

# On the CUSP: STOP BSI

## The Comprehensive Unit-based Safety Program (CUSP):

An Intervention to Learn from Mistakes and  
Improve Safety Culture

# Learning Objectives

- To understand the steps in CUSP
- To learn how to investigate a defect
- To understand some teamwork tools such as daily goals, AM briefing, Shadowing

# Safety Score Card

## Keystone ICU Safety Dashboard

	2004	2006
How often did we harm (BSI) ( <i>median</i> )	2.8/1000	0
How often do we do what we should	66%	95%
<b>How often did we learn from mistakes*</b>	100s	100s
<b>% Needs improvement in</b>		
<b>Safety climate*</b>	84%	43%
<b>Teamwork climate*</b>	82%	42%

CUSP is intervention to improve these\*

# Pre CUSP Work

- Create an ICU team
  - Nurse, physician administrator, others
  - Assign a team leader
- Measure Culture in the ICU  
(discuss with hospital association leader)
- Work with hospital quality leader to have a senior executive assigned to ICU team

# Comprehensive Unit-based Safety Program (CUSP)

An Intervention to Learn from Mistakes and Improve Safety Culture

1. Educate staff on science of safety  
[http://www.jhsph.edu/ctlit/training/patient\\_safety.html](http://www.jhsph.edu/ctlit/training/patient_safety.html)
2. Identify defects
3. Assign executive to adopt unit
4. Learn from one defect per quarter
5. Implement teamwork tools

Pronovost J, *Patient Safety*, 2005

# 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

# Identify Defects

- Review error reports, liability claims, sentinel events or M and M conference
- Ask staff how will the next patient be harmed

# Prioritize Defects

- List all defects
- Discuss with staff what are the three greatest risks

# Executive Partnership

- Executive should become a member of ICU team
- Executive should meet monthly with ICU team
- Executive should review defects, ensure ICU team has resources to reduce risks, and how team accountable for improving risks and central line associated blood stream infection

# Learning from Mistakes

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

Pronovost 2005 JCJQI

# To Identify Most Important Contributing Factors

- Rate Each contributing factor
  - importance of the problem and contributing factors in causing the accident
  - importance of the problem and contributing factors in future accidents

# To Identify Most Effective Interventions

- Rate Each Intervention
  - How well the intervention solves the problem or mitigates the contributing factors for the accident
  - Rates the team belief that the intervention will be implemented and executed as intended

# To Evaluate Whether Risks were Reduced

- Did you create a policy or procedure
- Do staff know about the policy
- Are staff using it as intended
- Do staff believe risks have been reduced

# Teamwork Tools

- Call list
- Daily Goals
- AM briefing
- Shadowing
- Culture check up

Pronovost JCC, JCJQI

# Call List

- Ensure your ICU has a process to identify what physician to page or call for each patient
- Make sure call list is easily accessible and updated

# AM Briefing

- Have a morning meeting with charge nurse and ICU attending
- Discuss work for the day
  - What happened during the evening
  - Who is being admitted and discharged today
  - What are potential risks during the day, how can we reduce these risks

# Shadowing

- Follow another type of clinician doing their job for between 2 to 4 hours
- Have that person discuss with staff what they will do differently now they walked in another shoes

# CUSP is a Continuous Journey

- Add science of safety education to orientation
- Learn from one defect per month, share or post lessons (answers to the 4 questions) with others
- Implement teamwork tools that best meet the ICU teams needs
- Details of CUSP are in the manual of operations

# References

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