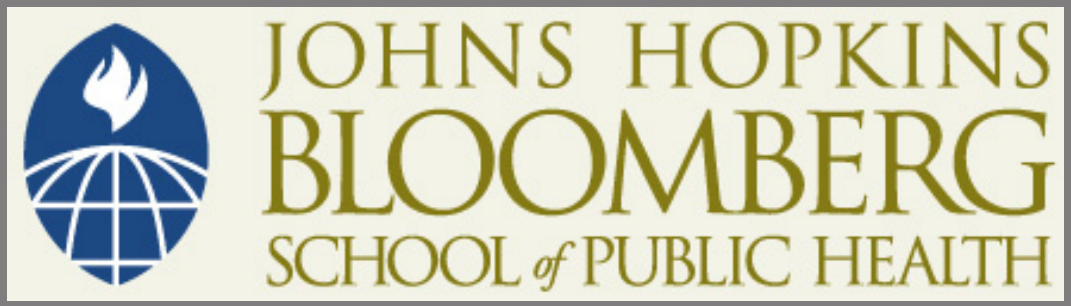

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CUSP: Designing a Comprehensive Unit-based Patient Safety Program

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CUSP: The Concept

- CUSP is a five-step program designed to ***impact safety climate by empowering staff*** to assume responsibility for safety in their environment

- CUSP is a strategic ***intervention*** that provides a road map to learn from mistakes, improve safety culture, and improve systems to make them safer

- CUSP helps achieve the above through …
  - Education and awareness
  - Enabling access to organizational resources
  - Providing and helping develop a toolkit of interventions

CUSP: The Concept (cont.)

- Goals
  - Improve patient safety
  - Improve safety culture
  - Integrate safety practices in daily work
- Five-step framework implemented at the unit level
- Cyclical process not linear

CUSP: Getting Started

- Pre-CUSP work
- CUSP steps

Pre-CUSP Work

- Obtain leadership support

- Assemble a safety team, including …
  - Project leader/unit champion (e.g., RN or MD leader)
  - Nurse manager
  - Physician champion
  - Other integral members of unit (e.g., pharmacist, respiratory therapist)
  - Senior executive (e.g., CEO, dean, president)

- Assess unit safety culture using a validated instrument and rigorous survey methodology

Pre-CUSP Work: Why Culture Matters

- Decubitus ulcers in med/surg units
- Delays in OR and ICU
- Bloodstream infections in the ICU
- VAP in the ICU
- Wrong-site surgeries
- Post-op sepsis
- Post-op infections
- PE/DVT per 1,000 surgical discharges
- RN turnover
- Absenteeism
- Incident reporting rates/ reporting harm
- Burnout
- Spirituality
- Unit size

Source: J. Bryan Sexton.

CUSP: The Five Steps

1. Educate staff on science of safety
2. Identify defects
3. Senior executive to partner with unit
4. Learn from one defect per month/quarter
5. Implement teamwork tools

Source: Pronovost. (2005).

Step 1: Science of Safety Education

- Purpose
  - To bring everyone on the unit on the same page with regard to the concept and knowledge of patient safety (systems theory, concepts of safe design, investigation of system defects)
  - To highlight how they can make a difference
- Process
  - Safety trainers deliver the talk in person
  - Large group training is more efficient
  - Track staff trained with attendance sheet (form)
  - Distribute staff safety survey form at end of training
- Challenges: Educating everyone (each shift)
- Solutions: Educate in smaller groups, use online training version—http://www.jhsph.edu/ctlt/training/patient_safety.html

Step 2: Staff Identify Defects

- Purpose
  - Tap into expertise and knowledge of frontline providers
  - Empower and engage in safety
- Process
  - Staff safety assessment survey (form—two questions)
  - Assign one person the task of survey administration
  - Collate and group responses into common defects (e.g., communication, patient falls)
  - Consider existing data sources like event reports, sentinel events, patient satisfaction, M&Ms, claims
  - Periodically repeat this step
- Challenges: Hesitant to speak up/write, logistics of preparing a collated, actionable report
- Solutions: Make it anonymous, CUSP rounds

Step 2: Staff Identify Defects (cont.)

- Components of staff safety survey

Name: (can be anonymous) Unit: Job Category: Date:
1. Please describe how you think the next patient in your unit/ clinical area will be harmed. 2. Please describe what you think can be done to prevent or minimize this harm.
Return this form to your project leader **Thank you for helping improve safety in your workplace!**

Step 3: Senior Executive Partnership

- Purpose
  - Connect senior management with frontline providers
  - Speedily address safety issues and remove barriers for implementing improvements
  - Advocate for unit (at the institution level)
- Process
  - Preplan: Project leader finds out the number of units implementing CUSP and the number of senior executives available—enough for each unit?
  - Unit safety team meet and orient executive
  - Set up monthly safety rounds with executive
  - Brief frontline providers about purpose of safety rounds
  - Safety rounds: Discuss safety issues (from Step 2—executive, safety team, and unit staff); document safety issues discussed
  - Identify and manage improvement projects

Step 3: Senior Executive Partnership (cont.)

- Challenges
  - Executive's busy schedules
  - Fewer executives than units
  - Not as many executives aware of patient safety

- Solutions
  - Adapt CUSP meetings to executive and staff availability
  - Let leaders spread the word
  - Expand the pool of executives
  - One executive adopts more than one unit

Step 4: Learning from Defects

- Purpose
  - Investigate why system(s) failed and implement improvement efforts
  - For eliminating sources of potential harm at a steady but sure pace (“de-weeding”)

- Process
  - Identify safety defect
  - Investigate at least one defect per ____
  - Complete case summary form
  - Share case summary (optional)

Step 4: Learning from Defects (cont.)

- Components of learning from defects
  - What happened?
  - Why did it happen (system lenses)?
  - What could you do to reduce risk?
  - How do you know risk was reduced?
    - Create policy/process/procedure
    - Ensure staff know policy
    - Evaluate if policy is used correctly

Source: Pronovost. (2005). *JCJQI*.

Step 4: Learning from Defects (cont.)

- Challenges
  - Selecting the “right” defects
  - Institutional bureaucracy
  - Complexity of problems involving more than one discipline leading to slower solutions

- Solutions
  - Ask the staff which are the three greatest risks
  - Multi-disciplinary CUSP team
  - Engage the executive so he/she advocates for the unit

Step 5: Teamwork Tools to Improve

- Purpose
  - Practical tools to implement improvements
  - Enable culture conducive to safety improvement

- Examples of tools
  - Morning briefing (communication and rounding efficiency)
  - Shadowing profession (collaboration, teamwork, communication)
  - Daily goals (communication, care plan)
  - Observe/structure rounds

Source: Pronovost. (2009). *JCJQI*.

CUSP: Moving Forward

- A continuous journey
  - Repeat Steps 4 and 5 identifying new defects and resolving new ones as you go along
  - Repeat Step 1 when a new staff joins

- Share results and successes

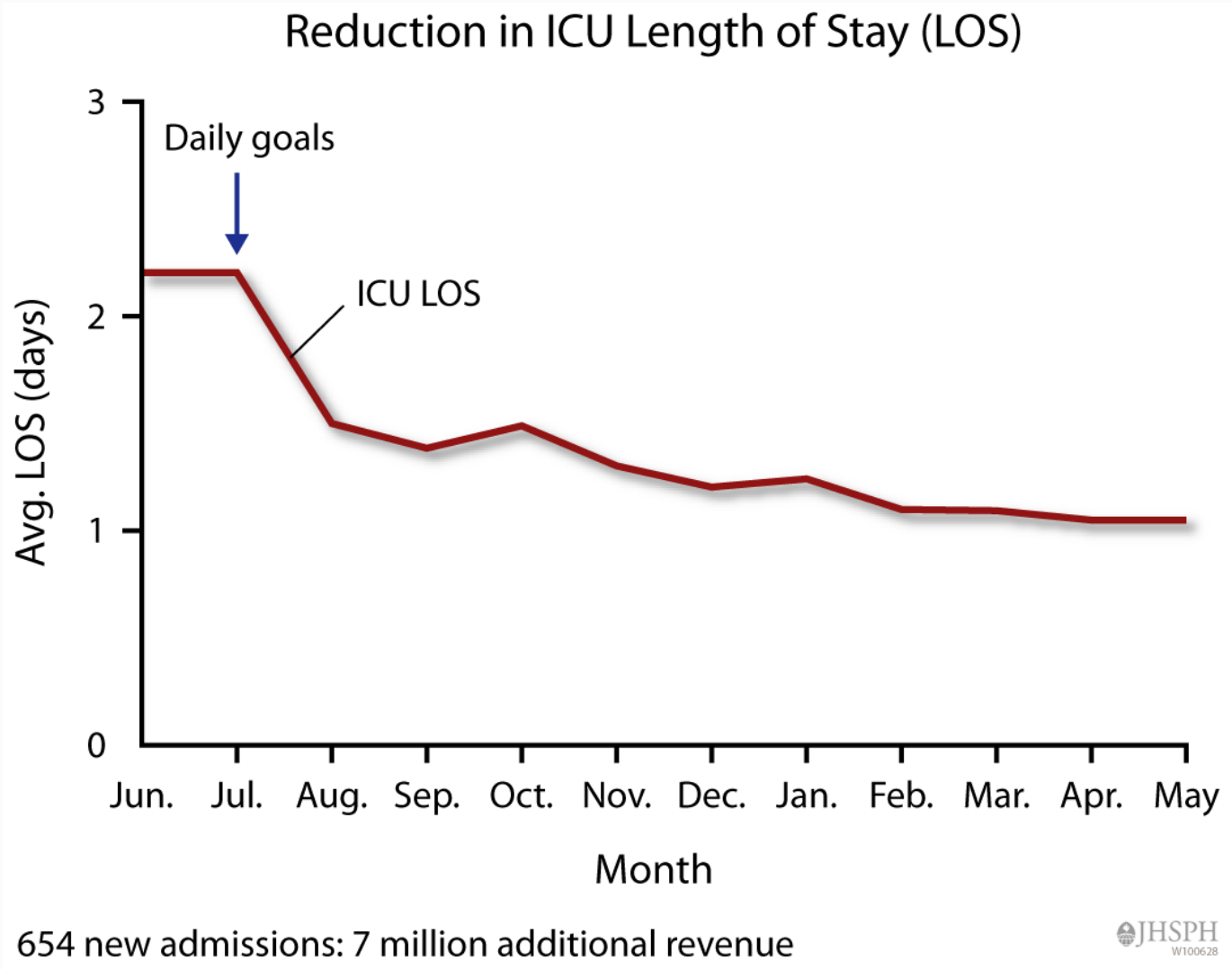
CUSP Success: Example

- Impact on length of stay and nurse turnover in two ICUs

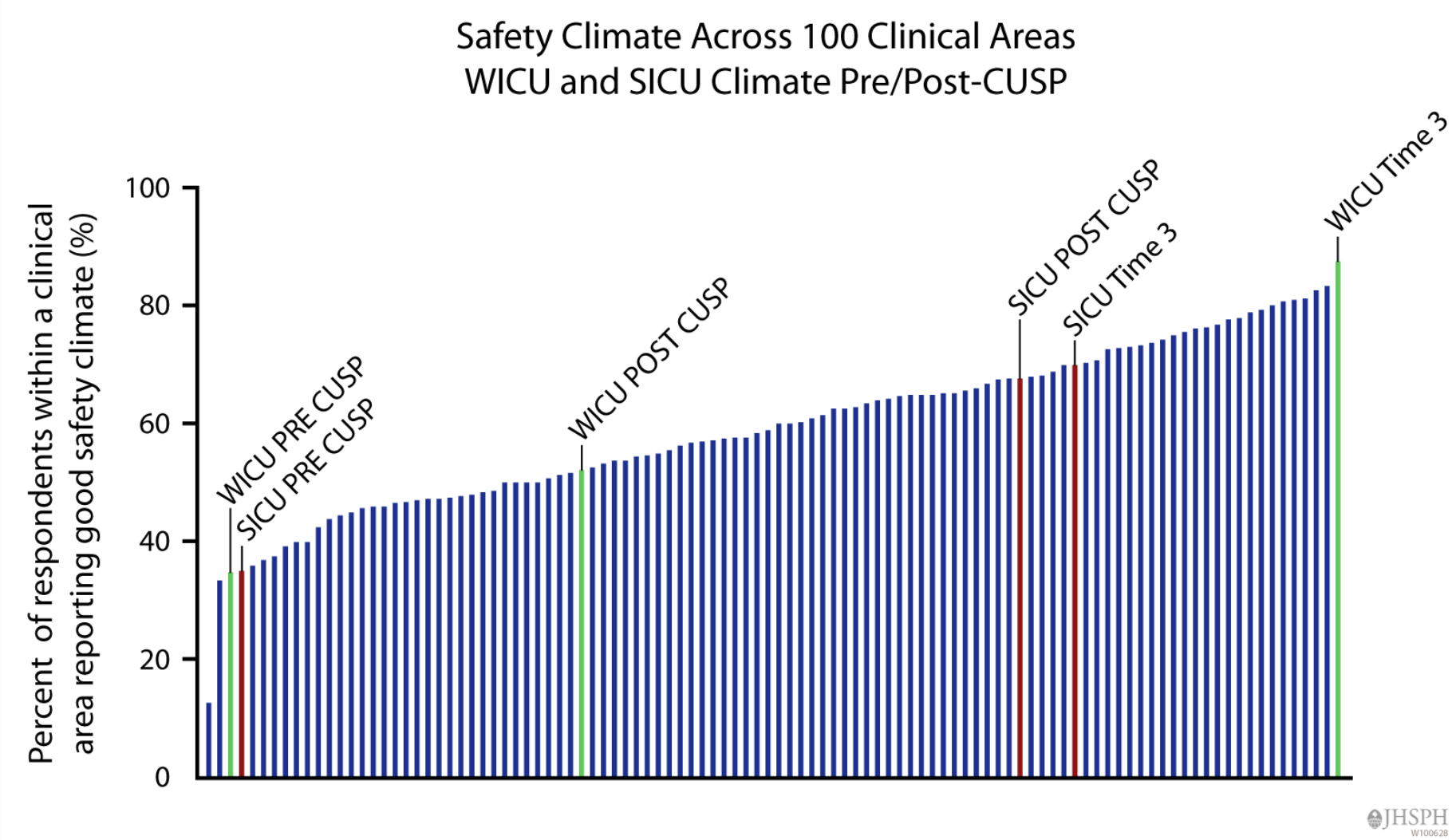
	WICU		SICU	
	Pre-CUSP	Post-CUSP	Pre-CUSP	Post-CUSP
ICU LOS (days)	2.2	1.1	3.2	2.3
% nurse turnover	9	2	8	2

Source: Pronovost.

CUSP Success: Example



CUSP Success: Example



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Resources

- Staff education on patient safety: http://www.jhsph.edu/ctlt/training/patient_safety.html

- CUSP successes in ICUs: http://safercare.net/