



**You have joined the *CUSP Communication & Teamwork Tools* Informational Session!**

The session will begin shortly.

**To access the audio for the session,**

Dial: **800-977-8002**, Participant code **083842#**

Registrants received an email yesterday containing today's presentation and accompanying documents.

**All participants will be in "listen only" mode during the presentation.**

Questions may be submitted using the "chat" feature on your screen.

If you experience any problems, please call Marilyn Nichols at the MOCPS office at 573-636-1014, ext 221 or [mnichols@mocps.org](mailto:mnichols@mocps.org).



**CUSP Communications & Teamwork Tools**

Information Session

May 6, 2011

## Documents for this Session

(All were emailed to you before this webinar/conference call. They can also be found in the People, Priorities & Learning Together section of the MOCPS web site: [www.mocps.org](http://www.mocps.org))

- ✓ This PowerPoint presentation
- ✓ Commitment Form
- ✓ An audio file recording of this session will be emailed to you shortly after the call today



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## Agenda

- Briefly review the People, Priorities & Learning Together (PPLT) initiative
- Describe the prerequisites and goals of *CUSP Communications & Teamwork Tools*
- Define the project interventions
- Describe the project organization
- Identify next steps
- Answer questions



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## PPLT Review

- Building upon previously-sponsored programs
  - Just Culture
  - CUSP/Stop BSI Collaborative
  - TeamSTEPPS™
- Building upon lessons learned from participants
  - Establishing patient safety culture at the bedside continues to be a challenge
  - Confusion on which programs to implement
  - Need for greater flexibility in programs
  - Support in getting executives and physicians engaged
  - Support in improving overall organizational safety culture



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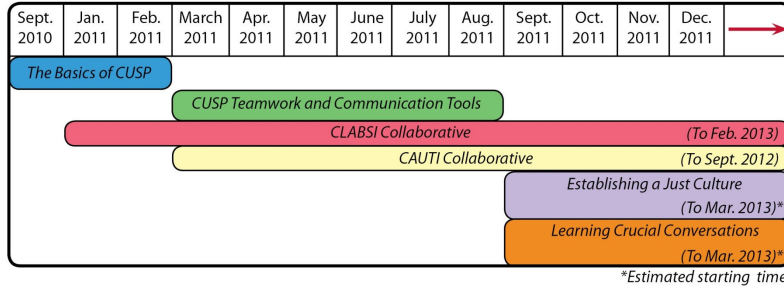
## Unit-Based Patient Safety Culture

- Patient safety and quality happens at the local level
- Build capacity at unit level to tackle multiple problems
- Build capacity at the leadership level to support unit-based safety culture
- Raise the quality and safety bar on the units
- Surviving the tsunami!



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## 2010/2011 PPLT Timeline



- Separate recruitment for each module
- Future modules under consideration
  - Fall injury prevention
  - Hand hygiene



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## Module 2: CUSP Communication & Teamwork Tools Jun 2011 – Nov 2011

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## ***CUSP Communication & Teamwork Tools*** **Prerequisites & Goals**

- Prerequisites
  - The Basics of CUSP
  - Functioning CUSP team in place
  - Executive and physician support
- Goals
  - To implement multidisciplinary rounds (with daily goals) in each participating unit
  - To implement huddles in each participating unit
  - To solve one defect, using the “Learning from a Defect” methodology (introduced during *The Basics of CUSP*)



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## ***CUSP Communication & Teamwork Tools*** **Interventions**



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## Silence Kills

### 2005-Vital Smarts and AACN

- Observational study-focus groups, interviews and workplace observations
- 1,700 respondents (1,143 nurses, 106 physicians, 266 clinical-care staff, 175 administrators)
- Study identified the categories of conversations that are especially difficult and, at the same time, especially essential for people in healthcare to master
- The quality of these conversations relates strongly with medical errors, patient safety, staff commitment and employee satisfaction

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## Silence Kills

### 2005-Vital Smarts and AACN

- Seven areas of concern:
  - Broken rules
  - Mistakes
  - Lack of Support
  - Incompetence
  - Poor Teamwork
  - Disrespect
  - Micromanagement
- 84% of physicians observed colleagues who took dangerous shortcuts when caring for patients and 88% worked with people who showed poor clinical judgment
- Less than 10% confronted their colleagues about their concerns
- Most of healthcare workers didn't believe it possible nor even their responsibility to call attention to these issues
- Half of respondents say the concerns have persisted for a year or more
  - One in five physicians say they have seen harm com to patients as a result of these concerns
  - 23% of nurses say they are considering leaving their unit because of these concerns

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## Silent Treatment

### 2010:Vital Smarts-AACN-AORN

- Observational study
- 6,500 nurses and nurse managers
- Results of study suggest that without support from physicians, nurses and administrators system improvements cannot guarantee patient safety---***Tools don't create safety— People do***

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## Silent Treatment

### 2010:Vital Smarts-AACN-AORN

- 85% of respondents have been in a situation where a safety tool warned the of a problem. 32% said this happened a few times a month—Safety Tools Work
- 58% were in a situation where they felt unsafe to speak up about the problems or were unable to get others to listen

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Can we change practice through  
process improvement alone?

*or*

Will successful change require  
an altering of the value structure  
within the unit?

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## Communication is Key



- 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
- Assertion/Critical Language
- Psychological Safety
- Effective Leadership
- SBAR, structured handoffs
- Key words, the ability to speak up and stop the show
- An environment of respect
- 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

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## Tools and Strategies to Improve Safety and Teamwork

- ***Daily rounds/goals***
- ***Huddles***
- ***Learn from a defect***
- Executive Safety Rounds/Partnership
- Handoff standardization
- Pre-procedure briefing
- Morning briefing

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## 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

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## The Effect of Multidisciplinary Care Teams on Intensive Care Unit Mortality

Arch Intern Med Feb 22, 2010

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

Variable	OR (95% CI)	P Value
Model 1: multidisciplinary care staffing alone		
– No multidisciplinary care	1 [Reference]	
– Multidisciplinary care	0.84 (0.76-0.93)	.001
Model 2: intensivist physician staffing alone		
– Low intensity	1 [Reference]	
– High intensity	0.84 (0.75-0.94)	.002
Model 3: interaction between intensivist physician staffing and multidisciplinary care teams		
– Low intensity+ no multidisciplinary team	1 [Reference]	
– Low intensity + multidisciplinary team	0.88 (0.79-0.97)	.01
– High intensity + multidisciplinary care	0.78 (0.68-0.89)	.001

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## 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

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## 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
- 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

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## Nursing Card


**Interdisciplinary Rounds:**  
**Nursing Objectives**

VAP

Delirium

Sepsis

1. Target RASS/Current RASS.
2. Current Sedative/Analgesic Infusions/Intermittent dosing.
3. SAT/SBT-spontaneous awakening trial/spontaneous breathing trial.
4. CAM-ICU results.
5. Sepsis screen (results)/sepsis bundle (review bundle with team).
6. Current Vasoactive Infusions
7. Skin
8. Restraints - need/order
9. Nutrition/Bowel Regimen
10. Other nursing concerns/issues.



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## Huddles

- Enable teams to have frequent but short briefings so that 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 recovery immediately from defects---IE: falls, sepsis and daily to focus on unit outcomes*

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### Components

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

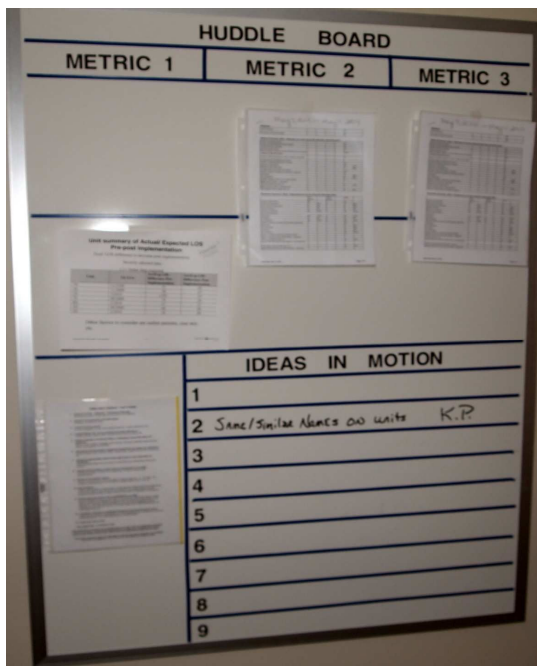
Daily Critical Communications

Information

Ideas in Motion

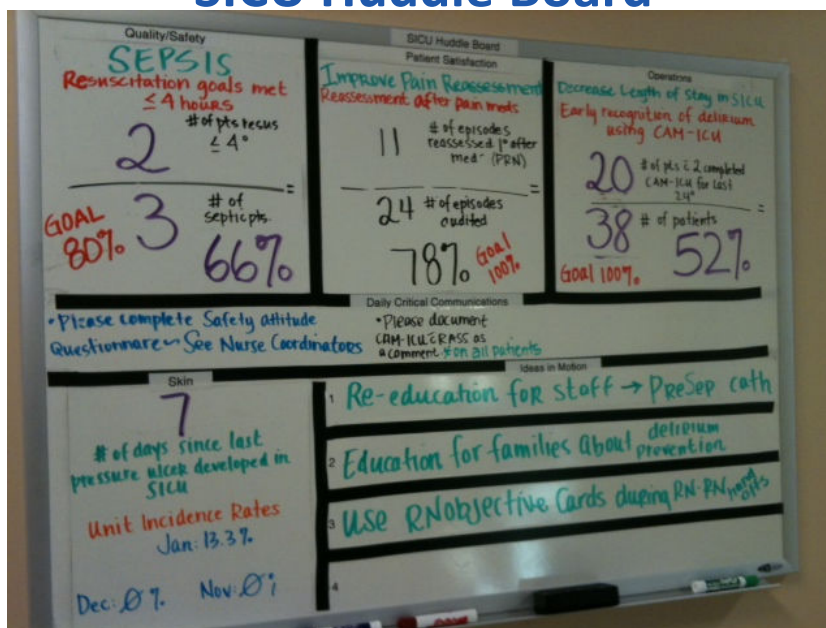
### How to do it?

- Beginning or mid shift
- 5 minutes
- Lead by member of unit leadership team



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## SICU Huddle Board



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## Impact of a statewide intensive care unit quality improvement initiative on hospital mortality and length of stay

BMJ, February 2011

### Method

- Retrospective comparative analysis
- Study period: October 2001 to December 2006
- Study sample: all hospital admissions with an ICU stay for adults age 65 or older at hospitals with 50 or more acute care beds and 200 or more admissions to the ICU during that time period
- 95 study hospitals in Michigan compared with 364 hospitals in surrounding Midwest region
- Look at hospital mortality and length of hospital stay



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## Impact of a statewide intensive care unit quality improvement initiative on hospital mortality and length of stay

BMJ, February 2011

### Results: Odds ratio for mortality in Michigan and comparison hospitals

	Study group	Comparison group	P value
Pre-Implementation	0.98(0.94 to 1.01)	0.96 (0.95 to 0.98)	0.373
Post-Implementation 1-12 months	0.83 (0.79 to 0.87)	0.88 (0.85 to 0.90)	0.041
Post-Implementation 13-22 months	0.76 (0.72 to 0.81)	0.84 (0.81 to 0.86)	0.007



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## ***CUSP Communication & Teamwork Tools***

### **Project Organization**

- Monthly coaching calls will be held every third Tuesday of the month, from 12-1pm (beginning on 6/21/2011)
- Six coaching calls
- Coaching calls will be recorded
- Facilitated by Pat Posa, RN, BSN, MSA
- Team leaders will be provided agendas and materials for monthly unit team meetings (can be modified)
- Project deliverables: At end of 6 months, each unit will have implemented multidisciplinary rounds and/or huddles, and solved at least one defect
  - Submit Case Summary from Learning from a Defect Tool to MOCPS by November 30, 2011



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## ***CUSP Communication & Teamwork Tools***

### **Next Steps**

- Submit commitment form to MOCPS by Friday, June 10, 2011
- Monthly appointments (6) will be sent to team leaders by Wednesday, June 15, 2011
- Materials for first coaching call will be sent to team leaders by Friday, June 17, 2011
- First coaching call – Tuesday, June 21, 2011
  - Team leaders should attend coaching calls
  - Expectation: team leaders will share the information discussed during the coaching calls with their team members at their monthly CUSP team meetings



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## We Are On a Continuous Journey

- We have toolkits, manuals, websites, and monthly calls to learn from and with each other.
- Your job is to join the calls, share with us your successes and more importantly the barriers you face.
- Commit to the premise that harm is untenable.

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## Questions?



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