

PERFORMANCE ANALYSIS

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HRD 8200: Instructional Systems Design

February 2, 2025

INTRODUCTION

An experienced nurse (RN1) observes a decline in the perceived quality of patient care at her workplace, Hospital A, Unit Z. There has been an increase in patient complaints about delayed response to calls for assistance and increased number of falls. Patient satisfaction scores have declined for the second consecutive quarter. Response times to calls for assistance and the total number of inpatient falls trend higher. Nurses and certified nursing assistants (CNAs) appear stressed and discouraged. A second nurse (RN2) who works on the same unit as RN1 reports the same concerns.

RN1 is a Registered Nurse and former charge nurse with a master's degree in nursing and 31 years of experience in this setting. RN2 is a Registered Nurse with an associate's degree in nursing and 12 years of experience in this setting. Both RN1 and RN2 work on the general medical unit at the hospital, which falls between critical care and observational stays in terms of urgency.

Many factors could play into these issues; my limited performance analysis will investigate some of them.

TARGET PERFORMANCE METRIC DESCRIPTION

Desired performance:

- An 85% response rate for satisfaction surveys mailed to patients upon discharge, with all responses rated as "excellent."
- Ensure a prompt response to patient calls for assistance, with no specific metric currently defined.
- The goal is to maintain a maximum of 2.75 inpatient monthly inpatient falls.

Actual performance:

- The return rate of "excellent" responses has declined from 73.3% in the first half of 2024 to an average of 64.25% in the second half of 2024.
- Response times to call lights are trending longer than desired, as indicated by data recorded by unit secretaries and patient feedback from satisfaction surveys.
- The number of inpatient falls has increased throughout 2024:
 - Q1: 1.72 falls/month
 - Q2: 1.88 falls/month
 - Q3: 2.80 falls/month
 - Q4: 3.01 falls/month

SUMMARY OF FINDINGS

I interviewed RN1 and RN2 for data gathering ([See Appendix A](#)). Both nurses have an education in nursing and have years of experience in the healthcare industry, particularly in the hospital setting. They report similar insights.

Both nurses clearly understand the hospital's objectives regarding patient satisfaction surveys, timely responses to call lights, and the target for minimizing inpatient falls. They emphasize that delayed responses are associated with a higher risk of falls.

Performance expectations are communicated through various channels, including emails, posters, staff meetings, and in-service training sessions. Resource (floating) team members receive orientation packets with unit-specific protocols. Monthly feedback allows staff to assess personal, departmental, and hospital-wide performance. Individual on-the-job feedback does not happen regularly.

Time-consuming tasks seem to contribute to delays in responding to call lights. Emergent patient care and responsibilities typically handled by CNAs significantly impact efficiency and patient satisfaction.

Training includes initial shadowing and annual staff development. Specific unit needs may require additional, self-initiated learning. All staff have an employee guidebook containing policies and procedures for patient care. Gaps are noted in time management among less experienced staff and their understanding of the relationship between response times and fall risks. Resources and equipment are generally accessible, but coordination is needed for specialized items.

Teamwork and communication face barriers such as strong personalities, inconsistent interdepartmental communication (especially from the Emergency Department), and staffing shortages. Nurse-to-patient ratios range from 1:6 to 1:10, and CNA-to-patient ratios range from 1:8 to 1:20, depending on staffing. CNAs are reportedly underpaid, and transferring between departments is difficult due to administrative policies.

There are no existing monetary incentives, personalized recognition, or non-monetary incentives. There are no hiring incentives for CNAs. Aside from required continuing education classes, further skills development is left to individual initiative. However, both RNs believe Hospital A's staff are motivated to provide excellent patient care and meet hospital goals.

ANALYSIS AND TOOLS

Behavior Engineering Model

Thomas Gilbert, a psychologist and pioneer in human performance studies, was among the first to apply behavioral psychology to workplace performance (Winiecki, 2015). He developed the Behavior Engineering Model (BEM) to identify barriers to performance by distinguishing between individual contributions and environmental supports (Chevalier, 2003).

I used BEM to analyze Hospital A's Unit Z issues because it emphasizes systemic barriers rather than placing blame on individuals. BEM is user-friendly and holistic, accounting for individual and environmental factors and helping practitioners identify strengths (driving forces) and weaknesses (restraining forces). Focusing on strengths and appreciation is essential in a human-centered, high-stress healthcare setting. This model effectively identifies performance issues at both individual and team levels, making it ideal for examining the collaborative dynamics between nurses and nursing assistants in patient care.

Gilbert's Behavior Engineering Model (BEM) uses a 2x3 matrix to analyze organizational performance through two primary influences: environment and behavior. These are further divided into three categories—information, instrumentation, and motivation—covering the individual and their working environment. By examining environmental supports and behavioral repertoires, the model identifies where and when errors occurred and how individual performance contributed. The matrix is a visual tool for identifying contributing factors, enabling a comprehensive analysis before determining root causes and recommending the next steps.

For my analysis of Hospital A, Unit Z, I constructed my matrix, modeling Gilbert's BEM (see Figure 1).

Figure 1.

Gilbert's Behavior Engineering Model applied to Hospital A, Unit Z

Gilbert's Behavior Engineering Model applied to Hospital A, Unit Z	Information	Instrumentation	Motivation
Environment	- Are nurses & aids aware of the hospital's goals for response times, satisfaction scores, and in-patient falls? - Are they made aware of how their performance aligns with hospital's target goals?	- Are there systemic inefficiencies delaying responses? - Do they have the necessary tools and resources?	- Are there financial incentives or recognition when performance goals are met? - Are nurses and nursing assistants given opportunities to develop their skills?
Individual	- Are there any skills gaps that prevent performance objectives from being met? - Have they been trained specifically on time management, prioritizing patient needs, and the correlation between call light response time and the risk for falls?	- Are staff given the opportunity to voice department or unit preference? - Are there time-consuming tasks affecting their ability or capacity to deliver expected performance?	- Do staff members feel personally invested in achieving the hospital's goals? - Are they motivated to perform with the available incentives?

I began by examining the information component to assess whether employees know what is expected of them and if they receive guidance about their performance. RN1 and RN2 state that Hospital A expects an 85% return rate on patient post-discharge surveys with 'excellent' scores, 'prompt' call light response and a target of fewer than 3 monthly falls. Responding promptly to call lights is crucial because delayed assistance can lead patients to attempt to get out of bed or perform tasks independently, increasing the risk of falls, especially for those who are weak, disoriented, or recovering from surgery. According to data from the unit secretary (not disclosed here) and patient feedback from the mailed surveys, most falls occur due to long waits for assistance. Expectations are communicated through emails, meetings, in-services, and posted displays throughout the facility, including break rooms and behind the nurse's desk. Monthly feedback is provided at the facility, departmental, and individual levels, and employees find this helpful because it allows them to compare their department's performance to that of the entire hospital. However, when asked about real-time feedback during shifts, RN1 noted that nurse managers are typically busy with administrative duties, such as addressing urgent issues ("putting out fires"), communicating with physicians and pharmacists, and managing patient family concerns, which limits their ability to provide immediate feedback. RN2 mentioned that nurse managers will address behavioral issues immediately if they become aware that a nurse or CNA is not following proper protocols.

Specific training for performance goals seems lacking. While training is provided during onboarding and annual staff development sessions, employees are "expected" to know the proper procedures based on Hospital A's Patient Policies for General Nursing. For instance, the policy on improving patient satisfaction and reducing falls outlines the frequency of patient rounds but lacks specific guidance on response times to call lights. ([See Appendix B](#)). RN1 mentioned that staff must proactively seek any additional training. Finally, neither RN identified any significant skills or knowledge gaps, aside from the experience disparity between seasoned

nurses and newer staff regarding patient care prioritization and understanding the link between delayed call light responses and fall risk.

I examined instrumentation at both the environmental and individual levels to assess whether the necessary infrastructure is in place to support staff in their roles. Both RNs identified staffing shortages as the most significant barrier to expected performance. The healthcare industry is facing a nurse shortage. Although Hospital A strives to fill open positions quickly, the lengthy onboarding process, including several weeks of required orientation, delays nurses' ability to begin patient care. Once on the floor, nurses must familiarize themselves with the unit and the patient population. The gap between hire and performance can be lengthy. Both RNs noted that when nurses or CNAs call in sick, it puts the team in a difficult position. Staff shortages also affect patient charting, as nurses in hands-on care may struggle to complete detailed documentation. They mentioned that documentation is already time-consuming due to federal and state requirements. CNAs experience high turnover rates because they are reportedly underpaid for their work. Other barriers include personality differences among nurses, stemming from varying clinical training techniques and departments failing to provide a complete patient report before transferring patients to other units, resulting in a sudden new patient with very little background information to begin treatment.

Staffing is a significant concern. A typical unit has 30-35 patients, with staffing levels determined by the total facility and departmental or unit census. The usual model is one nurse for every 5-6 patients, and CNAs may be assigned anywhere from 10-20 patients or even up to half the floor if other CNAs are absent. RN2 notes that extra help is always needed, and many nurses take on extra shifts to cover staffing shortages. Night shifts tend to be more consistently staffed and have higher pay incentives. Both RNs agree that having extra staff available during shortages would improve patient care and call light response times, particularly for bathing, feeding, and medication administration. CNAs are not always available to assist with patient tasks, usually due to staffing, so primary nurses often take on these responsibilities. Delays in care frequently lead to negative feedback from patients and families. RN1 and RN2 both suggest that a balance of experienced and less experienced nurses and CNAs, or access to bring in resource staff, would be beneficial. Nurses feel rushed to complete tasks on time, and CNAs feel they are to blame.

In addition to time-consuming tasks, unit placement for CNAs affects their capacity and ability to perform. Nurses apply for and are hired for specific units, while CNAs are assigned to units without much input on their placement. If a nurse wants to change departments, the process is relatively simple: they submit a request to their nurse supervisor, and if an opening is available, the transfer can be made. However, CNAs have little control over their assignments based on patient census, care needs, and nurse staffing requirements. To request a transfer, a CNA typically needs to have a documented conflict with a nurse or a specific type of patient care.

Staff can easily access most equipment and resources needed for their tasks. However, the unit secretary must contact the central supply department to deliver items like compression devices and suction canisters. There is no formal inventory tracking system; instead, the secretary "keeps an eye" on these supplies.

Analyzing motivation through BEM reveals no financial incentives for meeting performance goals. Non-financial incentives are inconsistent and often limited to a cafeteria meal voucher or a verbal "thank you." There are no hiring incentives for CNAs. Both RNs indicate they are committed to meeting Hospital A's goals, and they believe most employees

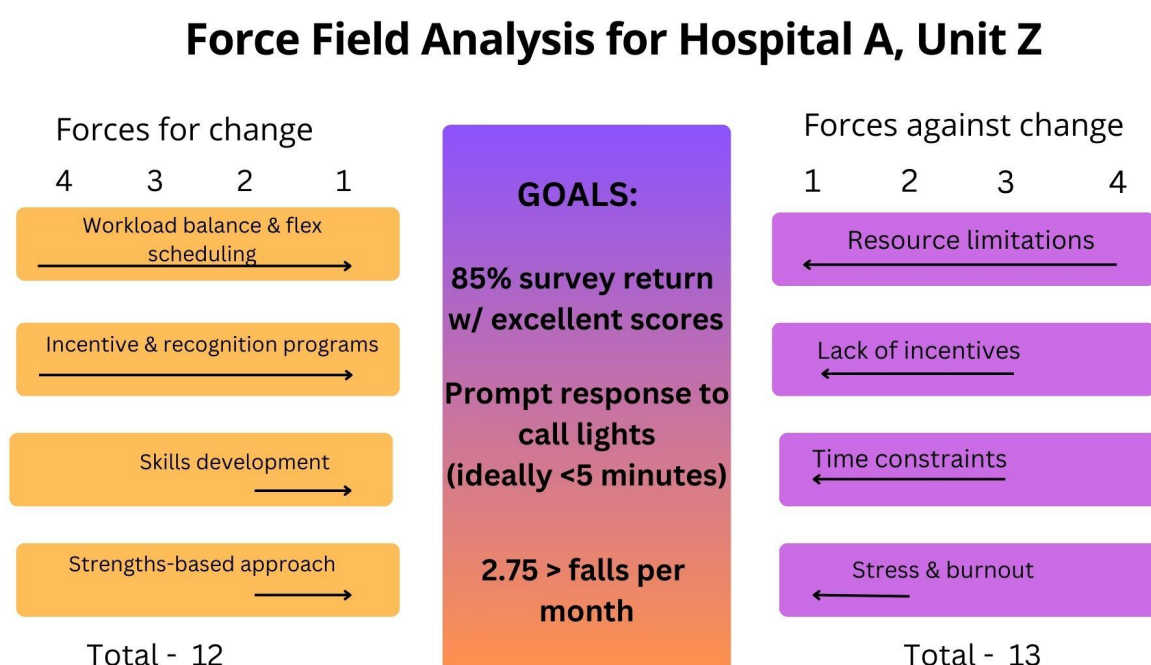
share this commitment. They also acknowledge that nursing is a role that prioritizes others over oneself, and the job can be demanding. Both RNs report that staff often feel "beat down" and are "just trying to get through the week."

Force Field Analysis

Force field analysis evaluates individual and environmental gaps and quantifies their value based on their overall impact on the performance problem. Driving forces promote change and increase the likelihood of success, while resisting forces create obstacles that hinder change. Based on the interview responses from both interviewees, I created a force field analysis for Hospital A, Unit Z (see Figure 2). This helps assess the situation, even without a ton of quantitative data from the hospital.

Figure 2.

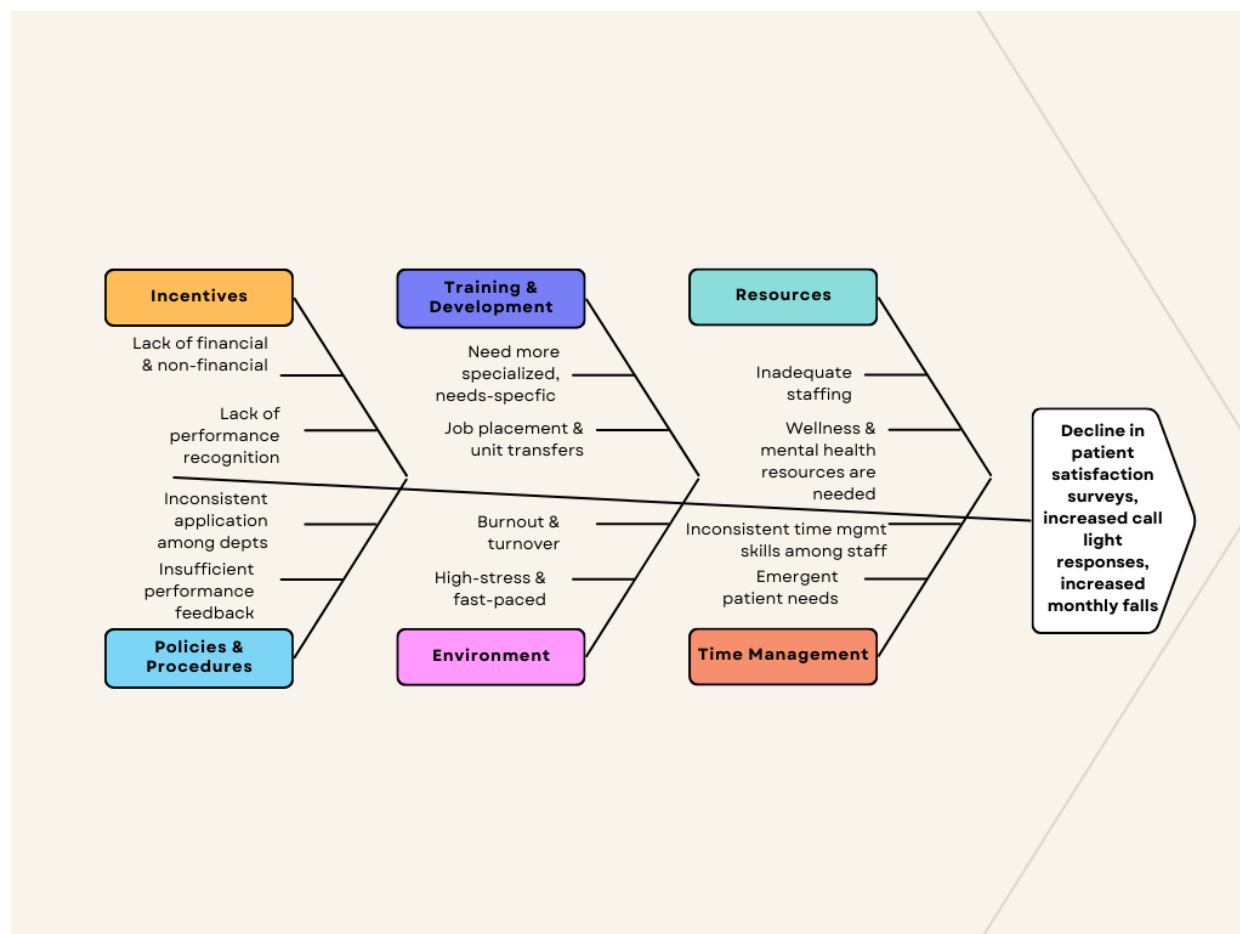
Force Field Analysis for Hospital A, Unit Z



Fishbone Diagram

The fishbone technique is often used to build a menu of interventions to improve performance across potential problems identified during the needs assessment (Watkins et al., 2012). The effect is shown at the end of the diagram, with broad cause categories listed in bold at the top of each branch. Specific causes are listed along the branches below each category. After analyzing Unit Z's required performance, I created a fishbone diagram to illustrate potential cause-and-effect relationships on Unit Z (see Figure 3). I brainstormed several factors affecting staff performance and continued asking, "Why is this happening?" around each cause category.

Figure 3.
Fishbone Diagram for Hospital A, Unit Z



PRELIMINARY CONCLUSIONS

Preliminary conclusions from my analysis highlight several key factors impacting performance, including hospital staffing, insufficient performance feedback, time management challenges, lack of employee incentives, and staff burnout and frustration. Many of these factors are beyond the individual's control, emphasizing the need for a strengths-based approach to create a positive work environment that addresses these challenges and incentivizes employees to meet performance goals. The force field analysis and fishbone diagram suggest that interventions should be tailored to individual and unit needs, focusing on improving resources, incentives, and time management to enhance patient care and staff wellbeing. There is also a clear need for more accessible training, specifically while on the job, to ensure nurses and assistants are equipped with the skills needed to meet their goals effectively. Finally, managing staffing levels across units and the organization is essential to ensure adequate support for meeting performance expectations.

NEXT STEPS

Additional analysis steps, with data source suggestions:

- Where can daily huddle meetings be introduced to review performance metrics and share feedback? Voice concerns and discuss solutions to improve? (Brainstorming, round-robin reporting, future wheel, and focus groups among nurses and staff)
Improve response times, increase patient satisfaction scores, increase employee satisfaction and motivation
- How can Hospital A ensure that the unit has adequate staffing? [[See Appendix C](#) for SWOT analysis of current staffing] (Dual surveys, brainstorming, SWOT, and focus groups among hospital administration leaders and all managers)
To improve response times, increase patient satisfaction scores, increase employee satisfaction and motivation, decrease monthly falls, reduce staff burnout and turnover
- How can Hospital A implement a recognition program to reward units with the highest patient satisfaction scores, quickest response times, and most improved scores and times? (Brainstorm, nominal group technique, nominal group technique, round robin reporting and focus groups among hospital administration leaders and nurse managers survey all staff)
Increase employee satisfaction and motivation, improve response times, increase patient satisfaction scores, reduce employee turnover rate
- Can Hospital A provide training and resources focused on time management, prioritizing patient needs, and managing high-stress situations? (Brainstorm, if-then analysis and focus groups among hospital administration leaders)
To decrease staff burnout, increase employee well-being, increase staff performance
- Can a resource pool of nurses and nursing assistants be routed and dedicated solely to immediate staffing needs? (Hierarchical task analysis, future wheel, and focus groups among hospital administration leaders)
To alleviate staff shortages in real-time, reduce staff burnout, increase patient care quality, increase patient satisfaction
- Are wellness programs (mental health, physical, emotional) available and/or obtainable to encourage employees to be mentally and emotionally capable of meeting performance expectations? (Pair-wise companion, SWOT with hospital administrators, staff, and nurse managers)
To reduce staff burnout and frustration, increase employee morale, and improve the quality of patient care
- Can a timely feedback system for OTJ performance be created? (Pair-wise companion, document review with nurse managers)
Increase quality of patient care, improve employee satisfaction
- How are patient rooms monitored for environmental hazards related to falls? (Tabletop analysis, document review, performance observations, SWOT analysis, and survey among nursing staff and facility maintenance)
To reduce fall risks
- Is flexible scheduling an option to relieve staff burnout? (Focus group, brainstorming, round-robin reporting with all nurse managers)
To reduce nurse burnout, to increase hire incentives, to reduce turnover
- What can be done to ease job placement transfer requests? (Nominal group technique among recently transferred employees; Dual survey and round robin reporting from hospital administration, nurse managers, and all staff)
To reduce turnover and increase employee satisfaction and motivation through a smoother transition process
- Can Hospital A create a supply and equipment inventory tracking system for each unit, including unit secretaries and central supply monitors? (Dual survey and focus groups among administration, nurse managers, and unit secretaries)

To minimize time spent ordering needed supplies and equipment and delivery of those items

- Is there a clear policy and procedure for intra-departmental patient transfer procedures? (Document review, tabletop analysis, among hospital administration and all staff)

To evaluate inter-departmental calling transfer reports before transferring patients to a new unit and to provide a refresher on the policy if there is one in place

- What feedback and suggestions from past patient satisfaction surveys are feasible, appropriate, and can be considered for implementation? (Delphi technique among discharged patients)

Use for problem-solving and decision-making to deliver better patient care

REFLECTIONS AND INSIGHTS

Overall, the most significant insight I have learned is that when looking at performance, individuals cannot be viewed in isolation from their work environment. Individuals must recognize and own their value in the workplace. It is equally essential that the organization acknowledge and appreciate its employees' value. While most people understand this concept at a surface level, a performance analysis highlights that employee satisfaction extends far beyond a competitive salary, paid leave, or having pleasant co-workers. It involves fostering a sense of purpose, providing support, and creating an environment that enhances professional growth, collaboration, and well-being. When employees feel genuinely valued and supported, their personal well-being, motivation and commitment to the organization can be significantly enhanced.

I have learned to appreciate a strengths-based approach, focusing on existing skills and capabilities rather than solely addressing what seems to be the most obvious issue. Studying performance analysis has reinforced the importance of collaboration across various roles and responsibilities. A strengths-based approach emphasizes ways to drive change within a team without pointing fingers at an individual's poor performance. Sharing the workload or offering flexible scheduling can positively impact the organization.

I have also understood the need for a balance between autonomy and support. As discussed in many of our posts, there is often uncertainty about when we are trusted to rely on our intuition for interventions and when support is available. I believe this is a "both-and" situation: individuals need the freedom to manage their work, relying on their knowledge and skills, but they also require support systems to ensure they meet goals and manage the stress of their roles. Both autonomy and support can co-exist.

Finally, I want to emphasize how much I value the insight provided by Gilbert's BEM model, which demonstrates that each component in the performance analysis matrix must be fully addressed before moving on to the next. This approach truly illustrates the importance of having foundational elements before moving on to subsequent ones. When one component is incomplete, it can hinder the progress of the others, disrupting the overall performance improvement process. We ensure that the whole system functions efficiently and effectively by addressing each component in order.

REFERENCES

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APPENDIX A INTERVIEW QUESTIONS

PERFORMANCE CONCERN INTERVIEWS

Please state your job title, level of education, and years of experience in this field.

1. Can you describe the hospital's goals for patient satisfaction surveys?
2. Can you describe the hospital's monthly goals for call light response times and falls?
How are these two related?
3. How are these expectations communicated to staff?
4. How often do staff receive feedback on this performance, and is it useful?
5. Describe any immediate feedback mechanisms currently in place during typical shiftwork.
6. What specific training do you receive concerning answering calls for assistance and prioritizing patient needs?
7. What gaps (information, skills, knowledge) do you often see among staff?
8. Describe any systemic issues that could prevent you from delivering expected patient care or prompt response times.
9. Describe any existing barriers between unit staff.
10. Tell me about your access to equipment or supplies needed to deliver prompt patient care.
11. Tell me about staffing levels on your unit for a typical shift.
12. What are the most time-consuming tasks in your role that could affect your efficiency?
13. What tools or support could help improve your performance when staffing is short?
14. Tell me how nurses and nursing assistants are assigned to which unit they work on.
15. What happens if a nurse or an aid develops a dispreference for a particular unit? How does the transfer process work?
16. Do you feel well-prepared to manage the load of patient needs during your shift, and why?
17. What rewards or incentives are in place for consistently meeting goals and expectations?
18. What financial or non-financial incentives would entice you to exceed expectations and target goals?
19. Do you feel personally invested in meeting the hospital goals for call response times, delivering excellent care, and doing your part to mitigate the risk of falls?
20. Are nurses and nursing assistants given easy access to opportunities and resources to develop their skills to meet performance goals?
21. What suggestions can you offer to provide extra incentives for nurses and aides to meet performance goals in this role?

APPENDIX B

ROUNDING ON PATIENTS POLICY

Rounding on Patients Policy GENERAL NURSING		
Effective Date: 05/07/2014	Revision Level: 1	Page 1 of 1
Printed copies are for reference only. Please refer to the electronic copy for the current version.		
<u>PURPOSE:</u> 1. To improve patient satisfaction. 2. To decrease patient falls. 3. To prevent nosocomial skin breakdown. <u>SCOPE:</u> All inpatients at [REDACTED] <u>RESPONSIBILITY:</u> RN, PCT, NA <u>REFERENCES:</u> The Nurse Leadership Handbook, the Studer Group, 2010. "Does Regular Rounding by Nursing Associates Boost patient Satisfaction?" - A. Bourgault, M. King, P. Hart, M Campbell et. al., Nursing Management, No. 2008 <u>RELATED DOCUMENTS:</u> None <u>POLICY/PROCEDURE:</u> 1. Introduce the concept of rounding to patients and their families. "Rounding means we will be checking on you every hour during the day and every 2 hours at night as part of our excellent care on _____ floor." 2. Between 0700-2200 hourly rounds will be performed. 3. Between 2200-0700 rounds will be performed every 2 hours. If the patient is confused or on high risk for falls, rounds will be hourly round the clock. 4. The 5 P's should be used during each rounding session. a. Pain b. Potty c. Re-positioning d. Placement of call light, water, tissues, phone, etc. e. VTE Prophylaxis (SCDs, foot pump, on if ordered)		

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APPENDIX C
SWOT ANALYSIS FOR HOSPITAL A STAFFING

SWOT ANALYSIS

HOSPITAL A STAFFING



STRENGTHS

- Current staff are motivated to provide excellent care
- Hospital is esteemed, as evidenced by the large applicant pool when jobs are posted



WEAKNESSES

- Difficulty maintaining CNAs due to pay and transfer process
- Low staffing produces less-than-desired outcomes and burnout among staff
- Lack of balanced and flexible scheduling



OPPORTUNITIES

- balance work assignments between experienced and non-experienced staff
- create bridge program with local colleges for clinical-to-hire program
- offer recognition, incentive and reward programs



THREATS

- high turnover rates
- possible budget constraints for hiring incentives
- Competing providers that may offer higher pay and other incentives