Positive Deviance: A Culture Change Management Approach to Reducing Health Care Acquired Infections

Michael Gardam
Ontario Agency for Health Protection and Promotion
University Health Network
Consider...

- A family member is admitted to the ICU following a heart attack. She initially does well but then suddenly dies after inadvertently being given too high a dose of a beta blocker.
Consider...

- A family member is admitted to the ICU following a heart attack. She initially does well but then suddenly dies after developing septic shock from a hospital-acquired MRSA infection.
Are these different?

• Both events resulted in death
• Both events were preventable

But:

• One is an “error”
• One is a “cost of doing business”
...We know what to do

• Hand hygiene
• Environmental cleaning
• Surveillance, precautions
• Practice bundles
• ...

Why don’t we do these well?

- Funding
- Lack of awareness of the issue(s)
- Quality of data supporting the intervention

- Focus on treatment rather than prevention
- Depersonalization of the issue
- Somebody else’s problem
- Nothing works so why bother?
Time for an attitude adjustment…

“What fits your busy schedule better, exercising one hour a day or being dead 24 hours a day?”
Why turn to a behaviour change approach?

- Current “top down” approaches have had limited success and are resource intensive
- “best practice” approach has been disappointing

- We need to acknowledge that healthcare workers are human!
Sharing best practices

• Solutions imported from external sources results in “social immune response” in the same way that our body triggers an immune defense response
The Premise Of Positive Deviance

No matter how seemingly intractable a problem, in every community there are individuals whose uncommon practices/behaviours enable them to find better solutions to problems than their neighbours who have access to the same resources.
In any group...
Malnutrition in Vietnam Children
This is about...

• Creating sustainable change
• Transforming culture
• Developing new behaviours so that they become habits

• Acting your way into a new way of thinking
Who have the knowledge?
The “Awareness” Iceberg

4% Problems known to top managers
9% Problems known to middle managers
74% Problems known to supervisors
100% Problems known to front line managers

This internationally acclaimed study conducted by Sidney Yoshida, was initially presented at the International Quality Symposium, Mexico city, 1989. It indicated how management's failure to understand its processes and practices from the perspective of its customers, suppressed the company's profits by as much as 40%.
PD and MRSA

- US pilot project
- Implementation of PD followed by 20 month follow up period
- No attempt to decolonize patients
- 26-62% reduction in MRSA clinical infections

- 1 site had an 80% drop in MRSA infections

SHEA 2009
How does it work?

• Invite those who are interested
• Front-line staff must be there (the “Gurus”)
• Let them discover and adopt their own solutions
• Identify and analyze the positive deviants
• Track and publish results
Reinventing the wheel

- The role of infection control is to define the what the wheel looks like...not how to build it
Who is included?

• Who are “the touchers”?  
  – Get the right people around the table  
  – Who isn’t here?  
  – “nothing about me without me”

• Don’t answer questions nobody has asked yet-  
work on those that people have asked and  
want to find solutions for
Who is Included?

• The front line owns the project
• Everyone that touches the problem are invited to join in
• Often “unusual suspects” join and take unexpected leadership roles
PD Tools

- Kick offs
- Improvisation
- Sharing Stories
- Discovery and Action Dialogues
- Social Network Analysis
Discovery and Action Dialogue

• 15-20 minutes per session
  • How do you know if your patient carries MRSA?
  • What do you do to prevent spreading MRSA?
  • What prevents you from doing these things all the time?
  • Is there anyone who has a way of doing things that helps them to overcome these barriers
  • Do you have any ideas?
  • What can we do now? Volunteers?
The power of storytelling

- One death is a tragedy; one million is a statistic.
Canadian PD study

- CPSI-funded study of 4 CDN hospitals
- Collaborative effort
CDN PD study

- **Process measures**
  - Use of alcohol based hand rub
  - Gown, glove usage
  - Social network mapping

- **Outcome measures**
  - MRSA, VRE, CDAD rates
  - Costs
But wait, there’s more!

• Possibility for 4 additional sites interested in combining PD with molecular testing

Act now and eliminate twice the MRSA!!!
How to apply

• Applications available at postivedeviance.ca by July 15th
  – Tell us your story, why you want to participate
  – Show us your hospital’s support
• Applications close by August 15th
• Telephone interview

• Successful sites to attend a meeting in Toronto in September
Learn from the people
Plan with the people
Begin with what they have
Build on what they know.
Of the best leaders
When the task is accomplished
The people all remark
We have done it ourselves

Lao-Tzu’s Tao Te Ching
(6th Century BCE)