Comprehensive Unit Based Safety Program

Implementing the Comprehensive Unit Based Safety Program

Objectives

- Describe the CUSP method for improving Patient Safety Culture
- Describe the Harrison Experience
- Compare Successes and Challenges during the Initial implementation phase

Harrison Medical Center

Harrison is 297-bed acute care not-for profit hospital

Services provided include:

- Surgical, Labor & Delivery, Pediatric
- Level III trauma Emergency Care,
- Urgent Care and Primary Car

What is CUSP?

It's a unit based safety program designed to improve safety culture

- Integrating safety practices into the daily work of a unit or clinical area
- Provides a scalable intervention (program)
- Draws from frontline providers
  "respect the local wisdom"

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The program is comprised of five key steps..

- Education in Science of Safety
- Staff Identification of defects
- Executive Partnership
- Learning from defects
- Implementing teamwork tools

This is just the foundation to a continuous process.

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Assemble a Safety Team-

- Unit champion or project leader
- Nurse Manger
- Physician champion
- Senior Executive Sponsor*
- Staff

List out the names of the team members and plan to post it for the department to see.

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- Measure your Safety Culture-
  - AHRQ
  - SAQ

Explain to the staff why it they are filling out the questionnaire..

"Tap into their wisdom, opinions and perception of safety in their unit"

Ensure that they will receive feedback of the results

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Step 1

Educate staff on the Science of Safety-
- Understand that safety is a property or real estate of the system.
- Understand what are the basic principles of safe design
  - Standardization of work
  - Create independent checks for key process
  - Learn from mistakes
  - Recognize that the principles of safety design apply to technical as well as team work
  - Teams make wise decisions when there is diverse and independent input.

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Step 2
Identify Defects

- Incident reports, liability claims, sentinel events
- Most important.. Seek the source

  ASK the *staff* two key questions…
  - How they think the next patient will be harmed
  - What they think can be done to prevent or minimize this harm.

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Step 3

Need to have a partnership with a senior hospital executive
- Makes rounds on assigned unit and meets with key members of the health care team
- Helps the team prioritize needed improvements
- Provides resources for improvement efforts as needed or alternative methods to make improvements if resources are not available.

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Step 4
Begin Learning from Defects

Look at the defects & ask the following questions…
- What happened
- Why did it happen
- What you did to reduce the risk
- How do you know the risks were actually reduced

Learn from at least one defect per month

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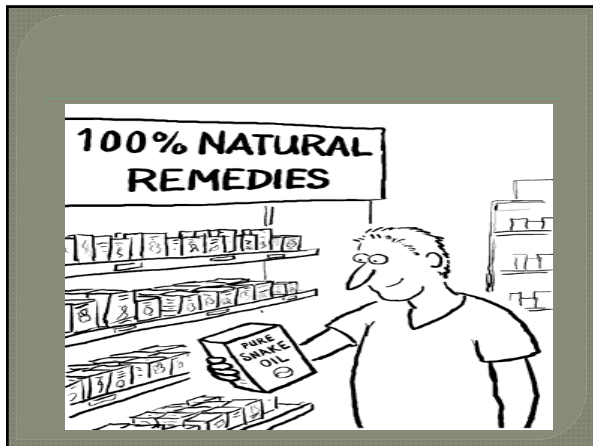
Step 5
Use tools to improve teamwork, communication, and other systems of work on the clinical unit.
- Daily Goals sheets
- Morning Briefings
- Rounding- Physician with nurse/charge nurse
- Observational Rounds



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Michigan Health & Hospital Association's Keystone Center for Patient Safety & Quality

- noted reductions in occurrence of Blood Stream Infections (BSI) from central line use by more than 30 percent.

http://www.ahrq.gov/qual/clabsiupdate/

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Harrison's CUSP team

There are currently two unit based councils that are beginning their safety journey with CUSP.

Successes..

- Staff have participated in the Science of Safety training
- Performed the AHRQ safety survey
- Recruited physician(s) to participate and we have a senior executive sponsor.

Wouldn't be a Journey without struggles!!

- Team meetings to solidify projects
- Staff concerns
  - *Too much work to do*
  - *Already have projects that we're working on*

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Questions?

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