CUSP IN ACTION

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CUSP

- CUSP – Comprehensive Unit Based Safety Program
- "On the CUSP"

Objectives

- Evaluate how a CUSP team changed the improvement processes in one hospital.
- Empower staff to assume responsibility for safety in their environment
- Utilize CUSP change model and evidence based interventions to improve safety in your facility.

How became involved

- In 2010 the Wyoming Hospital Association started an initiative which included CUSP and CLABSI initiatives.
- Michigan – MHA Care Counts data collection webtool and prevention strategies.
- NHSN reporting of CLABSI.
- Development of the CUSP Team

Part of cohort 5

- Multistate cohort participation – conference "immersion" calls, coaching calls and education
- States were AZ, CA, ID, IA, KS, Miss, MT, NV, ND, WY
- Great video "Science of safety" – Dr. Pronovost

CUSP team

- CCH chose to initiate a clinical wide team (not individual units)
- Included administration, physician support, ICU, OB, M/S, pharmacy, cardiopulmonary, OR, and ER representatives.
- Encouraged staff and leadership participation.
  - Really wanted staff participation!

CUSP Team

- Science of Safety
- Leading change
- Culture of safety in our organization
- Used a focus of infection prevention and clinical staff involvement.

CUSP Team Tools

- AHRQ's Hospital Survey on Patient Safety Culture
  - Results were about teamwork
  - Leadership expectations
  - Perceptions of patient safety
  - Communications about errors
  - Reporting events
  - Nonpunitive response to errors
  - Survey was completed in 2011, 2012 and 2014

Survey responses

- Responses demonstrating a culture of safety at CCH:
  - 100% felt that CCH was actively doing things to improve patient safety.
  - Mistakes have led to positive change here – 100% response
  - After we make changes to improve patient safety, we evaluate their effectiveness – 91%

Safety Assessment Questions

- Staff Safety Assessment
  - Main Question:
  - Please describe how you think the next patient in your unit or clinical area will be harmed?
  - Please describe what you think can be done to prevent or minimize this harm?
  - Reduce probability that another patient can be harmed.

Culture of Safety

- Research per Dr. Pronovost shows that a perceived harm correlates with actual harm.
- Change – value the dissenter, seek to understand the "why".
- Health care workers care deeply and barriers affect their job.
- Look for risks we don't see
- ID new risks.

Safety Assessments

- Issues identified
  - Fatigue
  - Checklist for orientation
  - Medication reconciliation – may miss meds
  - Hand off communication
  - Transcription errors
  - Central line dressing changes inconsistent
  - Falls
  - Equipment needs
  - MRSA decolonization not being ordered

Answers to safety assessments

- Each one of those safety issues were identified and worked on with action plans
- Great way to get staff involved and feel a part of the culture of safety.

Simple Review

- 4 questions
  1. What happened?
  2. Why?
  3. What can do to reduce risk?
  4. How know you reduced risk?

- Every CAUTI is reviewed by the CUSP team.
- Every process team looks at what, why, reduce risk and did it work – how?

Improvement Projects

- First project – assessed our CLABSI rates in ICU and M/S
- Looked at Bundling, insertion cart, documentation (check-list), PICC team, and EBP for insertion and care – standardized work
- Initiated spread sheet with data collection and submission to NHSN

CUSP projects

- 2nd project – CAUTI Catheter associated urinary tract infections
- Followed NHSN surveillance criteria
- Submitted to NHSN – ICU and M/S
- Reviewed EBP and nursing's role
- Decreased CAUTIs significantly with education and by developed Nurse Driven Foley Catheter Removal protocols

Data shows improvement

- Numbers very low
- No CLABSI since 2011 in ICU or M/S
- M/S CAUTI 8 in 2012; 2 in 2013, last CAUTI June 2014; 0 in 2015
- ICU last CAUTI Nov 2014; 0 2013 and 0 2012

- Believe that getting staff involved has made the difference.

CUSP projects

- Hand hygiene – each manager or designee was observing 10 hand hygiene per month.
  - It was put on their dashboards and showed 100% all the time.
- Developed a secret shopper program – looking at clinical areas
  - 2014 rate of correct observations/total observations was 78%
- Continuing this project. Including education, signage, reminders, etc.

New projects

- Looking at PPE and precautions (supplies, yellow door bag, signage, and education and communication)
- Looking at cleaning for precaution rooms, policies, having bleach for CDI and norovirus.
- Have been asked by administration and quality for CUSP team to work with the HRET_HEN 2.0 hospital quality initiatives.

Questions

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  - THANKYOU!