Comprehensive Unit-Based Safety Program (CUSP): Teamwork and Communication Tools September 7, 2012

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What is CUSP?

• An intervention to learn from mistakes and improve safety culture
• Improve or reinforce good cross-disciplinary communication and teamwork
• Enhance coordination of care
• Address overall patient safety
• Work towards healthy unit culture
The “Secret Ingredient” Comprehensive Unit-based Safety Program

**Pre-CUSP work**
- Assemble a safety team
- Partner with a Senior Executive
- Measure unit culture

1. Educate on the Science of Safety
2. Identify Defects (Staff Safety Assessment)
3. Senior Executive Partnership
4. Learn from Defects
5. Implement Teamwork & Communication Tools

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**CUSP & Clinical Interventions**

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<th>Adaptive /Cultural</th>
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<td>5. Implement Teamwork &amp; Communication Tools</td>
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Agenda

- Learning from defects examples
- How to implement MDR with DG
- How to implement structured huddles
- Action planning when we get results from HSOPS survey
- Identify next steps
- Answer questions

Annual Accidental Deaths
Errors Provide Useful Information

We can learn more from our failures than from success

Our processes can be improved when studied

“Give me a fruitful error anytime, full of seeds, bursting with its own corrections. You can keep your sterile truth to yourself.”

Vilfred Pareto

The “Secret Ingredient” Comprehensive Unit-based Safety Program

Pre-CUSP work

- Assemble a safety team
- Partner with a Senior Executive
- Measure unit culture

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2. Identify Defects (Staff Safety Assessment)
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How is CUSP different?

CUSP identifies problem areas -
• what staff think are impeding patient care vs. what managers/directors think are priority areas
CUSP improvement tools are designed for bedside caregivers - easy for busy staff to use
• unit drives its own quality
Lean/Six Sigma/CQI – focus more on streamlining the process than identifying the problem areas
CUSP can complement other quality improvement methods – must use multiple tools!

Learn from a Defect

• Designed to rigorously analyze the various components and conditions that contributed to an adverse event and is likely to be successful in the elimination of future occurrences.
• Tool can serve to organize factors that may have contributed to the defect and provides a logical approach to breaking down faulty system issues
Finding Defects to Learn From

- Staff feedback
- Event reporting
- Quality and safety measures
- Gaps in application of the evidence
- Have staff complete short 2 question survey (Staff Safety Assessment)

Learning From Defects

What happened?
- Brief defect description

Why did it happen?
- *System* factors, e.g. staffing, workload, equipment, production pressure, training, fatigue, physical environment, etc.

What can we do to reduce the risk of it recurring with different caregivers?

How will we know the risk was reduced?

With whom should we share our learning?
Case Summary Learning Tool

• Summarize findings
  ▪ One-page summary of four questions, directly taken from findings in the Learning from a Defect tool
• Share within your unit
• Share within your organization
• Celebrate your accomplishments!

Case in point:

System Failures

- Overhead paging of Anesthesia.
- Airway cart not available in CCU
- Anesthesia beepers not readily available.

Opportunities for Improvement:

- Utilize digital paging for contacting Anesthesia.
- ER will bring cart to all code blues.
- Current beeper numbers posted at each phone.

ACTIONS TAKEN TO PREVENT HARM

• Paging operator will now page Anesthesia and the supervisor in the event of a code blue.
• ER staff will now bring airway cart to all code blues.
• All dead zones will be evaluated.
• Overhead paging will be added to the sleep room.
• Current list of pager numbers posted by each phone.
• Communication to nurses on the need to digitally page Anesthesia when needed.
• Current call list and beeper numbers will be provided by Anesthesia.

Safety Tip:
Utilize the digital paging system whenever Anesthesia is needed.

There was a code blue called for a patient that had obstructed her airway secondary to swelling and secretions. Due to the patient’s difficult airway the ER physician was unable to successfully intubate the patient. Anesthesia was then paged overhead with no response. Anesthesia was in their sleep room and did not hear the overhead pages or the code blue. They were contacted by calling the room directly and they came down and fiber-optically intubated the patient. The problem identified in this case is that there was a delay in intubation with a potential for an adverse outcome.
Learning From Defects

What happened?

• Patient didn’t receive pneumovac medication before discharge

Why did it happen?

• Order is scheduled for day of discharge
• Order not easily visible
• Nurses think the patients are too sick to get vaccines
• Have to rely on memory

What can we do to reduce the risk of it recurring with different caregivers?

How will we know the risk was reduced?

With whom should we share our learning?

• Educate/create fact sheet for staff about safety of vaccines and importance of giving them
• Revise order so at top of scheduled meds and not just on day of discharge
• Establish routine to give vaccine on day of admission or to not to wait till day of discharge
• Include status of vaccine in bedside handoff

How will we know the risk was reduced?

• Decrease frequency or no missed vaccines

With whom should we share our learning?

• Staff on unit during staff meetings and huddles
Staff Safety Assessment
Learning from a Defect Tool
Questions/Feedback

- What if staff are identifying ‘catch all concerns’ like medication errors rather than a specific incident to be able to walk through the LFD tool?
- What if we received a low response rate to the SAS?
- Can you share some examples of how to do the SAS in ancillary departments?
- Can you share some examples of SAS issues in a small hospital and how to apply LFD tool?
- Not enough time

Learning from Defects—Next Steps

- Collate results of Staff Safety Assessment
- Select defect
- With CUSP team or other staff members complete LFD tool
- Define action plan—what, when, by whom and how to measure impact
- Share with rest of unit and executive partner
**CUSP Communication & Teamwork Tools**

Can we change practice through process improvement alone?

*or*

Will successful change require an altering of the value structure within the unit?
Effective communication amongst caregivers is essential for a functioning team.

The Joint Commission reports that ineffective communication is the most commonly cited cause for a sentinel event.

Observations of ICU teams have shown errors in the ICU to be concentrated after communication events (shift change, handoffs, etc).

30% of errors are associated with communication between nurses and physicians.

Reader, CCM 2009 Vol 37 No 5; Donchin, CCM 1995 Vol 23

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**Effective Communication and Teamwork Requires:**

- **Structured Communication**
  - SBAR, structured handoffs

- **Assertion/Critical Language**
  - Key words, the ability to speak up and stop the show

- **Psychological Safety**
  - An environment of respect

- **Effective Leadership**
  - Flat hierarchy, sharing the plan, continuously inviting other team members into the conversation, explicitly asking people to share questions or concerns, using people's names
Learn from a defect

**Daily rounds/goals**

- Pre-procedure briefing
- Morning briefing

**Huddles**

- Shadowing
- Crucial Conversations
- Executive Safety Rounds/Partnership
- Handoff standardization

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**Multidisciplinary Rounds with Daily Goals - What is it?**

- A strategy to assemble the patient care team members to review important patient care and safety issues and improve collaboration on the overall plan of care for the patient
- Improve communication among care team and family members regarding the patient’s plan of care
- Goals should be specific and measurable
- Documented where all care team members have access
- Checklist used during rounds prompts caregivers to focus on what needs to be accomplished that day to safely move the patient closer to transfer out of the ICU or discharge home
- Measure effectiveness of rounds—team dynamics, communication, quality measure compliance, LOS
Evidence For Impact Of MDR Rounds

- Research studies on the effect of structured interdisciplinary rounds show:
  - Earlier identification of clinical issues
  - More timely referrals
  - Improved ratings by nurses and physicians on teamwork, communication and collaboration.
- Research also indicates variable effects on LOS and cost, with some studies showing improvement and others having no impact.

**Improving teamwork: impact of structured interdisciplinary rounds on a medical teaching unit.**


The Effect of Multidisciplinary Care Teams on Intensive Care Unit Mortality

*Arch Intern Med* Feb 22, 2010

Retrospective cohort study (using state discharge data from Pennsylvania Health Care Cost Containment Council)

- 112 hospitals
- Non-cardiac, non-surgical ICUs
- 30 day mortality
- Looked at 3 types of multidisciplinary care models
  - Multidisciplinary care staffing alone
  - Intensivist physician staffing alone
  - Interaction between intensivist physician staffing and multidisciplinary care teams
The Effect of Multidisciplinary Care Teams on Intensive Care Unit Mortality

Association Between Intensivist Physician Staffing and 30-Day Mortality for All Patients

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<th>Variable Value</th>
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<td>No multidisciplinary care</td>
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Multidisciplinary Rounds with Daily Goals

Steps to Implementation

1. Commitment by all that MDR with daily goals is a strategy that will be implemented to improve communication and patient outcomes
2. CUSP team takes on initiative—identify if there are any additional team members needed
3. Evaluate current rounding process
4. Identify gaps between current process and what you want it to look like
5. Define the standard work of rounds, roles and responsibilities of each member and develop checklist and goal process
6. Define metrics to evaluate MDR
MDR with DG Action Plan

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Standardized Work Paradigm

Old Paradigm - I know you’ll be able to figure it out. Just get it done the best way you can.

New Paradigm - In order to have consistent results we must do things the same way every time.
Standard Work System

- Standardized Work is a system for achieving a stable baseline for a process in order to systematically improve it.
- Standardized Work Systems are the basis for Continuous Improvement.

“What you permit, you promote”
“We deserve what we tolerate”

Current State Assessment

What is the state of rounds on your unit?
1. Describe the structure of the participating unit(s). For example, the type of unit (i.e. ICU, Med Surg, Ancillary), whether the unit is open or closed, whether or not the unit has intensivists or hospitalists, how many beds the unit has, etc.
2. Are rounds currently held on the participating unit(s)?
3. How often are rounds held?
4. Who usually attends rounds?
5. What are the roles of each member?
6. Where do rounds usually take place?
7. Is there a defined structure/process for rounds? If so what is it? Or does it depend on who is running them?
8. Are daily goals part of the rounding structure/process?
9. How have rounds made a difference during the past year in improving the performance on your unit?
10. What is the major barrier for multidisciplinary round implementation on your unit?
Daily Goal Sheet (continued)

Medication Review

Interdisciplinary Rounds;
Nursing Objectives

Delirium
1. Target RASS / Current RASS
2. CAM - ICU (results)

VAP
3. Current Sedative / Analgesic
4. Infusions / Intermittent dosing

Sepsis
5. SAT / SBT - spontaneous awakening trial / spontaneous breathing trial
6. Mobility - what level is patient at?

7. Current Vasopressor infusions
8. Skin
9. Restraints - need / order
10. Foley/Central Lines - Are they needed?
11. Nutrition / Bowel Regimen
12. Other: any procedures planned / nursing concerns / issues
Why Checklists?

- Levels of cognitive function are often compromised with increasing levels of stress and fatigue in certain fields of work.
- Aviation, aeronautics, and product manufacturing have come to rely heavily on checklists to aid in reducing human error.
- The checklist is an important tool in error management across all these fields, contributing significantly to reductions in the risk of costly mistakes and improving overall outcomes.
- Such benefits also translate to improving the delivery of patient care.
- Despite demonstrated benefits of checklists in medicine and critical care, the integration of checklists into practice has not been as rapid and widespread as with other fields.
Multidisciplinary Rounds with Daily Goals

- Purpose: Improve communication among care team and family members regarding the patient’s plan of care
- Goals should be specific and measurable
- Documented where all care team members have access
- Checklist used during rounds prompts caregivers to focus on what needs to be accomplished that day to safely move the patient closer to transfer out of the ICU or discharge home
- Measure effectiveness of rounds—team dynamics, communication

Multidisciplinary Rounds with Daily Goals Challenges and Opportunities

- Should be done in ICUs and all units in hospital
- Hard initiative to implement, especially if you have an open unit and/or no intensivists or in non-ICU area
  - Standardize the structure and process for all units
  - Benefits seen even if physician can not attend consistently or at all
  - Second rounds should be done in afternoon—include at least physician and bedside nurse
    - Evaluate if goals for day have been met; readjust if necessary
    - Identify if patient can be discharged (or transferred) the next day and if so, what needs to be accomplished
Multidisciplinary Rounds with Daily Goals Challenges and Opportunities (continued)

- Focused first on defining daily goals and recording those either on the white board in the room or on a sheet of paper
- Then standardize rounds—who should attend and what is discussed
- Implemented nursing objective card—to clearly define role of nurse in multidisciplinary rounds
**MDR with DG Action Plan**

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**Who?**

- **Physician**
  - Team leader: guide rounds, ensure follow defined process, elicit input from all members, summarizes define daily goal
- **Resident**
  - Present patient in system format
  - Place orders in computer during rounds
  - Document note in chart
- **Bedside nurse**
  - Provide clinical information, current patient status, changes over previous 24hrs, patient or family concerns/issues (if not present on rounds)
Who?

- Case manager/social work
  - Could function as leader if physician not present
  - Oversee discussion of discharge planning
  - Define patient/family concerns/issues
- Charge nurse/CNS/CNL
  - Function in leader role if designated and physician not present
- Others
  - Pharmacist, respiratory therapy, PT/OT, pastoral care, palliative care

Structure of MDR

- Time of day
- Frequency
- Process for each patient
  - Checklist
- Documenting
  - Which pieces of rounds?
  - Daily goal
- Define daily goal follow up process
MDR with DG Action Plan

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MDR with DG Evaluation: Outcome Metrics

- Length of Stay
- AHRQ HSOPS results
  - “In this unit, people treat each other with respect”
  - “Staff feel free to question the decision or actions of those with more authority”
  - “Staff are afraid to ask questions when something does not seem right”
MDR with DG Evaluation: Survey the Process

Attending: ___________________________  Resident: ___________________________
RN: ___________________________  Intern: ___________________________
Circle others in attendance:  Pharmacy  Nutrition  Respiratory Therapy  CNL
Room #: ___________________________
Rounding outside patient room: yes no
Nursing notified: yes no n/a
Nursing present during rounds: yes no
RT present during rounds: yes no
Checklist followed as outlined: yes no
(If no, what objectives were omitted) __________________________________________
Sepsis screen, sepsis bundles reviewed/signed by team: yes no
Daily goals in room board updated by intern: yes no
Plan of care/daily goals clarified with team: yes no
Nursing questions/concerns addressed: yes no n/a
Physician questions/concerns addressed: yes no n/a
Patient/family questions/concerns addressed: yes no n/a
Were team members listening to each other: yes no
Did leaders ask others for input: yes no
Feedback to team members (professionalism, team interaction, timeliness, efficiency, thoroughness, organization and clarity):
Was criticism positively presented: yes no

MDR with DG Evaluation:  Survey the Participants

5 point scale

➢ Was your voice/opinions heard and valued?
➢ Did you have a understanding of what the goals and plan for the patient was for the day?
➢ Did the leader facilitate the rounds to ensure efficiency and open communication?
➢ What was the goal per day for each patient?
➢ Did MDR with DG improve how you cared for your patient?
➢ What worked?
➢ What could be improved?
Huddles

• Enable teams to have frequent but short briefings so they can stay informed, review work, make plans, and move ahead rapidly.

• Allow fuller participation of front-line staff and bedside caregivers, who often find it impossible to get away for the conventional hour-long improvement team meetings.

• They keep momentum going, as teams are able to meet more frequently.

• Use this strategy to begin to recover immediately from defects---IE: falls, sepsis. Use daily to focus on unit outcomes

Components

Metric 1: Quality/Safety
Metric 2: Patient Satisfaction
Metric 3: Operations

Daily Critical Communications

Information

Ideas in Motion

How to do it?

• Beginning or mid shift
• 5 minutes
• Lead by member of unit leadership team
Structured Huddles Action Plan

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<tr>
<td>Select Huddle metrics for first board: operational, quality/ safety and patient satisfaction</td>
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<td>Define huddle process:</td>
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<td></td>
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<tr>
<td>• Define time of day and frequency</td>
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<tr>
<td>• Who will lead huddle</td>
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<td>• Expectations of staff—who will attend</td>
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<tr>
<td>• Create agenda (in first huddles include overview of purpose of huddles and huddle process)</td>
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<td>Hang huddle board and fill in metrics</td>
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<td>Identify when huddles will begin</td>
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<tr>
<td>Define process for changing huddle metrics</td>
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<tr>
<td>Create evaluation process: how will I know if huddles are successful?</td>
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Selecting Metrics

- Should reflect improvement opportunities that have been identified by unit, aligned with unit and hospital goals and objectives
- Must be specific and measureable – and feasible to monitor frequently
- Identify who will be collecting data and updating board
- Define goal for metric---this will help you decide how long to keep metric going

**Quality:** IE: core measures, hand-washing, falls, delirium, skin etc.

**Patient Satisfaction:** IE: use results from hospital’s patient satisfaction survey----- pain is controlled, noise at night etc.

**Operations:** IE: unit functioning, efficiencies---% of patients discharged by 11am, time from transfer or discharge order till patient moved

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Selecting Metrics

**Quality:** (IE: core measures, hand washing, falls etc.)

**Med-surg:** pneumonia core measure—your unit is falling short in one area—vaccination.
- Metric: # of patients who received the vaccine (PNE)
- # of patients who qualified for it

**ICU:** ventilator associated pneumonia prevention—your unit is not consistently performing the spontaneous awakening trial (SAT)
- Metric: # of patient who received a SAT
- # of patients who qualified for SAT

**LAB:** turnaround time for stat lab—CBC
- Metric: # of CBC resulted within 30 minutes
- # of CBC in previous 24 hrs
Selecting Metrics

**Patient Satisfaction:** IE: use results from hospital's patient satisfaction survey-
Med-surg: call lights being answered within 5 minutes
  - Metric: # of call lights answered within 5 minutes
  - # of call lights in 24 h
ICU: pain reassessment in 1 hour
  - Metric: # of patient who’s pain was reassessed in 1 hour
  - # of patient episodes audited
Radiology: patient waiting
  - Metric: # of in-patients that waiting in the hallway 5min
  - # of inpatients brought to department for testing in 24 hrs

**Operations:** IE: unit functioning, efficiencies-
Med-surg: percent of patients discharged by 11am
  - Metric: # patients discharged by 11am
  - # of patients with discharge orders in place before 11am
ICU: delirium assessment
  - Metric: # of patient with 2 documented CAM-ICU in last 24 hours
  - # of patient in ICU
Radiology: no show rate
  - Metric: # of out patients that miss schedule appointment
  - # of outpatients scheduled for testing in 24 hrs
### Structured Huddles Action Plan

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<td>Define huddle process: • Define time of day and frequency</td>
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<tr>
<td>• Who will lead huddle</td>
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<tr>
<td>• Expectations of staff—who will attend</td>
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<tr>
<td>• Create agenda (in first huddles include overview of purpose of huddles and huddle process)</td>
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<tr>
<td>Hang huddle board and fill in metrics</td>
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<tr>
<td>Identify when huddles will begin</td>
<td></td>
<td></td>
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<tr>
<td>Define process for changing huddle metrics</td>
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<tr>
<td>Create evaluation process: how will I know if huddles are successful?</td>
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### Saint Joseph Mercy Health System

**Daily Huddle Process**

The purpose of daily huddles is to help to facilitate safe, effective, and efficient patient care. SJMH has developed this process to align the organization's overall strategic goals with unit based team goals, and the day to day activities of staff. This empowers all staff to have an impact on positive change leading to remarkable care.

To accomplish such an alignment, unit based teams will choose 3 metrics that align to key objectives for SJMH. These objectives are:

- Quality/Safety
- Patient Satisfaction
- Operational Performance

In choosing the metrics, the unit based team will collaborate with the unit staff to identify and track the metrics. These metrics should represent areas identified in the unit team dashboard and/or other improvement opportunities that align with the hospital key objectives. The team will complete the accompanying Huddle Metrics Selection form, documenting the proposed metrics and rationale for selection.

The unit will communicate progress on the 3 key metrics using the standardized Huddle Board. This board will be reviewed by all staff on the unit each shift, daily, as part of the Huddle Process. In addition, the team will analyze trends in metrics and identify opportunities for improvement.

Once a metric has achieved the target goal and shown sustainability (typically for 3 to 6 months), then it should be removed from the Huddle Board and replaced with another metric proposed by the team and unit staff.
Huddle - Process Definition

The purpose of daily huddles is to help to facilitate safe, effective and efficient patient care. SUMH has developed this process to align the organization’s overall strategic goals with unit-based team goals, and the day to day activities of staff. This empowers all staff to have an impact on positive change leading to remarkable care.

The huddle process will include:
- Brief mandatory team huddle with all unit personnel
- Review of specific unit QI metrics
- Ideas in Motion: Capturing opportunities for immediate action and/or improvement

Huddles are to be conducted each shift, at the assigned time, and with all associates within a 15 minute timeframe. The agenda will regularly focus on the 3 metrics chosen by the unit for quality/performance improvement.

Manager:
- Ensure the huddles are being conducted each shift following the standardized Huddle Agenda.
- The Manager can conduct the huddle(s) or assign a huddle leader (for example a CNS, unit practice council member, CNL or charge nurse) to conduct the huddles.
- Will assign an individual to update the metric information board prior to daily shift huddles (for example the unit clerk, CNL or charge nurse)
- Ensure follow-up and feedback is provided in the huddle on environment or equipment issues identified on prior days. (Examples may include, missing tele packs, Broken IV pumps, lack of laundry, tele pagers, etc.)

Huddle Leader (Manager or Designee):
- Obtain all information necessary for leading a successful huddle at least 15 minutes prior to the huddle start.
- Lead the huddle following the standardized Huddle Agenda.
- Maintain attendance log (or assign someone to take attendance)

Staff:
- Huddle attendance is mandatory on each shift at the designated time.
- Staff who cannot attend a shift huddle due to unavoidable issues will review the huddle board and meet with manager or designee to discuss missed information and reason for missing huddle.

Huddle Video
Huddle Evaluation:
Outcome/Process Metrics

• Improvement in metrics on huddle board
• AHRQ results:
  ▶ “Our procedures and systems are good at preventing errors from happening”
  ▶ “We are actively doing things to improve patient safety”
  ▶ “After we make changes to improve patient safety, we evaluate their effectiveness”
  ▶ “In this unit, we discuss ways to prevent errors from happening again”

Structured Huddles Evaluation:
Survey the Staff

1. Select which department you work for:
2. I have attended a daily huddle
   - Once
   - 2-5 times
   - 5-10 times
   - 10-20 times
   - 20 or more times
   - I have not attended a huddle
3. I understand the purpose of the daily huddles
   - Strongly agree
   - Agree
   - N/A
   - Disagree
   - Strongly Disagree
4. I feel comfortable asking questions and expressing ideas during the huddles
   - Strongly Agree
   - Agree
   - N/A
   - Disagree
   - Strongly Disagree
Structured Huddles Evaluation: Survey the Staff

5. I feel that the daily huddle provides me with information to be able to provide safe, effective and efficient care to my patients
   - Strongly Agree
   - Agree
   - N/A
   - Disagree
   - Strongly Disagree

6. The huddle board has provided me the opportunity to see how my practice impacts patient outcomes
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

7. The huddle board and daily huddles empowers me to improve my own practice
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

8. Please provide any suggestions to improve both the huddle board and the huddle process

Responding to the Results from Culture Survey
Institute of Medicine

“...The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm”

A Positive Culture of Safety

.....recognizes the inevitability of error and proactively seeks to identify latent threats

Nieva, V F Qual Saf Health Care 2003;12(suppl)
Why Measure Unit Culture?

- Determine how bedside staff are feeling related to communication and recognizing defects
  - Diagnose and assess the current status of patient safety culture.
  - Identify strengths and areas for patient safety culture improvement.
  - Examine trends in patient safety culture change over time.
  - Measure/evaluate the cultural impact of patient safety initiatives and interventions.
- CUSP is the intervention that will help you improve culture results

AHRQ’s Hospital Survey on Patient Safety (HSOPS)

42 items assess 12 dimensions of patient safety culture

1. Overall perceptions of patient safety
2. Frequency of event reporting
3. Supv/mgr expectations & actions promoting patient safety
4. Organizational learning--continuous improvement
5. Teamwork within units
6. Communication openness
7. Feedback & communication about error
AHRQ’s Hospital Survey on Patient Safety (HSOPS)

8. Nonpunitive response to error
9. Staffing
10. Hospital Management support for patient safety
11. Teamwork across units
12. Handoffs & transitions

Patient safety “grade” (Excellent to Poor)

Number of Errors reported in the last year

Response Rates

• Best if over 60% --- representative sample
• Between 50 and 60% --- probably representative
• Less than 50% --- alone probably not representative
  ➢ Gather/validate more information from staff
  ➢ Look for similarities of issues between HSOPS, Staff Safety Assessment, incident reports and prior Root Cause Analysis on your unit
Reviewing the Results

- Look at each dimension
  - Can calculate an overall percent of positive responses for each dimension
  - Focus on the dimensions that have less than 60% positive, or the lowest percent positive
- Look at the questions in each dimension
  - Look for questions that demonstrate safety strengths (>75% positive)
  - Look for questions with percent positive is less than 60%---here are areas of opportunity

Reviewing the Results

- Interpreting negatively* worded questions
  - Want to see greater that 60% in the disagree/strongly disagree response
- Example:
  - *We have a patient safety problem on this unit
    - 51% disagreed/strongly disagreed with this statement, 27% felt that there was a patient safety problem on this unit and 22% neither agreed or disagreed
  - Result: want to see at least greater than 60% of the staff disagree/strongly disagree with this statement.
Survey Action Planning

- Assessment data is likely to point to many different area of culture that can be improved
- There will be many different ideas regarding potential actions
- Incremental changes can be implemented and tested on a small scale, changing one process or practice at a time
- Remember—in patient safety this is no one “silver bullet”

Summarize 5 MOST positive

- **Supervisor/manager expectations/actions promoting safety**
  - Considers staff suggestions for improving pt safety-76%
  - *My supervisor overlooks pt safety problems that happen over and over—76% disagree*

- **Organizational Learning—Continuous Improvement**
  - We are actively doing things to improve patient safety-80%

- **Teamwork**
  - People support one another in this unit-86%
  - When a lot of work needs to be done quickly, we work together as a team-85%
  - In this unit, people treat each other with respect-78%
Summarize 5 LEAST positive

- **Communication Openness**
  - Staff feel free to question the decisions or actions of those with more authority—39%

- **Feedback and Communication about Error**
  - We are given feedback about changes put into place based on event reports—46%

- **Nonpunitve Response to Error**
  - *Staff feel like their mistakes are held against them—46% disagree*
  - *When an event is reported, it feels like the person is being written up, not the problem—43% disagree*
  - *Staff worry that mistakes they make are kept in their personnel file—33% disagree*

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Summarize 5 least positive

- **Hospital Handoffs and transitions**
  - *Things “fall between the cracks” when transferring patients from one unit to another—33% disagree*
  - *Problems often occur in the exchange of information across hospital units—38% disagree*

- **Teamwork Across Hospital Units**
  - *Hospital units do not coordinate well with each other—39% disagree*
Evidence Based local solutions:

**Safety “If-Then”**

- **If** staff lack consensus about quality and safety issues?
  - **Then** Safety as a System Training (free 27 Minute online course) [www.dukepatientsafetycenter.com](http://www.dukepatientsafetycenter.com)
- **If** staff feel unengaged in safety and quality?
  - **Then** build grassroots with Learning from Defects
- **If** staff feel unengaged, unsafe, & unresourced for quality?
  - **Then** build infrastructure & capacity with Structured Huddles and Executive Partnerships

**Teamwork “If-Then”**

- **If** staffing levels inadequate/info lost at shift change:
  - **Then** Morning/ Shift Briefings/ Huddles
- **If** interdisciplinary patient management issues:
  - **Then** Daily Goals
- **If** conflicts unresolved/role clarity lacking:
  - **Then** Shadowing Exercise
- **If** difficulty speaking up:
  - **Then** standardizing with SBAR, Critical Language, Crucial Conversations or TeamStepp training
### Action Plan Development

<table>
<thead>
<tr>
<th>Issue</th>
<th>Interventions</th>
<th>Responsible person</th>
<th>How will I know there is an improvement?</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feedback and Communication About Error: given feedback about changes based on event report</td>
<td>*Evaluate current process for follow up on event reporting</td>
<td>manager</td>
<td>10% improvement on this indicator on next survey</td>
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<tr>
<td></td>
<td>*standardize process for feedback</td>
<td>Manager/CUSP team</td>
<td></td>
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<tr>
<td></td>
<td>Utilize LFT tool to problem solve events and safety issues on the unit—once a quarter</td>
<td>CUSP team</td>
<td>Case summaries displayed</td>
<td></td>
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</table>

### CUSP-Challenges and Strategies

<table>
<thead>
<tr>
<th>Issues</th>
<th>Strategies</th>
</tr>
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<tbody>
<tr>
<td>Engaging frontline staff (including off-shifts) owning this work</td>
<td>Part of team (especially night shift staff), bulletin boards, newsletters,</td>
</tr>
<tr>
<td>Timely follow through with identified defects or safety issues and strategies to resolve</td>
<td>Manager shares updates/status at staff meetings, communication at huddles, created huddle book</td>
</tr>
<tr>
<td>Continued engagement of the executive</td>
<td>MHA Keystone letters to executive, locally at each hospital—through one on one conversations</td>
</tr>
<tr>
<td>Implementing strategies and tools to help improve culture and teamwork</td>
<td>Learn from a defect, MDR with focus on communication, survey team members on perception of communication, morning briefings, debriefings, huddles, crucial conversations</td>
</tr>
<tr>
<td>Continual learning from defects</td>
<td>Have each unit learn from a defect monthly and share at meetings</td>
</tr>
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</table>
What are your next steps?

✓ Educate CUSP team on the Science of Safety
✓ Define staff education plan for Science of Safety Education and roll out plan
✓ Administer Staff Safety Assessment
✓ Collate results from Staff Safety Assessment and select issue to use for Learning from a Defect
✓ Pick one Teamwork or Communication tool to implement in the next 6 months
✓ See the Team Leader Checklist

QUESTIONS??