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Hello I want to welcome you to the CUSP in action webinar. Can you hear me? Today we have Veronica Taylor and Julia Norlin as presenters they will be explaining the CUSP program and its success. They are both registered nurses and infection prevention specialist at Campbell County Memorial Hospital. Before we get started I want to remind you that we have evaluation at the end of this presentation and I would urge you to fill that out so you can let us know how we're doing. We also have chat available so there will be. So you can ask questions and I will be moderating the chat so you can include your questions Veronica and Julie also be taking questions at the end as time permits.

Thank you so much for doing this webinar for us.

Hope you can hear me all right. I'm the director of infection prevention professional development and disaster preparedness at Campbell County Memorial Hospital. Campbell County is a new world-class organization we have everything from acute-care to ambulatory surgery, long-term care, medical clinics, hospice and home health. We're pretty excited about our organization, I believe that we are on the CUSP of the future of healthcare. Saying that, I would to share with you that our journey when we began involved in CUSP in action. CUSP stance were comprehensive unit based safety program. Or as many people call it they were being on the CUSP. We were lucky to be very involved in a Wyoming Hospital Association project that happened in 2010 but before I get into all of that history as my story, I want to share with you our objectives as every good speakers should let you know what direction the story is going.

The first thing we want to do is share how our CUSP team changed the improvement processes at Cabell County Memorial Hospital. Which now is called Campbell County health. Because where total organization not just a hospital. The second objective is to empower staff to assume responsibility for safety in their environment. In other words, staff has to owns the process. And the third objective is that we believe that if you utilize CUSP change model and evidence-based interventions you will improve the safety at your facility.

Now I will go on to our story.

In 2010 the Wyoming Hospital Association started an initiative which included CUSP and CLABSI initiatives. These initiatives have been started to Michigan and it was the NHA care accounts data collection web tool, this was before we started NHSN and we became involved because of Neil Hilton and a project at the Wyoming Hospital Association. So when we started this, the emphasis was on CLABSI and prevention strategies. As we move along, Ellen Williams was instrumental in getting all of us into an HSA and reporting our CLABSI data in fact, we were reporting both into the NHA care accounts and into NHS and. Then as time progressed, we were able to take out information from NHSN and we do not have to do that your counts anymore. So when we joined this a piece of it was to develop the CUSP team.

We decided as we got involved it was kind of like what is going on now with the new project it was a multistate project. We were part of cohort number five and the project included a lot of immersion calls, coaching calls, webinars, similar to what we do now with our lands are a lot of states involved but our cohort included Arizona, California, Idaho, Iowa, Kansas, Mississippi, Montana, North Dakota and Wyoming. We had a lot of people to share what was working and that seemed -- that was really an excellent way to learn and to use evidence-based practice

We started off with looking at the science of safety. Dr. Pronovost and his team, developed the video and I believe you can still watch it on YouTube. It's an excellent video to help you look at the science of safety and how to develop a CUSP team. At CCH we decided that we were too small to have a team in each unit. So we developed one team with representation from a lot of clinical areas. So we have administration, physician support, ICU, OB, MedSurg, pharmacy, respiratory, surgical services and the ER we try very hard to have both a person and a leadership role and then also staff representation. We really feel that the staff representation is the real key to making CUSP work.

We began our journey with first the science of safety, then the second piece of CUSP that was really important was looking at change theories and how to lead change. Then we also did evaluations and I will talk about this a little bit more in a few minutes but we look at the culture of safety in our organization. And we -- because we started this we used the focus of infection prevention and also fit well with the CLABSI piece of CUSP and we also wanted that clinical staff involvement.

One of the tools that we were provided only for started CUSP was the AHRQ Hospital survey on patient safety culture. This survey is really a great tool to look at staff perception on how your facility looks at safety. There are questions on teamwork, leadership expectations, perceptions of patient safety, there are questions on communication about errors, and how you are expected to report any events that occur, there's also a section on no punitive responses so really look at not only a culture of safety, but it they just culture in other words, that you expect people to report but it's not punitive. We did this survey several times. We did it the first time in 2011, or it was all of our staff completed at work a pretty good percentage, then in 2012 we did -- it was a smaller group that completed it, and then in 2014 we did the whole organization again. We found this tool to be very effective to help us to look at our culture safety -- safely. I picked a couple of responses that demonstrated to CCH that we really do have a culture of safety on board. One of those was that CCH was actively doing things to improve patient safety. That helps us to know that our staff really recognizes the efforts we are making for safety.

The second one was mistakes have led to positive change here, we all make mistakes. Bullets really important is to look at those stakes and really determine how we can make a positive change from those mistakes. So when 100% of our responders said we are doing that, it helps us to recognize that we do have a culture of safety.

The last one that I pulled out all our results was after we make changes to improve patient safety, we evaluate their effectiveness. We have a 91% response on this. As nurses will is talk about closing the loop and making sure that we do evaluations whenever we start a new process. So when our staff could say, that yes, we're looking at change and we are evaluating that change, that's a really positive culture if you will that shows that we are doing what we should be doing.

There's another tool that CUSP recommends and it's really a simple one. It's called, the staff safety assessment. This tool we've done several times and it's time for us to do it again actually. But I've described for you hear is the very first time as a CUSP team that will use the staff safety assessment. There are two questions that the staff uses.

The first one is, please describe how you think the next patient in your units or clinical area will be harmed. What the staff on the team did was they went back to the units and they asked the staff on the unit how will the next person be harmed? And then if they got some examples of what the staff will then they were asked

[ No Audio ]

We cannot hear you.

[ No Audio ]

Okay. I lost you. I have this terrible noise on my phone. Hopefully now you can hear me again.

Yes I can hear you.

Okay. We will go back where I was at, so the staff went back and they asked these questions and the first time they did this -- can you still hear me?

Yes.

They went back to the staff and they asked these questions and here are some examples that came back to us.

The example from the safety assessment. The first one that came up at that time and remember this was in 2010 when we did this, at that time we were finding that we had a few staffing issues and there were some people that were working a little more than they should have been, a little longer hours, so staff fatigue was one of the things that they felt could cause harm to patients. The next one was that we really do not have a checklist for orientation. Actually this is been a great project and we worked a lot on it and across the organization we now have checklists for everyone -- every orientation for all of our staff. Medication reconciliation was a big one. We worked on this extensively and now that is all on our electronic medical record. And that was quite an evolution.

And then handoff communication, and one of the projects we work on from that was the panda which is a handoff especially useful tool between the staff nurse in radiology or if the patient is being moved from one area to the other.

Transcription errors were a concern. Since then we now have what they call a CP OE which is computer physician order entry and are transcription errors have decreased tremendously.

Central line dressing changes were thought to be inconsistent. This process is totally been let that through bundling and I will actually discuss that at a -- when she talks. False was another issue and we had a team that is worked extensively on this and our numbers have decreased significantly.

Equipment needs -- this was another one that he did not have the right equipment or you are not trained on equipment that cause errors. And then the last one that they talked about was MRSA decolonization not being ordered by the physician. We still have issues with this one because if MRSA is just a piece -- a nasal test and it is not an actual infection, our doctors have a hard time ordering the decriminalization but that's another issue we will talk about at a later time.

Those were some of the topics that were brought up from our safety assessment questions. The very first one we did.

What Dr. Pronovost would say that is if you perceive a harm so of those questions -- how would your -- how would your patient be harmed in your unit? So there's all a perceived harm so that in itself from the studies correlates with actual harm. So it is kind of interesting that those are ways to come up with really good projects for your safety CUSP group to work on. Give thing he talked about was change. And that you always value that the center so always seek to understand that person that's the why. That person that is saying I don't think you should change it. I like the way we do it right now. So that you have reason to show people -- to answer the questions why.

Another thing that came out of CUSP was that healthcare workers care deeply and that barriers can really affect their job. So when you do the safety assessments, if they say they do not have the right equipment, or if they say that their staffing is not right. Or they had a barrier -- they do not have the right resources, then we have to look at that and really say, how can we fix this? So we have to always be looking for ways for improvement, we have to always look for risks and what risks that we are not seeing maybe someone else is seeing, and then we have to identify those risks and work on preventing them.

As I said each one of those safety issues were identified and we develop action plans, each unit if they had a concern that was specific to a unit they worked on it. And we found that by doing the simple little exercise, that was a great way it staff involved and to feel a part of the culture of safety. So we try to do this exercise once or twice a year just to really look at what is -- have the stealth of tell us was going on with the unit

A simple review that the culture of safety and CUSP talk about work 4 questions, always review what is going on. In other words, what happened. And then ask that question why. Why did it happen? What can you do to reduce the risk? And had you know you have reduced the risk? So every time we have a CAUTI which we have not had very much lately, we reviewed that situation with the CUSP team . We asked what happened, we asked why, we asked can we reduce the risk, and how do we know we reduced the risk? Very simple review.

We look at every process, and we see if that works. I will stop for one minute and I will let Julie go on and she will share with you the various improvement projects that we are initiating to our CUSP team. Julie is my right hand person, she's an infection prevention is an hazard degree from the University of Wyoming she has her master's from the University of Maryland she is one of the most skilled and knowledgeable clinical nurses that I know of I was extremely fortunate to convince her to an infection prevention role. So Julie, I will move out of your way and let you -- make your presentation.

The first project for improvement we took about our CLABSIs and we looked at that we looked bundling we look at how can we improve the process and make sure we're doing everything the same way every day each time. We looked -- we built and searching carts and that's important -- we started out with this project. And documentation, we got the same checklist to make sure it was done correctly each time we give up our PICC team and that's a certain people have the skills to put in a PIC line which we use a lot of. And they are on call 24 seven we have a nurse that comes in and inserts these lines. It's a central line. They are on call. And it's all but evidence-based practice for insertion care and standardize work. We do it the same way every time each time.

Then we initiated a spreadsheet with the data collection and we submitted that to NHSN and would do it for MedSurg and ICU. And we develop a sheet for the floors that the MedSurg and in ICU they keep track of -- who has central lines and when they were inserted and how long they've been in and why they're still there and if there's any signs of infection. So they keep track of this in the clinic or care. They do it each day.

The second project was the CAUTI that's a catheter associated urinary tract infection. We followed the NHSN surveillance criteria for that. And we cemented our data to NHSN and ICU. We reviewed our evidence-based practice to make sure we had all of that in line. And it was nursing's role. And you have to hand it to the staff because they were the ones that did the work. This is their project. They decreased the CAUTI significantly with education by developing nurse driven Foley catheter removal protocols. That is where in our institution we tried to get out all of the Foley's within 48 hours after surgery or after whatever reasons that they are put in. We have special criteria that is on this nurse driven protocol that they meet this criteria that they can have a fully out the nurse continued to have in 48 hours. If you have a really good reason to leave it in, they are on sedation, they had a head injury or any of those things, then they can leave this in otherwise that comes out this anyway possible. They do not leave it in just because they had hip surgery. We take them out.

That's the important part about the catheter protocol.

Now the data shows improvement. Our numbers are very low, we have not had a CLABSI since 2011 in ICU. And on MedSurg in 2012 we had eight colonies -- CAUTIs. The last CAUTI was in 2014. The reason this happens is because we look at what we were doing and look at where the Foley is being put in and how it is being put in, or the under duress? -- Were they under duress? If they were put in OR under duress, for whatever reason was that the reason -- was it something that is brand-new? Do they need reeducation on the catheters? We look at all of that to look how we can improve the process and we did. You can see the count is coming down.

ICU last CAUTI was in November 2014 and having 2013 and 2012 we had none.

The staff owned the process they get really involved the CUSP team reviews all the cases look at for room for process improvement, we look at was any changes in product, any changes in prep, we do that the same thing -- was there a change in tray or prep? We inserted the line. Where is any reason why it happened? -- Is all clinical people who look at those.

We have another project now.

And hygiene, -- and hygiene each manager or designee observed 10 high genes per month. But when we decided to a person they let the people know they will watch them for their hygiene. We looked at the dashboard to work 100% all the time. So then we decided that in CUSP we would do a secret shopper program. We looked at the clinical areas, we signed people to do secret shopper programs so we started this in 2014 and we did these observations and our observations came out at 78%. So this is a continuing project we're looking at it we're doing education and reminders we're teaching the patient's and talking to the visitors, reminding each other that we need to do hand hygiene images also have to put it on their list, we had it -- HAI on the list but was -- they removed it so we have to work on that

Hopeful you can see how a simple team of very skilled leaders and staff can really take projects and look at them and go forward to help not just your infection prevention group but actually any group, to look at patient safety. And by asking those simple questions of how someone might be harmed, and really looking at it and you can come up with quite a program. Some of our projects we are working on now we're looking at our PPE and our precautions we're looking at our supplies, we have yellow door backs, signage, education, probably the most important thing we're looking at their is committed case in -- communication. We developed a very simple little bug that's a magnet that they put on the door that helps our EVS staff to know that they have C. Diff and so they have to wear protection and cleanup with bleach, there are special things that they have to do and that piece of communication is really effective.

That was started in CUSP we're also looking at the cleaning for precaution rooms and our policies having bleach for CBI and norovirus and making sure that the only the process is in place with policies and with supplies but also that all of the nurses and clinical staff on the units know what's expected of them and have the education whether it's very simple in a safety huddle or whether something that we have to have more education on.

We have just recently been asked to join the HRET HEN 2.0 project that Wyoming Hospital Association is involved with an our administration has asked that our CUSP team takes that long. So RT membership will grow a little because we will now have a few more people from quality on the team, plus we will make sure we have someone from the full team and someone from the wound team on the CUSP but CUSP will be the ones that make sure we're meeting on the requirements for this new project, this new initiative.

That kind of makes us feel good also because we know that we have been an effective team that has made some great strides in quality improvement. And we feel like that we are able to get things done. And that's what he team should be all about. Ultimately, the purpose of the CUSP team is too short that it is safety, safety of the patient and safety of the staff. So I hope that we would have one of our nursing directors here, she was going to share how CUSP has affected the MedSurg unit but she hasn't made it. So we did not last the 45 minutes I planned on but maybe he could open it up for questions and have some discussion.

That sounds good. Let's open it up for questions.

I guess I am curious how many of you are in the line -- on the line are actually developing a CUSP team in 2010, 2011 when this initiative for started.

Feel free to speak up. We would love to hear from you.

Any questions?

Maybe you could share your protocol on the listserv. You did a nice job of explaining what it is you are doing.

I thought about putting it on a slide but it was a little too busy. But yes we will be glad to do that.

If that is it I want to thank everyone for attending. I think they did a great job in explaining the program and how it was effective at the hospital. Please keep them in mind as a reference if you have me questions about developing a CUSP program because it is a great program and we're seeing a lot of success and we can do more with many of our hospitals to reduce the rates of our infections that we're having so thank you all for attending and thank you for providing us this information today. Do not forget to fill out the evaluation at the end of this presentation. Thank you all for joining us today.

Thank you everybody.

Thank you.

Goodbye.

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