don’t have to do it all.

There is no exact right size for a resource group. It should be big enough to benefit from diverse perspectives, yet small enough to make it easy to get together and get things done.

Resource Group Activities

The resource group will focus on **facilitating different activities** at different stages of the PD Initiative. Each stage will take different amounts of time and effort in different organizations. In a large organization you'll probably **repeat these stages** multiple times as you engage new parts of the organization.

1. Jump Start the Initiative

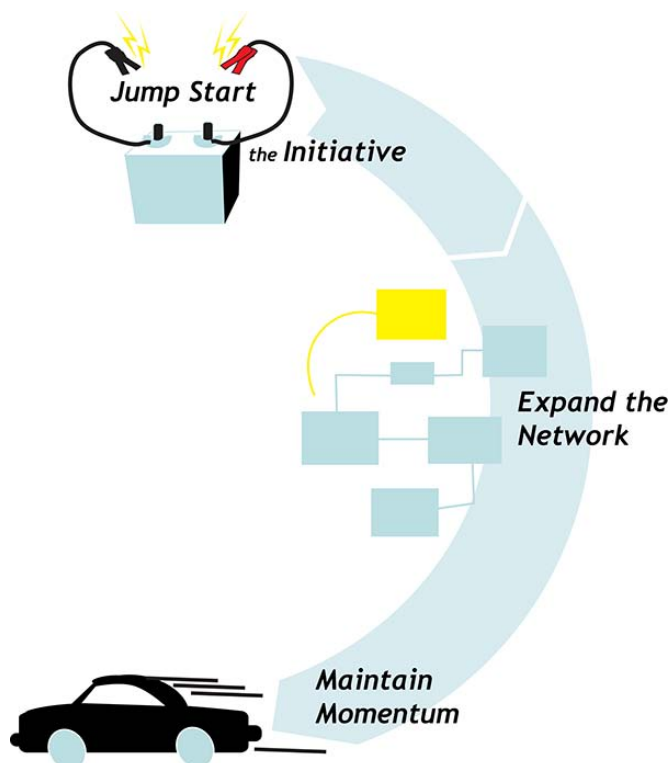
- Begin convening Discovery & Action Dialogues
- Recruit "**early adopters**" to volunteer to take the lead in their units
- Identify some quick wins and disseminate positive rumors of results
- Develop initial data collection and strategies to track what's happening

2. Expand the Network

- Plan one or more organization-wide events to create a "**buzz**" for change
- Find ways to galvanize individuals and units to volunteer and join the initiative
- Identify who's "**missing**" so far and do some outreach to recruit new volunteers
- Discover other organizational initiatives you can integrate and leverage

3. Maintain Momentum

- Re-convene initial and new volunteers to review and celebrate progress
- **Reflect on what's working** and what's not working and share learning and ideas for improvement
- Capture and report both **quantitative and qualitative results**
- Recruit and train additional people to facilitate Discovery & Action Dialogues and take on other **key roles**



What should you call YOUR Resource Group?

For the purpose of this Field Guide, we're using the term "**resource group**" to refer to the people in your organization who will be the "go to" group for supporting the PD/MRSA initiative. But you can choose a different name.

Core Team

Facilitation Team

Resource Group

"Go To" Gang

Your group might want to take a few minutes to come up with a name to use - think about a name that reflects the role of group as you understand it.

Brainstorm:

What words **resonate for you** when you think about your resource group?

Tips

Choose a time, place, and method for the resource group to check in regularly to create and maintain momentum.

First Friday Brown Bag lunch
Web-based group forum

Bi-weekly scheduled conference call
Monday Morning Stand-Up

Identify key roles that need to be played by members of your resource group. Recruit volunteers for these roles. Remember, different people can take turns playing these roles at different times.

Convener	Note-taker	Historian
Facilitator	Liaison	Photographer
Recruiter	Reporter	Task leader

Encourage and seed spreading the word about what's happening across the whole initiative.

Weekly e-newsletter
Web-based home room
Project scrapbook

Initiative bulletin board
Hall posters
Idea-of-the-month bulletin

Some Questions the Resource Group Should Work Through

- ◆ How are we going to respond as an organization to the requests that bubble up?
- ◆ The desire from many units to begin active surveillance
- ◆ Media inquiries
- ◆ Staff with history of MRSA infection—questioning bills and liability
- ◆ Staff requesting screening
- ◆ Ideas that emerge that are potentially harmful
- ◆ Ideas we do not view as likely to have an impact

Tips

- ◆ Include senior leaders in the Resource Team and involve them in the team's tasks.
- ◆ Anticipate a fluid composition for this group; welcome new members.
- ◆ Expect this group's role to be most intensive in the early months of the initiative.

The following are some **thoughts and tasks** that have been shared by others forming Resource Groups

Expand the membership of the Resource Team, some members might include:

- ◆ Director (CEO)
- ◆ Finance
- ◆ Chief nurse
- ◆ Chief of staff
- ◆ Public relations person
- ◆ Union representative
- ◆ Hospitalist
- ◆ Lab
- ◆ Environmental services
- ◆ Infection control professional
- ◆ Hospital epidemiologist or infectious diseases physician
- ◆ A patient
- ◆ Volunteers and clergy

Who else should you include and how?

- ◆ Prepare to make the "case" for the CEO by offering concrete estimates of the resources that might be needed in the early phases of the project and dollars saved as a result of positive outcomes.
- ◆ Estimate and anticipate lab capacity and potential need for more resources in the short term (gel, gowns, etc.).

Section Four

How Leaders Lead In Positive Deviance



How Leaders Lead In Positive Deviance

When looking back on successful Positive Deviance applications:

Senior leaders are often proud, amazed and not sure exactly what role they played in the transformation of their community,

Managers are often feel less burdened, more needed and are delighted but just a bit uncertain about their role when they reflect on the broad ownership and engagement in their midst

Frontline workers, families, volunteers find joy in their work. They feel emboldened by the impact of their contributions and a deep sense of personal responsibility. They clearly see the role they had in the changes in their midst.

What do Senior Leaders Do?

Senior Leaders **make a commitment to the principles of Positive Deviance** and demonstrate their belief in the people that make up their organization by inviting PD into their facility.

Senior leaders **understand the scope of the problem.** For example in the context of the MRSA epidemic they know that every person walking the halls of their facility can be transmitters of the organism.

Senior Leaders **take the moral high ground.** They are the first to halt blame and finger pointing. They keep the focus on the problem and its solution. They never accept arguments that minimize, rationalize the harm associated with the problem being addressed.

Senior Leaders **"show up" when their managers and staff are learning and using** the PD approach.

Some examples of how Senior Leaders show up:

- ◆ Telling a personal story about how MRSA affected their life at the start of a gathering
- ◆ When invited to introduce a meeting, they stay—and listen until the end
- ◆ Acting as the scribe while staff share solutions and ideas

- ◆ Writing a note—or saying thank-you to a frontline staffer who has contributed a solution
- ◆ Participating in a role play - during PD training
- ◆ Asking the PD team to keep them updated and notified when a barrier needs to be removed
- ◆ Acting to remove the barriers promptly

What do facilitators do?

Facilitators in PD often include a sizable representation of *managers*. That's because in most of our facilities, managers are responsible for ensuring successful operations so they step up to the leadership/facilitation plate with a natural ease.

In our application of PD these people become the PD facilitators. They become the *experts* on PD and are valuable internal resources when their institutions seek to use the method for different problems or in a wider context.

Facilitators often learn to act in ways that are very different from the actions that they are usually rewarded for. Here are some of the differences that come with the role of PD facilitator

What facilitators do very well, but have to “hold back” when facilitating PD

Identifying problems and using their expertise to design solutions

Establishing protocols for “rolling out” campaigns and initiatives

Assigning responsibility to individuals to carry out tasks

What facilitators *master* with PD

Listening and asking questions that encourage the people who must carry out actions to design solutions.

Establish opportunities to create “space” for the people who must change their actions to think and create solutions.

Guide those who are creating solutions to try them out and measure their effectiveness.

Facilitators help senior leaders know what, when, and how to reinforce their commitment to the PD process.

Here are a few guiding ideas or suggestions they might offer.

Participate	It's powerful when an executive opens a meeting by welcoming participants and saying something positive about the effort. But it makes a stronger point when they actually stay after their speaking part is over and participate in the whole meeting.
Listen	Leaders send a powerful message by being there to listen. During one volunteer meeting, a hospital CEO actually took the magic marker and captured ideas being generated by staff on the chart paper himself. Participants reported that this made them feel that he valued what they were saying enough to do some of the work of documenting it.
Demonstrate Interest	<p>Sometimes just showing up speaks louder than words (and much louder than memos) - especially because everyone knows that executives have impossible schedules.</p> <p>It worked for one hospital to have key leaders (the CMO, VP for Quality, CFO, and CEO) take turns attending the bi-monthly unit briefings where staff discussed their compliance and other data. This means there is always someone present who can demonstrate the interest of top management in what's happening.</p>
Reward With Attention	At one hospital, the Resource Team wrote personal notes to staff members that the CEO signed and mailed home to let staff know that their work was appreciated. It didn't take much time but the fact that they were <i>noticed</i> and acknowledged made a big impression on staff and their families.
Say Yes	<p>Word travels fast in most organizations. When a leader can approve an idea generated by staff early on in the project - even a relatively small one - it creates buzz.</p> <p>For example, van drivers in a long term facility asked if they could have some gel dispensers in the vans so they could wash their hands. This was approved by the CFO and the dispensers were installed in a matter of weeks. Word got around that it was now worth contributing ideas because leaders were ready to take action.</p>

*“If your actions **inspire others***

to dream more,

learn more,

do more and

become more,

*you are a **leader.**”*

--John Quincy Adams--

Section Five

Discovery & Action Dialogues Training Material

*They dance around in a
ring and suppose,
While the secret sits
in the middle and knows.*

--Robert Frost--



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Discovery Leads to Action

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A. What Are Discovery & Action Dialogues?

Discovery & Action Dialogues are the **MOST** important component of your PD initiative. Everything that makes PD a powerful “how-to” approach for stimulating changes in behavior is woven into the Discovery & Action Dialogues (“D&As”).

Discovery & Action Dialogues are gatherings that your Resource Group *seeks* an invitation to: You ask *unit managers, department managers, people you know within departments, people you know that already convene groups within your facility, and people who are coming to you because they are interested in MRSA*, when you might join their group for about 20-30 minutes to LEARN more from them about MRSA and opportunities for its transmission in your facility. Once invited to attend, a subset of the Resource Group that

we’ll call the “Facilitation Team” goes to the meeting to facilitate a Discovery & Action Dialogue. The Facilitation Team should consist of two people – one who will facilitate the D&A and the other to act as a backup and scribe.

During the Discovery & Action Dialogues you use the PD MRSA Questions (see Section Two) as a guide, with the goal of uncovering some existing Positive Deviant practices and generating some new ideas for solutions. The Facilitation Team captures these ideas and helps the group turn them into immediately actionable next steps.

A Facilitation Team repeats these Discovery & Action Dialogues over and over – with as many people as you can, during all shifts, weekends and weekdays.

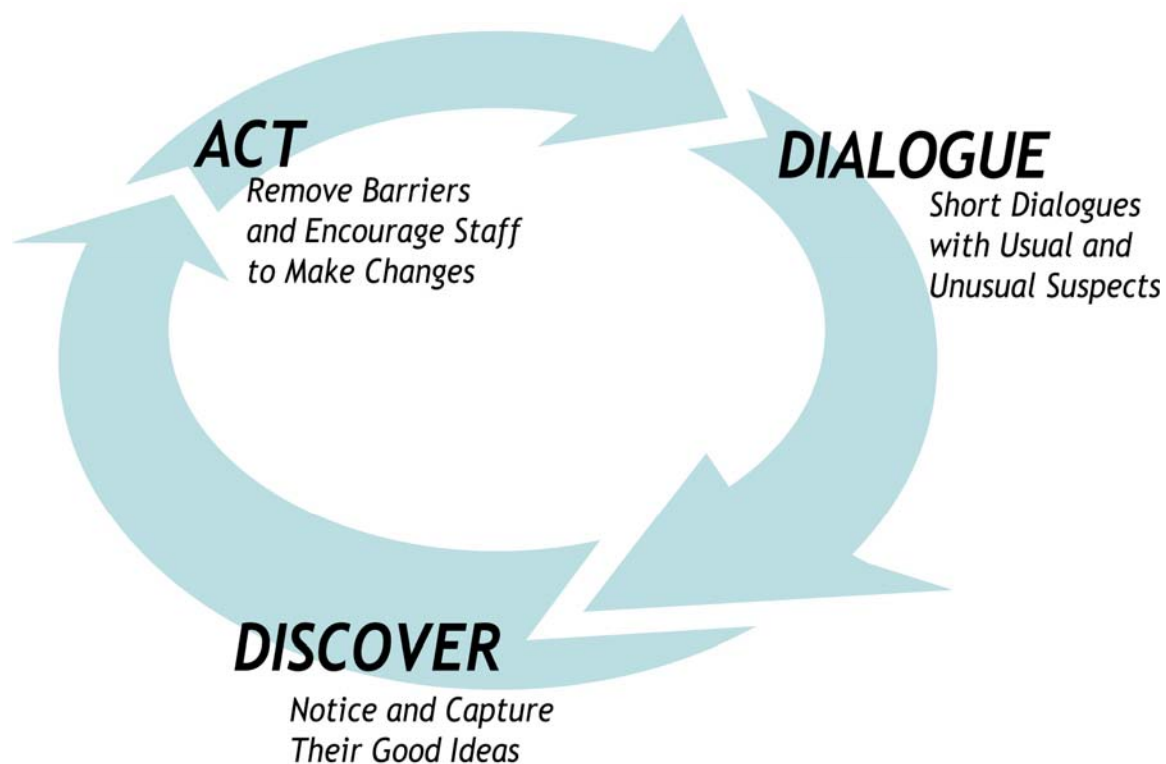
The job of the Resource Group as a whole is to go the extra mile to collect stories, retell and publicize the stories of successes both big and small.

Discovery & Action Dialogues are conversations with front-line staff designed to:

1. Engage staff in short, lively conversations to discover the existing solutions they already know and to create new ideas to eliminate and prevent MRSA.
2. Identify volunteers among this group to act on solutions and ideas.
3. Provide the facilitators and the PD resource group the opportunity to listen to staff and learn of barriers they may need to act to remove.
4. Build capacity- create networks of staff at all levels that foster peer-to-peer sharing of solutions.

How Discovery & Action Dialogs Incorporate the Critical PD Ingredients

The Critical PD Ingredients	Discovery & Action Dialogues
On every unit there are some unique practices that make it possible for some people to have better outcomes (or better compliance with evidence-based practices) than their peers	PD questions lead you to uncover existing PD practices
There are many additional practices living in the “subconscious” of people in the community just waiting to be unleashed	Discovery & Action Dialogues and PD questions allow new ideas to ‘bubble up to the surface,’ where they can be acted upon
To overcome serious and intractable problems, you have to go beyond “the usual suspects” and include all the people whose actions might directly or indirectly have an impact	Discovery & Action Dialogues are done with everyone - not just doctors and nurses. They include housekeepers, clerks, volunteers, clergy, patients, families, doctors and nurses, transporters, physical therapy etc. <i>NOTHING ABOUT THEM WITHOUT THEM</i> is a key corollary to this component. Discovery & Action Dialogues AVOID finger pointing by inviting everyone who is identified as involved or affected by the problem to the discussion
Communities are just like our bodies, they reject ideas that come from the outside. While it might seem efficient on the surface - externally introduced “best practices” rarely stick because they are viewed as “intrusive.” Creating a sense of “ownership” is a fundamental requirement for sustainable behavior change.	Discovery & Action Dialogues create the opportunity for the “community” to discovery its own set of “best practices.” By creating a space for genuine engagement - the Discovery & Action Dialogues promote “ownership” Getting as many people “thinking” as possible is as important a part of Discovery & Action Dialogues as the solutions that are uncovered
Practicing a new behavior is a more powerful way to make it stick than learning about it or as its described in PD It’s easier to ACT your way into a new way of thinking than it is to THINK your way into a new way of acting.	For facilitators and participants Discovery & Action Dialogues gives us a chance to practice a whole new way of acting. For facilitators the practice is in “listening” and diverting action to participants. For the participants the practice thinking through behaviors and their impact, creating solutions and taking responsibility for action on them.



B. Getting Started—Holding Your First Discovery and Action Dialogue

Getting Started with DISCOVERY & ACTION DIALOGUES

Discovery & Action Dialogues are repeated conversations that you organize and conduct with front-line staff about what they are doing to prevent MRSA and what keeps them from doing it all the time.

Discovery & Action Dialogues must involve both “usual” and “unusual suspects” - participants should include both the obvious and the not-so-obvious - nurses would be a good example of “usual suspects” and environmental service staff might be a good example of “unusual suspects.”



A Discovery & Action Dialogue in Progress. The scribe is taking notes, the facilitator is sitting at the same level as the group, and a wide variety of staff are represented (clothing includes scrubs, suits, and environmental services uniforms). This group has chosen to use post-it notes (back wall) to organize priorities or ideas.

“We kept talking about and planning Discovery & Action Dialogues, but our coaches kept saying really the thing is you just go do it. Finally, we just went and did it and we were just floored. It didn't go the way we planned—but we got exactly what we were hoping for.”

--Cheryl Squiers, VAPHS (Pittsburgh)--

How Long Should a Discovery & Action Dialogue Take?

D&As should take **15-20 minutes**—sometimes they go longer but the hope is that these will be high-energy/high-engagement conversations that staff look forward to.

Who Should be Invited?

If you know that there are **staff particularly interested in MRSA** issues, this is a good place to start—follow the energy of the group! Use natural gatherings that are already occurring: Stand-up briefings at nursing stations, the break room, etc. Remember to repeatedly ask “WHO else should be in this conversation?” How could we invite them?

When Can Discovery & Action Dialogues Be Conducted?

You may want to **test a variety of times** per shift to see what times are most productive—you’ll want to be sure to inquire about when participants would like to have the next conversation.

THE SIX KEY QUESTIONS in Early Discovery & Action Dialogues

1. How do you know whether your patient has MRSA or carries the MRSA germ?
2. In your own practice, what do you do to prevent spreading MRSA to other patients or staff?
3. What prevents you from doing these things all the time?
4. Is there anyone or any unit that has a way of doing things that helps them to overcome these barriers?
5. Do you have any ideas?
6. What would it take to make that happen here?
Any volunteers?

Where Should they be Held?

Because you want to “sit at the feet of the staff” and learn from them, you’ll want to **go to the staff, not vice versa**. Choose an informal, convenient and comfortable setting for staff. Hallways, nurses stations, break rooms, supply rooms, entrance to a unit, unusual locations may help you uncover unusual suspects, unsuspected barriers, etc.

How to Facilitate Great Discovery & Action Dialogues

It **works best if you have two facilitators**—one to convene the meeting and one to be the silent scribe who will take notes and help capture important ideas. The scribe can also act as a ‘backup’ for the facilitator and help to keep the D&A on track, as needed. The scribe’s job after the meeting is to give the facilitator good peer feedback. We’ve provided some sample questions to get you started on that process in the Discover & Action Resources (Section Six).

Materials

You will want to make your Discovery & Action Dialogues fun, exciting and interesting. What props, prompts, materials will help staff connect and engage as you introduce MRSA and a new way of thinking about how to change behavior?

You will want to have a **way of taking notes**, probably a flip chart. We suggest that you take a digital camera to capture key moments, **document the process and create excitement**.

Holding Subsequent D&As

Now, that you’ve gotten started, **keep going!** Your first few D&A set the stage for your next D&As because you’ve only just started the conversation – your next D&As will provide you and the participating staff with an opportunity to continue exploring the conversation and after the first few D&As staff who have volunteered to follow-up on specific actions will begin to have noteworthy items to report.

c. A Sample Discovery & Action Agenda

The next four pages provide a sample of how an actual D&A might unfold. This is only a sample and what actually happens in your D&As will differ.

1. Introduce yourself and make sure everyone in the group introduces themselves.

Remember, people aren't involved in a conversation until their voice has been heard by the group. Always ask participants in a D&A to introduce themselves.

If this is a group with which you are unfamiliar, you may want to start with some kind of very short ice-breaker. You may already know and use ice-breakers and if so, that's great—adapt one you already know and like for your D&As, just as you would for any other meeting. If you don't already use ice-breakers, do not worry. During training you will hear several ideas about possible ice-breakers but if none of these seem relevant, or if you want a little more help, this is a great question to raise with your coach.

2. Once everyone has introduced themselves, here are some preliminary questions to get into a PD “mode” now that the stage has been set for a congenial and trusting conversation

- ◆ What do you do that helps prevent the spread of MRSA? (Start with this question especially when you are holding a D&A on a clinical unit)
- ◆ What do you know about MRSA? Or, have you heard about MRSA? Use these questions when meeting with ancillary departments such as Environment, Supplies, Dietary, Pastoral Care, volunteers, Transports, others. (If the answer is “No” be prepared to provide some basic facts and knowledge on the spot)
- ◆ What prevents you from practicing these behaviors 100% of the time? (Here staff will begin the naming of issues...)

3. Questions for eliciting existing uncommon successful strategies to overcome a specific barrier or issue

Select one of the common barriers (lack of time, lack of access to supplies) and ask:

- ◆ Is there anyone here (or on the unit) who has overcome this barrier successfully?
- ◆ Who has been successful at doing X or Y?

If the group has a positive response—especially, if the named individual is present in the room—then you can ask:

- ◆ Would you mind sharing what you do about...?
- ◆ What does everybody think about what <insert name> shared with us?
- ◆ Is there anything we can learn from that and apply tomorrow? How?
- ◆ How can we practice these new behaviors that we've identified together?

Note 1: PD is about enabling people to practice new behaviors that work, so what are the ways we can practice these new behaviors that we've identified together?

Note 2: Usually this type of question will result in the group deciding to investigate more (via observations, trials, search for info, etc).

It is important, then and there, to identify who is going to do what!

If the group says that there are other individuals or groups not in the room, or if people in other units are described as PDs, then you can ask:

- ◆ Who is he/she? Who are they?
- ◆ What does this individual or team do to overcome the named barrier?

- ◆ How can we involve that person or group /unit?
- ◆ How can we learn from that person or group/unit?

If the group has NO suggestions about PD individuals or behaviors, you should ask: "So, nobody in your unit or in the hospital is able to...? Example: "So, NO doctor in the hospital washes his/her hands consistently?"

Note: usually the answer is "Of course not"...which you should respond to with the following questions:

Who are they? How are you going to find out what he/she/they do?
What do you want to do to find out?

Note: some individual usually volunteers to observe, or go and talk informally with the person/unit in question

Do you have any ideas about how to overcome this barrier/obstacle? (gowning, hand washing, etc...)

4. Questions to generate **ACTION on new IDEAS** and latent solutions (Note: latent solutions are solutions that are not quite consciously known but are just waiting to be discovered...latent solutions are often "recognized as soon as a brave soul articulates them)

(Direct)

- ◆ What are some ideas that you have in mind to address this problem?

(Inclusive)

- ◆ What can we do now or how can we start doing things differently tomorrow?

(Direct)

- ◆ Who could help us accomplish _____?

(Neutral)

- ◆ What would it take to get these ideas and existing solutions implemented?
- ◆ What needs to be done to make it happen?

The group may come up with a “to do” list with different individuals within the unit. Facilitators or Infectious Disease practitioners can assign themselves to specific tasks as requested or needed.

5. Sample questions for next steps

Follow-up:

- ◆ When do you want all of us, plus others, to meet or/and communicate again?

Expanding networks (horizontally)—questions to be raised within units, departments, and the resource team:

- ◆ Who else needs to be in this conversation?
- ◆ How can we involve them?
- ◆ What is the first step, who is going to contact this person/ them? And when?
- ◆ How can we expand our network?
- ◆ Do we need a contact person in the unit? What for?
- ◆ Who wants to volunteer to be a MRSA prevention point person for the unit, department, clinic, etc...?
- ◆ How can we address MRSA issues between departments?

6. Closure

Ask a participant to summarize what has been decided upon and the action plan (what, who, when,).

Decide when to do the follow-up on actions.

Set up the next meeting.

D. Discovery Leads To Action

As a D&A facilitator your job is to help specific D&A groups get moving. Of the six PD questions listed above (and on the laminated, pocket-sized 'cheat sheets') Questions 5 & 6 are the keys to creating new action.

How PD Questions 5 and 6 Can Help You Turn Latent & Emergent Knowledge into Powerful Action

When you ask the group

*PD Question 5. Do **you** have any **ideas**?*

THAT'S when your biggest job starts—this is when you really have to pay most attention and notice what's being offered, sometimes very slowly and tentatively by members of the group. You'll want to cue your silent scribe partner that you're looking for extra help and support right at this point both to capture the ideas but also, and maybe even more importantly, to help you create the sense, the energy, that you really expect an answer...you and your co-facilitator must communicate the unspoken message at the point that participating staff do have important ideas to share.

Some of the ideas that staff will share are going to be terrific, some may not strike you as important in the moment but will later prove to be extremely powerful, and some of the ideas offered are going to be nonstarters—either because the ideas don't meet the test of evidence-based medicine or because they are not practical for other reasons.

“With PD, the people who do it solve it.”

--John Ringdal, University Drive Hospital, Pittsburgh--

The Great Ideas

How you respond to the first two categories of ideas may not be as important as how you respond to ideas in the last category.

But first, clearly, when you hear a great idea, the group has probably noticed that it's a great idea, too. Get the group to help you make these kinds of ideas explicit by asking questions such as:

"What did you notice about what _____ just said?"

"Can someone restate what _____ just mentioned?"

Or, "_____, can you restate that?"

When you hear an idea that you are inclined to dismiss as not being "important" that's a big signal to YOU.

As participants are responding to your questions, if you hear yourself thinking that something isn't really important, SLOW DOWN. Take a deep breath and ask the group what they're thinking. The idea may not be very important and the group will help decide what is and isn't important. And, your question may help the group move in a different, related but unanticipated direction.

Or, you may be in for a real education as the group may provide concrete evidence that what you thought wasn't very important actually looms large for *them*.

And the Not-So-Great Ideas

What do you do when someone offers a "stupid" idea AND the group loves it?

Clearly, you could use superior status, training and knowledge to quash this nascent idea, but...is that really what you want to do?

Probably not in the PD process. Remember, we're not talking about business as usual. We're creating OWNERSHIP, not buy-in.

When you hear an idea that you know is too far-fetched,

or simply doesn't stand up in the face of current knowledge and research,

you will face one of your **toughest moments** as a D&A facilitator.

First, you should ask the group what others think. Some possible ways of asking might include the following questions:

- ◆ What does everybody think about what <insert the person's name> just shared with us?
- ◆ Is there anything we can learn from that and apply tomorrow? What? How?
- ◆ What do you think about that?

Then, depending on what's said, you might want to continue the conversation, expand it or make sure the scribe notes it and move on.

Usually during the responses to question # 5 there will be some ideas that, because of their obvious merit, generate strong enthusiasm from the group. Asking the group what can be done immediately and then asking for volunteers is a great way to build on this enthusiasm and create real momentum.

For example, you might ask:

- ◆ How can we practice these new behaviors that we've identified together?

Or, if the group needs to investigate further, bring unusual (or usual) suspects into the conversation, or needs some help from another unit or decision-maker, you might move on to question 6:

PD Question 6. What can we do now—any volunteers?

- ◆ What do we need to do next? Who could help do that?

Allow the group to investigate the solutions they have come up with.

How to Turn a Not-So-Great Idea into a Good Experience

You may choose to do what one nursing executive did when nurses on one of her PD units wanted to use stethoscope covers; the nursing executive knew that this idea was not supported by evidence-based research. However, instead of quashing the idea and the enthusiasm of the nurses, she wisely chose to turn to Question #6: “What can we do now - any volunteers?” Someone in the group suggested “We should do some research.”

The nursing executive then asked for more specifics about what kind of research and who might be willing to do this and two staff people volunteered to come back to the group in a week with reports from manufacturers and a literature review about stethoscope covers.

The two nurses on the unit did a great job of research and came back to the group and reported that the idea of stethoscope covers was a “nonstarter” and that they did not recommend taking the idea any further. In addition to learning that stethoscope covers weren’t the direction to take, they also learned and taught each other a great deal about a wide range of MRSA transmission vectors in just that simple exercise.

By allowing her staff to find the answers on their own, the executive wasn’t asking them to ‘buy-in’ to her knowledge -- the nurses on the unit owned that knowledge because they were given and took the opportunity to understand the issue for themselves. The next time a potentially viable solution surfaced in the unit there was active support—staff knew they were going to be heard and respected.

“We're getting staff volunteers for things we never imagined...

***one of the big problems** for us is that,
as leaders and managers, partly because of our training,
we tend to over-help...*

and we protect people from too much conflict...

*PD is helping us **get to real conversations**
and **conflict** because we're really
struggling with real problems.*

*And, we're finally
getting to
real answers.”*

--Nancy Iversen, Billings Clinic--

E. Sample “Debriefing” Questions after a D&A Dialogue

Some hospitals have found that it is helpful for members of the Facilitation Team to ‘debrief’ after each D&A and to share their observations with the rest of the Resource Group.

Below are some questions you will want to consider with your facilitation partner and the larger group:

D&A Dialogue Process:

What are your impressions?
 What worked? Why?
 What did not work? Why?
 What was different from other gatherings/meeting we usually lead?
 What should we definitely not do again?
 What should we try to do differently?

D&A Dialogues Outcomes:

- 1) What **CONCRETE ACTIONS** have been taken as a result of this D&A dialogue (what, who and when).
- 2) How can the **observations and ideas** that emerged during D&A dialogues be turned **into immediate actions**?

Dissemination: sharing the process and its results beyond the unit:

- 1) How do we intend to **record** ideas/observations/actions and **feed them back** to the community?
- 2) How can we **build momentum** so that a critical mass of people is involved and the flow of ideas/changes becomes visible to all?

Who should be involved in this discussion?

When should it be raised?

In which forum?

Note: *Robust feedback loops are essential to PD.* Finding ways to make these visual and tactile rather than simply oral or written will help staff access the information and values of PD.

Bulletin boards, posters, maps, displays or photos of new supplies, stories of small innovations and successes featured in hospital newsletters, etc. have all proven useful at other sites.

Section Six

Discovery & Action Dialogue Resources



Contents

- A. Tips for Facilitators
- B. Frequently Asked Questions
- C. Discovery & Action Dialogue Group Meeting Summary
- D. Notes from a D&A
- E. Sharing Successes

A. Tips for Facilitators

Remember that you are there to invite staff into an important conversation. You don't have to know all the answers—you are there to ask questions and listen!

As you become more experienced you will begin to feel more **confident and relaxed**. Here are a few tips that we think will help you in your early D&As:

Non-Verbal Behavior

- ◆ **Maintain eye contact** with people in the group as you speak
- ◆ **Practice active listening**: nodding, smiling, showing interest. Listen carefully and show interest in participants' responses and exchange
- ◆ Be **observant and notice** participants' level of comfort or discomfort
- ◆ Sit **in the group**, not higher or away from the group

Verbal Behavior

- ◆ Be sure **participants talk more** than you do and exchange among themselves
- ◆ **Refrain from making suggestions**, or giving advice, unless specifically asked
- ◆ Ask **open-ended questions** with "What, how, what if"
- ◆ Invite participants to **tell their story** or share their experience with the issue at hand

- ◆ Share **relevant personal experience** with participants to make them feel comfortable and develop trust by evoking feelings, beliefs, needs and your own vulnerability
- ◆ Let the conversation **guide** the group
- ◆ When you ask a question, **pause at least 20 seconds** to allow people in the group time to respond

Encourage Everyone to Participate in the Discussion by

- ◆ Acknowledging an individual's willingness to talk, even if the statement is incorrect or beside the point, by saying: "this is interesting....I never thought of it this way..."
- ◆ Asking other participants to answer questions that come up during the discussion - in this way you can often **avoid answering** these questions yourself.
- ◆ Ensuring that everyone can **voice their ideas** or opinion
- ◆ If one person dominates the conversation, acknowledging that person's contribution to the group but stress the need to learn and hear from **EVERYONE**

Quote Participants' Ideas, Remarks, and Opinions to:

- ◆ Single out **ideas** from participants
- ◆ **Summarize** ideas, opinion from the group
- ◆ **Broaden** the discussion
- ◆ Let people know that you **listened carefully** to what they said

Some Lessons Learned by Others Practicing and Conducting Discovery and Action Groups

- Try to keep the focus on existing solutions that are working or might work.
- Check to make sure you are listening by saying, "What I think I am hearing is...."
- Summarize the ideas as you go along. This makes it a little easier for the scribe.
- Ask questions as ideas and strategies emerge that lead to more "specificity." Ask the "how" questions.
- Remember to ask, "Do you know anyone who has solved this?"
- Use PDs that emerges to help you shift the focus of the conversation.
- Personalize MRSA early on in the group for the participants or for you.
- Lay the groundwork for having the discussion about MRSA. Be sure to emphasize that this is a new way of attacking the problem.
- Use humor.
- Stay at the same level as the participants. Don't stand if they are sitting.
- Be careful about saying "good point" as reinforcement.
- Share a personal story as a good way to break the ice. Share a MRSA-related story and/or how it felt to have your own good ideas heard and acted on.
- Listen instead of talk.
- Reflect back what you hear as a check or a test.
- Repeat back the "urban myths" universally to elicit exceptions. For example, a possible myth is, "Putting on gowns and gloves for an MRSA patient limits the care he or she gets." Your response: "Ok, so if I understand, 'at *our hospital*, there are no examples of where gowning and gloving is observed all the time and patients get all the care they need?"
- Have a team of two facilitators. The second facilitator adds a different perspective.
- Try to get the answers to questions from the group.
- Try the five "hows" instead of the five "whys."
- Recognize that silence is ok; it might be a "working silence."
- Allow wait time as you facilitate.
- Trust the process—it really works.
- Do not correct immediately if the "wrong" information about MRSA or a policy is offered. Instead, reach out to the participants to get a check on accuracy, using a phrase like "What do the rest of you think?"
- Allow the MRSA technical expert to answer questions about MRSA transmission and so forth, but answer the questions that are asked.
- Reach out specifically to quiet individuals.

B. Frequently Asked Questions

In the process of unleashing solutions for **preventing MRSA transmissions**, D&A Dialogue facilitators frequently encounter common questions from participants. We are building this **handy resource** into the Field Guide which can be used as a reference for responding to these FAQ's.

Each FAQ is followed by sample responses by the facilitator designed to either **evoke** the answer from the staff or **provide** technical answers in response to their questions. This is followed by a brief summary of the fundamental knowledge upon which the answers are based. References are included when helpful and available.

It is hoped that this short list will grow as others add to it. Like the rest of the Field Guide, this section is **a living document** to which others are invited to contribute!

1. What good does it do for staff to perform hand hygiene when patients who are MRSA positive are out and about smearing their germs everywhere?

Facilitator asks:

- ◆ Can you think of ways we might engage patients to be part of the solution starting with hand hygiene?
- ◆ Could something be done at the time of admission to inform, supply and invite patients to participate with staff in preventing HAI's
- ◆ How would you go about doing this? Do you want to volunteer to work on the patient engagement piece?

References and Resources for patient education and participation include:

- ◆ University of Pennsylvania has produced an excellent 5 minute DVD geared to patients emphasizing the importance of hand hygiene for them and their care givers. Information is available at:

http://www.healthtransformation.net/cs/university_of_pennsylvania_school_of_medicine_partners_in_your_care

2. Why don't we treat colonization?

The facilitator has an opportunity to answer a specific question posed by the staff rather than “in-servicing” them with answers to a bunch of unasked questions.

Fundamental knowledge includes:

Eradication of MRSA carriage is NOT routinely recommended because of:

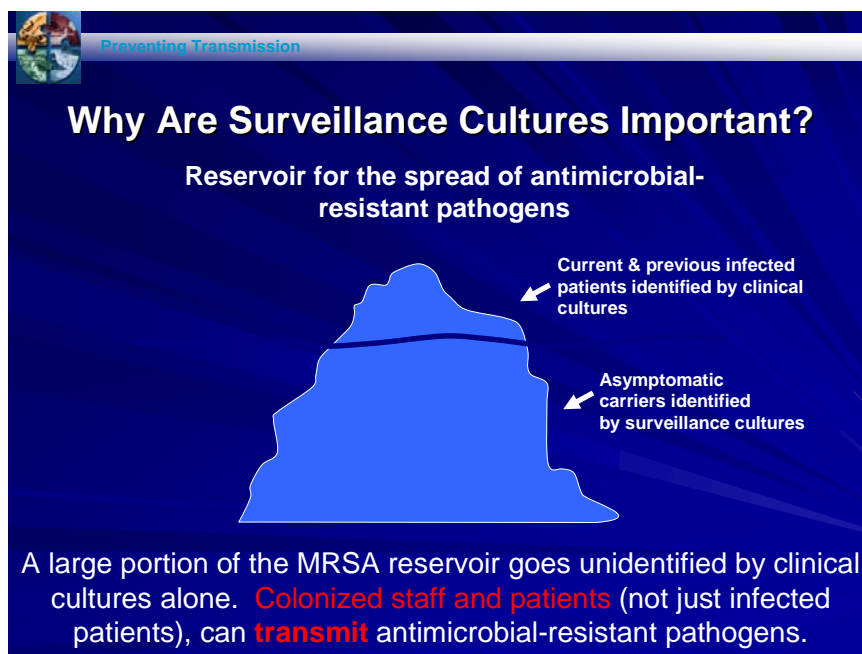
- ◆ **Difficulty** in achieving long term eradication (most colonization returns).
- ◆ Most antibiotics **do not reach** sufficient concentration in nasal secretions to be effective.
- ◆ Promotion of **resistance**.
- ◆ **Complications** due to side effects.
- ◆ **High cost** of monitoring long term results.
- ◆ **References:** Jones, James, et al, CID 2007:45 (Mupiricin Resistance in Patients Colonized with MRSA in SICU)

3. Why do we need to culture every patient on admission?

Facilitator might ask the group:

- ◆ “Is it possible to carry MRSA without being sick with it?” This leads to a discussion of **MRSA colonization** (having it on you) and **MRSA infection** (having it in you).
- ◆ “What do people who are colonized with MRSA (asymptomatic carriers) look like?”

Fundamental Knowledge:



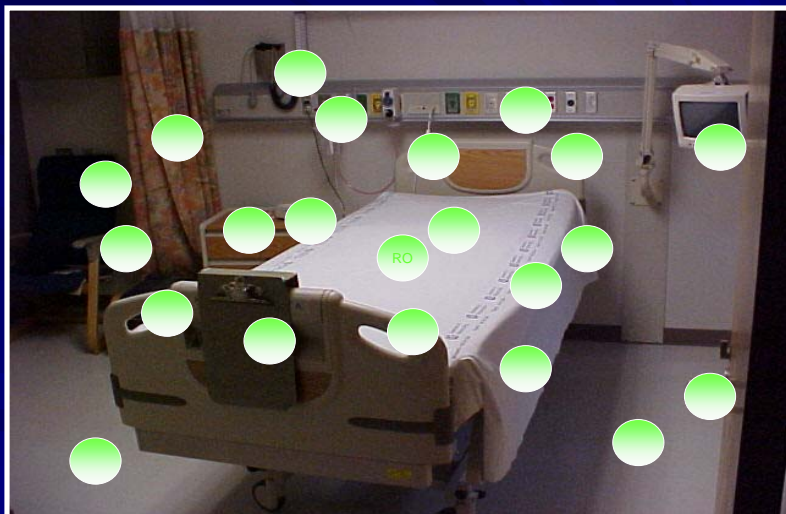
- ◆ Clinical cultures only identify 25 to 30% of patients with MRSA.
- ◆ Surveillance cultures help identify all patients who carry MRSA
- ◆ **Reference:** Muto, et al. SHEA Guidelines for MRSA and VRE, ICHE May 2003

4. Why gown when you're just going in to an isolation room to check a patient's IV or something simple like that?

Facilitator might want to pass this picture around and then ask the PD questions:

- ◆ The dots indicate sites where MRSA has been cultured. How long do you think it lives on environmental surfaces?
- ◆ What's the likelihood that you might be asked to get something in the room for the patient or do something for the patient at the patient's request or urgently? How would you respond if you hadn't put on PPE?
- ◆ How likely is it that you can reliably and consistently walk in and out of an isolation room and not touch any of these environmental surfaces where MRSA is routinely cultured and where it can live for weeks?
- ◆ GermGlo or glitter could be put to good use here.
- ◆ Continue the discussion long enough to let some one emerge who advocates for strict adherence, let them make the case for strict adherence to contact precautions when entering an isolation room. Let the advocate take the lead with her/his peers on this issue.

Modifying Patient Rooms to Support Precaution Compliance



Fundamental Knowledge:

- ◆ **MRSA is a hearty pathogen** and lives on various environmental surfaces for up to 90 days.
- ◆ Studies show that **42% of gloves** become contaminated with MRSA when they touch surfaces in the room of a patient with MRSA without actually touching the patient.
- ◆ According to one study, white coats are contaminated **69% of the time** during care of patients colonized with **MRSA**. The pathogen is transferred to the healthcare workers' hands **27% of the time**.
- ◆ MRSA can **survive** more than **38 weeks** on environmental surfaces such as door knobs, faucets, keyboards, telephones, even sterile goods packaging
- ◆ **References:**
 - Boyce JM et al. Environmental contamination due to MRSA: possible infection control implications. Infect Control Hosp Epidemiol 1997; 18: 622-627
 - Dietz B et al. Survival of MRSA on sterile goods packaging. J Hosp Infect 2001; 49: 255-561

5. How should we practice hand hygiene and contact isolation?

The facilitator has a golden opportunity to foster a little learning-by-doing by having the staff demonstrate how they actually perform standard and contact precautions, e.g. performing hand hygiene, putting on gown and gloves in the right sequence.

Fundamental knowledge:

- ◆ Hand hygiene is performed upon entering and leaving each patient room. **Alcohol-based hand rub** is superior to soap and water except for soiled hands or C.Diff.
- ◆ Every person entering the room wears a **new pair** of gloves and a new gown.

- ◆ All protective attire is **removed** upon leaving the room.
- ◆ All patient care equipment is **disposable** or **disinfected** upon leaving the room.
- ◆ **References:** CDC Guidelines on standard and contact precautions

6. Shouldn't we be doing nares cultures on the staff?

Facilitator might ask:

- ◆ What do you think the **MRSA carriage rate** is among healthcare workers?
- ◆ If staff becomes **colonized** is it always a **permanent** condition or can healthcare workers become colonized **transiently**?
- ◆ What is the **likelihood** of transmission to patients by colonized staff if precautions are adhered to?
- ◆ The fundamental knowledge needed to answer these questions includes:
 - Only a small percentage **(5%) of staff is colonized**.
 - Colonization of staff is **frequently transient** while they are caring for a MRSA positive patient and can clear spontaneously.
 - Colonized staff that adheres to standard and contact precautions **won't transmit**.
- ◆ **References:**
 - Perl, et al, NEJM, 2002; 346
 - Inka, et al, J Hosp Inf, 2006, 64; 162

Other General Questions

As you begin the Discovery & Action Dialogues, you're likely to have questions or concerns. Here are some common questions that other groups have had.

- Is it reasonable to pick easier ideas or practices to move on first?
 - How do you keep this from getting "out of control" or going too fast?
 - How do you get people to see the big picture beyond their immediate personal concerns or tasks?
 - How long does it take to see results?
 - Is there a limit to the number of people or units that should be included in these Discovery and Action Groups?
 - Do you involve agency staff? Residents? If so, how?
 - How simple do you keep the explanations and answers to questions? What knowledge base should you assume?
 - What if you don't get to everyone at first?
 - What if supervisors won't allow staff to attend?
 - How do you handle the obstructionist?
 - What is the mechanism for following up?
 - Is it important who says "let's move on that," or should that come from the group?
 - Should "homework" be assigned?
 - How do you engage people who are quiet?
 - What process is there for following up?
-
- For how long are Discovery & Action Dialogues a part of the PD implementation? Do they eventually stop occurring?
 - How do you keep them from becoming gripe sessions?

C. Discovery and Action Dialogue Group Meeting Summary Form

This sample form may give you some good ideas about what information you and your silent scribe will want to capture during your D&As and how you might want to organize your notes.

Discovery and Action Dialogue Group Meeting Summary		
Area:	Date:	Facilitators:
Those Present:		
1. How do you know who has MRSA? Who carries MRSA?		
2. What are YOU doing to prevent the spread of MRSA?		
3. What keeps you from doing it all of the time?		
4. Do you know of anyone who always does what is recommended to prevent the spread of MRSA?		
5. Do you have any ideas to prevent the spread of MRSA?	Idea	Action Plan Who-What-Where-When-How
6. Would anyone from this group volunteer to help with the next steps?		

D. Notes from a D&A

The following is an actual set of notes from a D&A in a hospital. These notes were produced by the facilitator and the scribe and shared with both the Resource Team and the D&A participants.

Discovery and Action Dialogue Notes from Meeting with EMS Volunteers Dec 14, 200*

Attendees: Andrew A, Chuck G and John L

Ideas and Suggestions:

- ◆ Include a personal bottle of hand sanitizer in the care package that volunteers give to patients when they're admitted with written and verbal encouragement to perform hand hygiene when they leave their room, upon return, before meals, etc.
- ◆ Signage in patient rooms to invite them to join the MRSA prevention initiative and to perform hand hygiene, e.g. "Patients are invited to join the infection prevention initiative at <NAME OF FACILITY>. Please make generous use of the hand hygiene dispenser in your room when leaving, upon returning, before meals, etc.
- ◆ EMS to hand out the patient information brochure on MRSA created by patients at <NAME OF ANOTHER LOCAL, SISTER FACILITY> to patients when they clean their rooms with encouragement to wash their hands.
- ◆ Put up more hand hygiene dispensers at strategic locations throughout the hospital for patients and visitors with signage encouraging them to participate in the MRSA prevention initiative at <NAME OF FACILITY> and to wash their hands. Sites to include: just inside the main entrance, at the admissions desks, by the computer terminals, cafeteria, patient waiting areas, etc.

- ◆ Standardize terminal cleaning of rooms. Chuck and a few others clean all rooms as if they were isolation rooms (except for changing drapes and disposing of unused supplies if not an isolation room) and recommend that this be made standard practice.
- ◆ Work with nursing staff in stocking isolation rooms appropriately to minimize wasteful disposal of excessive amounts of supplies.
- ◆ Clarify and enforce policy regarding cleaning and maintenance of walkers, wheelchairs and other items in patient rooms which are not cleaned by EMS. There is concern among EMS employees that these items are not always adequately disinfected.
- ◆ Attendees were vaguely aware of unit briefings but didn't realize that they are invited to participate. They suggested that the briefing schedule be sent to Bob H. with an invitation to all EMS staff to participate on their units. Unit managers should also be encouraged to invite their entire staff, including EMS.

Next steps:

- ◆ Recruit more EMS to participate and meet again on Thursday, January 11, 2007 at 8:00 am in small conference room outside PACU
- ◆ Include Dora (PACU RN) and John B. in next dialogue.
- ◆ Actively recruit EMS to participate in unit briefings to address their concerns and hear/act on their ideas.

E. Sharing Successes

This section demonstrates one way of telling the story of some of the small, powerful changes that emerge when both existing and latent PD solutions are identified by frontline staff.

Providing updates like this one for staff in your facility will help create excitement and momentum and you just may be surprised at how developing new ideas becomes contagious.

John Ringdal, pictured below, is a former millwright, now working on the 4West surgical unit at VAPHS-UD in patient transport. As a result of D&As in his department, John developed a **nifty, low-cost card** to help restock and resupply patient rooms. In addition to the supply cards, John has worked with support services receiving **MRSA positive patients** from isolation. Together they created a system for transporting and receiving these patients that essentially eliminates the risk of transmissions to other patients. In the picture below, the bag hanging from the IV stand contains gown, gloves and

Isagel hand rub. The bag serves as a signal to the receiving support service (X-ray, cath lab, PT, etc.) that contact precautions are indicated and provides the necessary supplies.

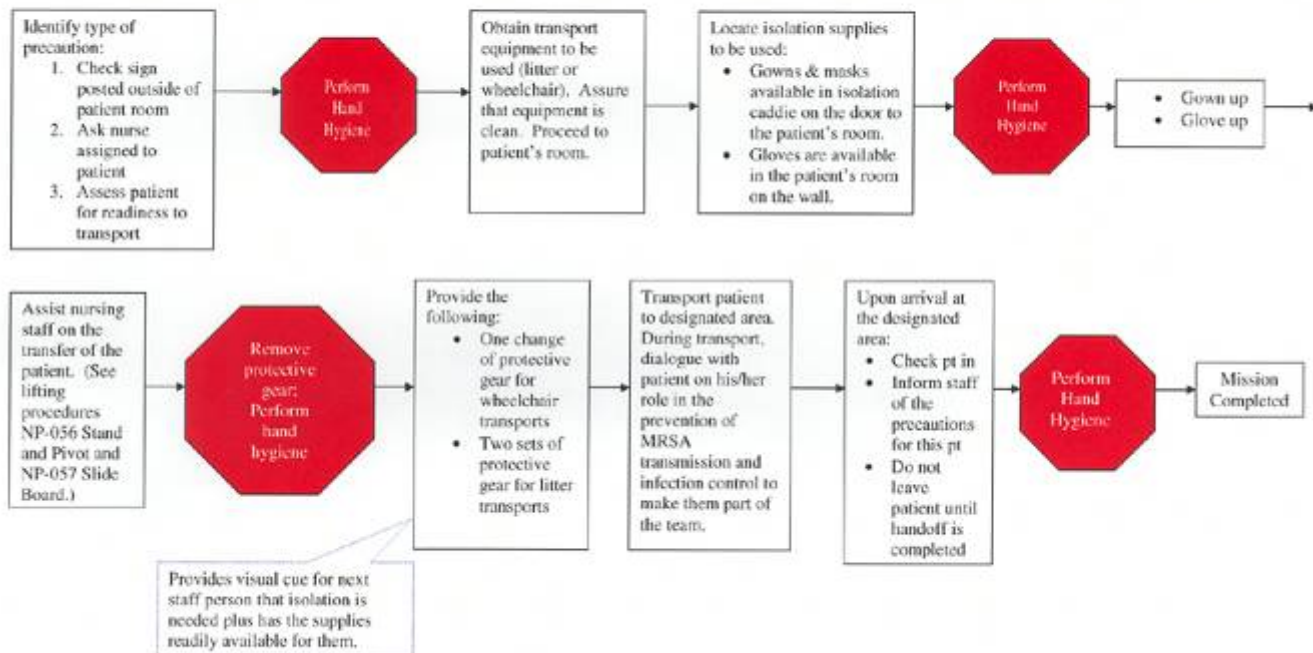
Transporting MRSA Positive Patient



The diagram below is the flow chart John and colleagues developed showing the precautions the staff created to prevent transmissions in the course of patient transport. The cool thing about this process, besides the fact that the staff created it and aren't going to turn their backs on it (ownership and sustainability of solutions), is that it vastly exceeds the SHEA guideline and exceeds past hospital policy.

Draft: 3/29/07

Transport of Patients with Contact Precautions using Wheelchair or Litter
University Drive



Section Seven

Guideposts and Red Flags



Contents

- A. Nothing About Them Without Them
- B. Take 20 Seconds
- C. Finish What You Start?
- D. Catching Butterflies - Your New Job!
- E. Why Do We Need To Keep Doing Discover & Action Dialogues?
- F. Evidence Based Practices Are Not Negotiable;
Best Practices Are Local
- G. Sustained Change Grows Out Of Ownership
- H. How Do You Know If You Are Doing Good
Discovery & Action Dialogues?

A. Nothing about Them without Them

When searching in your organization or community for behavior and solutions that are unusually powerful and effective (positively deviant) it is essential to broaden your conversations to include the people most involved. This is especially powerful when you can bring together people that don't normally talk with one another.

For example, a nurse might say: "Well, we would wear gloves if we had the supplies.....but they never bring enough."

A good PD response to this would be: "Who could we talk with in supplies that might be able to help us fix this?"

For the next D&A dialogue, you would want to make sure that someone from supplies is represented. Maybe they **don't know** that the unit is running out of gloves mid-way through a shift and they can help you solve the problem.

Or, during a D&A dialogue someone might say: "The doctors need to change their behavior by rounding on **MRSA positive patients** last."

A good PD response would be: "Which doctors could we ask about whether this makes sense? Who could approach one of these MDs?"

B. Take 20 Seconds

When facilitating D&A's it is more important to create a real conversation than it is to provide all the "right" answers—as facilitators we can do this by asking the assembled group good questions and then WAITING for people in the group to answer.

The most important thing to remember here is **not to begin speaking too soon after you've asked a question**. Pose the question and then wait at least 20 seconds for someone else to speak.

20 seconds of silence in a group can feel like a very long time—on average, facilitators **begin speaking after six seconds**—so, increase your tolerance of loooong pauses.

During these long pauses people in the group are often formulating their answers and working up the courage to respond—if you start talking too soon, you truncate that process and communicate (unwittingly) that you're the one with the answer.

So, learn to **pause for 20 seconds**—the first few times you do D&As ask your partner to time you—and find out how you're doing - learn to count off 20 seconds in your head and stretch those pauses out to at least 20 seconds.

One way to encourage the group to respond is to **look down at your shoes**—this disrupts your eye contact with members of the group, signals that this is time for reflection and thinking and takes a little of the pressure to begin talking off you.

C. Finish What You Start?

NOT IN D & A Dialogue!

There's probably a voice in your head repeating a lesson from your childhood: *Finish what you start!*

And that's effective advice in many areas of life—but it **isn't especially helpful** when you're doing Discovery & Action.

In a D&A Dialogue you don't have to finish the conversation, in fact, it's more powerful and effective to start the conversation, keep it short and the go back and back and back and back to the group to continue the dialogue in short, **periodic bursts** that are **high-energy, high-engagement** and, therefore, **high-impact**.

You don't have to finish, you **just have to start**. It's OK if you haven't answered every question or gotten every good idea from the staff about how to improve practice.

Just get started and keep going!

Let the group finish what you started

by having a participant **summarize** what you collectively talked about

AND announce the next steps

(even small steps such as making a phone call)

THEY are going to take

("to do" list, expanding their network, etc.)

D. Catching Butterflies—Your New Job

“Capturing butterflies” was the phrase coined by one of the PD/MRSA coordinators in the first round of hospitals using PD

He said: “I used to know my job—it was to tell people important things. Now, my job is **harder** because I spend all my time trying to capture butterflies.” (Source: D. Hares, AEMC)

“**Butterflies**” are those **lovely little ideas** that someone will float into a D&A conversation—these ideas are often either so small, or so obvious, that we in regular practice frequently fail to capture because we don’t explicitly notice them. And, because we don’t explicitly notice these butterflies, we can’t turn them from **ideas into action**.

Your job is to **capture those butterflies**! When you think a butterfly is floating around but hasn’t been made explicit, here are some good prompts to use to help capture it:

Wow, did you guys just notice what ____ said?

Can you repeat that?

What do you all think about that?

What would it take for this to happen?

*“The **range** of what we think and do is **limited** by what we **fail to notice**. And because we fail to notice that we fail to notice there is little we can do to **change** until we notice how failing to notice shapes our thoughts and deeds.”*

--R. D. Laing--

E. Why do we need to keep doing Discovery & Action Dialogues?

We have uncovered great solutions; let's shift gears, write these up and start spreading them!

This is **exactly** the question most facilities face in the first few months of doing PD. When it happens to you, stop for a minute and celebrate! You have proven that you can **successfully facilitate PD!**

But be VERY careful.

This is the point where some facilities lose their way and inadvertently **limit** what they can achieve.

It turns out that just as you see that these are great successes and spread is important—the staff will too—so instead of taking the task and ownership away from them, think about how you can encourage them to work through the details and **ASK** for your ideas or connections.

Don't STOP doing Discovery & Action Groups too soon.

They fuel the PD process. At every Discovery & Action people are invited to slow down and **think** about a serious problem and how they fit into that problem. After the gathering they are still thinking, and talking, and spreading the word. This activation is just as important as the ideas and your goal is to generate a critical mass.

When you start noticing lots of “**second generation**” changes happening throughout your facility along with numbers that tell everyone that lots of stuff is happening you will know that the Discovery & Action groups have done their job.

F. Evidence-Based Practices are not Negotiable; Best Practices are Local

For MRSA transmission prevention, the following practices derived from the SHEA guidelines are an example of **non-negotiable** evidence-based practices.

1. Identify the reservoir of infected and colonized patient
2. Wash hands before and after every interaction with a patient and before and after putting on gloves
3. Protect clothing from becoming a transmission source by wearing gloves and gown when interacting with an infected or colonized patient
4. Keep equipment from becoming a transmission source by using designated equipment or cleaning
5. Effectively clean the patient care environment

While there are many common themes that all facilities and units will encounter when they figure out how to make it easy to do these 5 things—*the solutions could look different within a facility and across facilities*.

That is a good thing! It means that the *design and adaptation is appropriate* for the factors that impact that unit—and it's more likely to work.

G. Sustained Change Grows Out Of Ownership

And ownership is NOT the same as buy-in

There is an **important distinction** between ownership and buy-in. These words are **not interchangeable** and they are not synonymous.

Ownership is when you own or share the ownership of an idea, a decision, an action plan, a choice; it means that you have participated in its development, that it is your choice freely made.

Buy-in is the exact opposite: someone else, or some group of people, has done the development, the thinking and the deciding, and now they have to convince you to come along and buy-in to their idea—so that you can implement their idea without your involvement in the initial conversations or resulting decisions. Aiming for buy-in creates lukewarm, pallid implementation and mediocre results.

PD helps you create true ownership and avoid the pitfalls of buy-in.

When it comes to solving intractable socio-technical behavioral problems in systems the notion of buy-in is just not useful – people in the system need to own the new behaviors.

Anytime you or someone around you thinks or talks about buy-in beware!

It is a danger signal telling you that your development and implementation process is missing the essential ingredient of involving all who should be.

With its emphasis on Discovery and Action with usual and unusual suspects, PD offers a **powerful means of avoiding the wasted time** and mediocre results affiliated with buy-in.

H. How do You Know if You are Doing Good Discovery & Action Dialogues?

We all want to know if we're doing a good job, especially when we're trying something new.

If you find yourself wondering how you are doing as a D & A dialogue facilitator, after you've conducted 4-5 Discovery & Action Dialogues stop and **take a look** at your personal To-Do list.

If you're doing effective D&A Ds, as a facilitator your own to-do list shouldn't be getting significantly larger or longer with action items from, or for, specific units. If you are conducting effective D & A's participating staff on units should be **volunteering** to take on new activities, play new roles and help remove barriers to better practice...in fact, you may find this shift disconcerting.

Does this mean your job will get easier? Not necessarily, you may find that you have to **work harder** at running interference for newly engaged staff, you may find that you're doing more outreach and offering new and different invitations to usual and unusual suspects and, in what may be your **biggest new role**, you may have to pay much closer attention to small ideas—and the potential power that can be unleashed by lots and lots of small ideas turning into **big change**.

So, keep track of what's on everyone's to-do list—if yours is the only one getting longer, you may want to think about how you are asking and listening to the answers to PDs important questions:

PD Question # 5. Do you have any **ideas**?

And,

PD Question # 6. What could we do now? Are there any **volunteers**?