WELCOME Oregon hospitals to the CUSP Overview webinar.

We will begin in just a few minutes.
Kristina Weeks: MHS, DrPh(c)

Kristina is a research faculty member of the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

She has extensive expertise in implementing CUSP in small and large settings as a part of her role as project manager of the national project On the CUSP: Stop BSI in the US as well as other international sites. Ms. Weeks holds a Master of Health Science degree from the Johns Hopkins Bloomberg School of Public Health and is doctoral candidate in that same department. Ms. Weeks's research interests focus on the translation of evidence-based medicine to safe and optimal quality care at the bedside as well as effective health policy.

For more than a decade she has dedicated her efforts in health services research toward understanding health systems related to patient safety and health disparities in the clinical environment.
CUSP Overview

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Objectives

• To explain the philosophy and approach of CUSP

• To describe the steps in CUSP

• To describe the examples of CUSP application

• To illustrate CUSP sustainability
What is CUSP?

• Comprehensive Unit-based Safety Program

• An intervention to Learn from Mistakes and Improve Safety Culture
Where does CUSP fit in?

CUSP Aligns With and Supports Other Quality and Safety Tools

- TeamSTEPPS®
- Six Sigma
- Institute for Healthcare Improvement Model for Improvement
- Plan-Do-Study-Act
- Root Cause Analysis
- Failure Mode Effect Analysis

As seen in TeamSTEPPS®
CUSP is a journey
The Vision of CUSP

The Comprehensive Unit-based Safety Program is designed to:

- educate and improve awareness about patient safety and quality of care
- empower staff to take charge and improve safety in their work place
- partner units with a hospital executive to improve organizational culture and provide resources for unit improvement efforts
- provide tools to investigate and learn from defects
Treat Safety like a Science
Getting from the books to the bedside

**Measure**

- Have We Created a Safe Culture? How Do We know We Learn from Mistakes?
- How Often Do we Harm? Are Patient Outcomes Improving?

**CUSP**
Comprehensive Unit based Safety program

1. Educate staff on science of safety
2. Identify defects
3. Assign executive to adopt unit
4. Learn from one defect per quarter
5. Implement teamwork tools

**TRIP**
Translating Evidence Into Practice

1. Summarize the evidence in a checklist
2. Identify local barriers to implementation
3. Measure performance
4. Ensure all patients get the evidence

**IMPROVE**
Steps of CUSP

1. Educate staff on Science of Safety

2. Identify defects

3. Assign executive to adopt unit

4. Learn from one defect per quarter

5. Implement teamwork tools

Step 1: Science of Safety

• Understand system determines performance

• Use strategies to improve system performance
  • Standardize
  • Create independent checks for key process
  • Learn from mistakes

• Apply strategies to both technical work and team work

• Recognize teams make wise decisions with diverse and independent input
Science of Safety ABCs

- Understand principles of safe design
- Standardize, create checklists, learn when things go wrong
- Recognize these principles apply to technical and team work
- Teams make wise decision when there is diverse and independent input
Step 2: Identify Defects

• Review error reports, liability claims, sentinel events or at an M & M conference

• Ask staff how the next patient will be harmed

• List and prioritize all defects
Step 2: Identify Defects

Complete the Staff Safety Assessment

Name (optional):
Job Category:
Date:
Unit:

Please describe how you think the next patient in your unit/clinical area will be harmed.

Please describe what you think can be done to prevent or minimize this harm.
Prioritize Defects

• List all defects

• Discuss with staff the three greatest risks

• Use Learning from Defect Tool to guide your efforts
Step 3: Executive Partnership

- Executives should become a member of CUSP teams (Surgery; ICU; Floor)
- Executive meets at least monthly with team
- Executive holds team accountable during monthly review and vice versa
Step 4: Learning from Mistakes

1. What happened?

2. Why did it happen (system lenses)?

3. What could you do to reduce risk?

4. How do you know risk was reduced?
   1. Create policy / process / procedure
   2. Ensure staff know policy

5. Evaluate if policy is used correctly

Pronovost 2005 JCJQI
Rank Order of Error Reduction Strategies

Most Effective

Forcing functions and constraints

Automation and computerization

Standardization and protocols

Checklists and double check systems

Rules and policies

Education / Information

Be more careful, be vigilant

Least effective
Step 5: Teamwork Tools

- Daily Goals
  - J Crit Care 2003;18(2):71-75
- Morning Briefing
- Learning from Defects
- Team Check Up Tool
- Shadowing
CUSP is Compatible with TeamSTEPPS³

<table>
<thead>
<tr>
<th>TeamSTEPPS Step</th>
<th>CUSP Toolkit Modules</th>
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<tbody>
<tr>
<td>Step 1. Create a change team.</td>
<td>Assemble the Team</td>
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<td>Engage the Senior Executive</td>
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<td>Step 2. Define the problem.</td>
<td>Identify Defects Through Sensemaking</td>
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<td>Understand the Science of Safety</td>
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<tr>
<td>Step 3. Define the aims.</td>
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<td>Step 4. Design an intervention.</td>
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As seen in TeamSTEPPS®

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CUSP is Compatible with TeamSTEPPS³

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<tr>
<th>TeamSTEPPS Step</th>
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<tr>
<td>Step 5. Develop a plan for testing the effectiveness.</td>
<td>Identify Defects Through Sensemaking</td>
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<tr>
<td>Step 6. Develop an implementation plan.</td>
<td>Engage the Senior Executive Identify Defects</td>
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<td>Step 7. Develop a plan for sustained improvement.</td>
<td>Understand the Science of Safety</td>
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<td>Step 8. Develop a communication plan.</td>
<td>Assemble the Team Engage the Senior Executive Identify Defects Through Sensemaking</td>
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As seen in TeamSTEPPS®
Integrating TeamSTEPPS®

- CUSP for CLABSI
- CUSP for CAUTI in hospitals and long term care
- CUSP for VAP\VAC
- Safe Surgery in Hospitals and Ambulatory Surgery Centers
Maximizing CUSP in your hospital

So, when is the next CUSP meeting?
We use daily goals during rounds to inform patients and families about care plans.
What does sustainability look like?

<table>
<thead>
<tr>
<th>SUSTAINING CUSP</th>
<th>TASK</th>
<th>TARGET DATE TO START</th>
<th>TARGET DATE TO COMPLETE</th>
<th>DATE COMPLETED</th>
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<tbody>
<tr>
<td>Complete Learning from Defects Tool</td>
<td>Do this at least once per calendar quarter. USE LEARNING FROM DEFECT TOOL (TOOLKIT)</td>
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NOTES:

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<thead>
<tr>
<th>COMPLETE SCORECARD</th>
<th>TASK</th>
<th>TARGET DATE TO START</th>
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<tbody>
<tr>
<td>Complete Scorecard</td>
<td>Do this at 6 months. USE SCORECARD TOOL (TOOLKIT)</td>
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<th>SHARE STORIES</th>
<th>TASK</th>
<th>TARGET DATE TO START</th>
<th>TARGET DATE TO COMPLETE</th>
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<tr>
<td>Share Stories</td>
<td>Work with your department/hospital and Central CUSP Coordinator to coordinate.</td>
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<th>ORIENT ALL NEW STAFF TO CUSP AND TEAM</th>
<th>TASK</th>
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<td>Orient All New Staff to CUSP and Team</td>
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<th>CONTINUE STAFF TRAINING ON CORE CUSP CONCEPTS</th>
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<td>Continue Staff Training on Core CUSP Concepts</td>
<td>Do this at least every 6 months.</td>
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NOTES:
 Resources & Tools

- AHRQ

- CUSP Toolkit
  http://www.ahrq.gov/cusptoolkit/

- Johns Hopkins Armstrong Institute for Patient Safety and Quality
  http://www.hopkinsmedicine.org/armstrong_institute/training_opportunities/CUSP_Guidance/

  CUSP Phaseline
  https://www.youtube.com/watch?feature=player_detailpage&v=KC7d4hcViS4
References


Thank you for joining!

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