CUSP Module: Building an Engaged CUSP Team

| **Facilitator Guide** | **Slide Number and Image** |
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| This module, titled “Building an Engaged CUSP Team,” is part of the Agency for Healthcare Research and Quality, or AHRQ, Safety Program for Intensive Care Units: Preventing Central Line-Associated Blood Stream Infection (CLABSI) and Catheter-Associated Urinary Tract Infection (CAUTI). CUSP is the Comprehensive Unit-based Safety Program.  The CUSP team you’ll be forming is the foundation for your CLABSI and/or CAUTI improvement project success, so we’ll explore strategies for identifying and engaging select members of the team to be actively involved implementing and sustaining interventions. | Slide 1 |
| Objectives for this module include:   * Identify tools and resources available to support your CLABSI and/or CAUTI improvement journey, including AHRQ’s Comprehensive Unit-based Safety Program * Develop strategies to build a successful CUSP team * Facilitate discussions with team members on how to build an engaged CUSP team | Slide 2 |

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| CUSP is a method that combines improvements in teamwork, communication, and safety culture together with evidence-based best practices to help teams make care safer. Created for clinicians by clinicians, CUSP is a combination of technical and adaptive improvement strategies bundled for practical implementation at the unit level and helps us implement evidence-based strategies in ways that work in our individual units.  Each one of us participating in and committing to this work is essential to drive safety in our units as we know work to improve our culture of safety is local, at the unit level. | Slide 3 |
| The CUSP model was originally developed through a collaborative effort of AHRQ and State- and national-level innovators in patient safety. CUSP dovetails with a range of efficiency models such as Six Sigma and Lean that rely on collaborative team effort to improve performance by removing waste and reducing variation.  Support from the top is crucial to the success of culture improvement efforts, but real, lasting change happens one unit at a time. Improving culture within the healthcare setting requires the model to be based on the understanding that all culture is local and that work to reform culture must be owned at the local unit level. The CUSP framework accomplishes this through stressing that patient harm is not an acceptable cost of doing business. CUSP is also unique in that it can be applied by anyone, anywhere, in any unit, at any time. Additionally, CUSP has a proven track record.  The CUSP model generates measurable results. The implementation of CUSP in the mid-2000s in the Michigan Keystone ICU Project was correlated with considerable improvements in the safety climate in 71 units, as measured by a unit culture survey. Overall mean safety climate scores significantly improved from 42.5 percent in 2004 to 52.2 percent in 2006.  In the national On the CUSP: Stop Blood Stream Infections (BSI) project that began in 2009, 44 States, the District of Columbia, and Puerto Rico had over 1,000 hospitals and more than 1,800 units that participated. Through the life of the project, these units succeeded in reducing CLABSI by a relative reduction of 41 percent. The percentage of units with zero CLABSIs for at least one quarter increased from 30 percent at baseline to 68 percent at quarter six. Participating non-ICU and pediatric units had similar, impressive reductions in CLABSI rates. States that started with low CLABSI rates achieved additional improvements, again demonstrating that "getting to zero" was possible, a notion clinicians had not broadly accepted previously. More details about this success story can be found by clicking on the [“Stories of Success: Using CUSP To Improve Safety” link.](https://www.ahrq.gov/hai/cusp/cusp-success/whatiscusp.html)  In addition, as you do the adaptive work of improving patient safety and confront challenges that will seem messy and intractable, remember that in thousands of units all over the country, CUSP has brought measurable results, and has the potential to make it easier for you to address challenges in the future.  CUSP will help ICU teams achieve:   * Heightened engagement of staff and senior leaders, * Improved communication among care team members, * Shared mental models, * Expanded knowledge of potential hazards and barriers to safety, and * A collaborative focus on systems of care and other patient safety efforts. | Slide 4 |
| A well-functioning team is essential to deliver services safely and efficiently every day in an intensive care unit or ICU.  Knowledge sharing across disciplines is foundational to effective care. Evidence suggests that teams of people from different disciplines who work together can improve work processes and patient care outcomes, in part because the diverse perspectives can provide a more complete picture of what needs to be done and a framework for how the team can accomplish the goal together. This shared mental model across disciplines helps bridge knowledge of evidence-based practices and implementation of this knowledge.  Teamwork and communication among multiple disciplines is what helps units move from working in silos to working as a true team. Providers who are effective in working as a team can help provide a more efficient, productive, safe, and enjoyable work environment. To work effectively as a team, there must be not only shared technical knowledge, but also shared attitudes and behaviors. | Slide 5 |
| Your ICU CUSP team should understand that patient safety culture is unit based—that is, safety and culture issues are best examined and improved at the level of the individual unit. The ultimate goal is for all members of the ICU team and the CUSP team to be engaged and take ownership of patient safety. Be sure to include team members who have different levels of experience and can appreciate the wisdom of all members of the team.  The team should plan to meet regularly. Try to provide or acquire adequate resources to carry out this work as much as possible. With that said, regardless of how you form this team, try to integrate it into the work you’re already doing as much as possible. Remember, CUSP is meant to enhance existing patient safety work and dovetail with various other quality improvement models. | Slide 6 |
| Think about which individuals from your unit and hospital could provide varied and engaged voices to help inform the changes that need to be made to your specific culture and processes, as well as to help implement those changes and influence others to do the same. From the list of potential CUSP team members, who are the critical members who should join the team? Remember that you do not need every role listed on this slide to build your CUSP team.  First, think about who from your unit may fit the need. Unit manager? Frontline staff nurses? Intensivists? Nurses’ aides? Others? Then, who from outside your unit may be needed on the team? Other physicians? Pharmacists? Environmental Services? Lab personnel? Infection preventionist? Quality staff? The list of potential team members on this slide may help stimulate ideas about who from your ICU and the hospital may be a good team member. Your list may vary, but it is important to think about everyone who provides care in your ICU as well as supports and influences the care provided.  We encourage bringing together team members who have different strengths—one may be highly organized and stick well to schedules, another may have great interpersonal skills, and others may be esteemed for their clinical expertise. Always think about their influence inside and outside your unit. Can they help make the changes needed to reach your goals?  The following slides will explore the different roles and responsibilities within the CUSP team. | Slide 7 |
| The CUSP team leader role is extremely important to assure an effective team. The team lead needs to engage with the senior executive and actively work to establish a relationship with that person.  The team lead should establish the multidisciplinary team and plan how it will act as a unified group. A team lead might invite individuals to join the team by sharing why they were selected, such as certain skills the lead sees they have or how their influence could engage the team.  The CUSP team lead will also encourage ICU team involvement and obtain feedback. The lead may also reach out to other units or departments to engage staff who provide care to patients in the ICU (e.g., dialysis team, PICC team, transporters).  The team lead will ensure this initiative moves forward by overseeing engagement, education, execution, evaluation, and management of CUSP activity documentation.  This role can be filled by a frontline provider, nurse educator, physician, or other ICU staff member, but it’s important that this role is filled by at least one person who is unit based. This will help drive ownership and accountability by the ICU team.  But let’s not forget about the recommendation of having a second team lead, or a co-lead, who could also be someone on the unit such as a clinical nurse specialist, or could be someone from the infection control or quality department. This also provides a CUSP team lead with a support system when things are challenging and the team is trying to maintain and sustain improvements. Another leadership dyad that teams have found to be particularly effective is a unit nurse–physician co-lead. This can be especially effective when there is a need to engage physicians. Co-lead pairings should be based on the unit’s needs and what would be most effective in the unit culture to successfully implement and sustain efforts. | Slide 8 |
| The senior executive’s role is critical to supporting the team’s journey to improving CLABSI and CAUTI rates. This person should help the team prioritize improvement efforts, help remove barriers, and provide resources to support preventing patient harm.  To make sure this senior leader is part of the team, consider ways that he or she can be involved in the ICU. In an ideal situation, this senior leader could attend all the team meetings and directly hear what is happening. Often, however, that is not possible due to extremely busy schedules. This is a great opportunity for the ICU team leads, such as the unit manager and charge nurse, to make communication with the senior executive efficient and effective. For example, if the senior executive is the chief nursing officer, the update may include the number of days since the last CLABSI or CAUTI, strategies the nurses are suggesting, interventions being tested and progress or results of these, and barriers the team may be encountering. Consider using the [Safety Issues Worksheet for Senior Executive Partnership](https://www.ahrq.gov/hai/cusp/toolkit/safety-checklist.html) from the CUSP toolkit to document issues, and propose solutions and resources needed to guide conversations. You can find this tool under the Recommended CUSP Tools and Resources slide.  In partnering with the senior executive, recognize that there may be a lack of clinical background and/or understanding of how clinical units function. It may be necessary to educate the senior executive about the unit and its patient population to help understand what a typical day in the unit is like and who does what. So, the team leads will need to assess learning needs the senior executive may have and address these through discussions with the senior leader.  Ask for a meeting with them at the beginning of the CUSP implementation to discuss their role. As the team leads engage in these discussions, they are cultivating the relationship with the senior executive. It’s a perfect time to learn what the executive cares about for use throughout the CUSP implementation and beyond. You also can convey the unit’s commitment to prevent harm. As the team leads are developing the relationship with the senior executive, it will be important to consider that the executive may need the team leads’ guidance in understanding what his/her role is on the team. The team leads may need to be explicit as they develop a shared mental model with the executive about his/her role on the team, such as: “We need you to keep executive staff apprised of this CUSP implementation, engage with unit staff, help us work through obstacles encountered, help us identify and secure needed resources, and mentor us as we work to improve our safety culture.” The team leads will need to plan with the senior executive how those things happen, including what reporting to executive staff will look like, strategies to engage directly with staff, and what is expected in regards to mentoring the team leads and the team, and any other role the team leads need the executive to fulfill. The key is to intentionally have such conversations with the executive at the beginning to plan and develop a shared mental model of what that executive’s role is on the team. From there, you’d ideally want to meet with or provide an update to the senior executive monthly.  What happens if you do not have a fully engaged senior leader? There may be turnover, or a senior leader has not yet identified the need to participate. Sometimes, role-specific engagement has to evolve. You will first want to identify one or more likely candidates. Then, open a dialog with that person to discuss the need and how they can add value to the team. The opening dialog may be accomplished through someone else, such as the ICU nurse manager or physician on your team, if not the CUSP team leader. The senior leader’s engagement can often be gained through appealing to how they can help the cause and make patient care safer. You may need to make a business case to the senior executive to make sure they are engaged with the project. | Slide 9 |
| Let’s discuss some strategies to engage senior executives in the CUSP team. Ideally, you will want to identify ways to regularly bring leaders into the ICU. Keep it simple and consider incorporating this visit into existing processes like daily briefings, rounding, or shared governance meetings. Other opportunities would be to meet with the ICU team monthly to review progress and celebrate successes.  Another approach is to implement senior leader patient safety rounding, which will be discussed in more detail in another presentation. This type of rounding is a great way to engage with all frontline staff (and not just the senior executive, nurse manager, or attending physician).  Finally, senior executives could interact with frontline staff during rounding by approaching conversations from a point of curiosity and acknowledging that being fallible is part of being human. This approach to leaders interacting with frontline staff, such as bedside nurses, can foster psychological safety and lead to more open dialogue to problem-solve for barriers to CUSP implementation. | Slide 10 |
| Moving on to the role of the physician champion, you’ll want to identify a physician or physicians who are influential and respected by their peers and nursing staff, who will serve as good role models for CUSP activities, and who can be a voice for physician care concerns, practices, and goals. Regardless of who is chosen for this role, physician champions will learn about CUSP and lead change efforts. They engage other providers to actively participate in HAI interventions and represent these providers by serving as a liaison between providers and the ICU CUSP team. As they engage other providers, they can act as a model through their actions and offer feedback to their colleagues. They respect the contributions made by their colleagues and have a deep understanding of the workflow. Physician champions participate in defect investigations, articulate germane workflow processes, and provide input to the team regarding patient-level factors. Some examples of potentially effective physician champions that can be strong allies to include in this work are the chief resident physician, ICU fellows, or the ICU medical director.  Ultimately, the physician champion or champions you recruit to be part of the ICU CUSP team must be capable of communicating and collaborating effectively with nurses, senior executives, and other team members participating in the initiative. | Slide 11 |
| As we discuss physician engagement, we want to speak to the impact of different physician staffing patterns on engagement of physicians. This pattern is a major driver of physician schedules and therefore, significantly impacts the time they have available for participating in unit focused quality improvement projects. Many ICUs have an open arrangement, meaning that the physicians practice in different hospitals or in different areas of the hospital and are not assigned to particular units. They may or may not be employed by the hospital. Commonly, these are surgeons or specialists in cardiology or pulmonology. Others may have a closed-unit structure, meaning the physicians are employed by the hospital and practice in assigned units, caring for all or most of the patients in those units. Intensivists can be an example of physicians that work under this type of structure. Others work in a mixed environment where there is a combination of these patterns. Practical strategies for recruiting and engaging physicians in different staffing patterns varies, based on multiple factors such as schedules, competing demands, practice incentives, and other non-direct–care professional responsibilities.  You’ll want to consider understanding their priorities, addressing their concerns, and communicating with them effectively. For example, physicians in open-model ICUs have competing responsibilities between different hospitals and/or an ambulatory practice and may not have the time to commit to much more than patient care. You can engage with the physician during rounding, via email, or via the physician’s collaborating partners if there is someone in this role, such as a nurse or physician assistant. The same can be said for open-practice intensivists, but there may be more interest and availability to participate in team meetings and other activities. Physicians employed by a hospital and assigned to specific units may have more availability simply because he or she is on the unit more often and can engage in direct communication more easily. This type of physician may also be financially incentivized to participate in quality improvement activities, if employed or contracted by the hospital. You may consider having a CUSP physician champion for each infection (CLABSI, CAUTI) or for both infections based on their expertise and ability to influence physicians in the ICU and other units.  It’s important to acknowledge a physician’s demanding schedule and assess availability and time allotted to participate in the CUSP team. Tailor your approach with some of these strategies other CUSP teams have used:   * Plan CUSP team meetings at times that are convenient for the physician. * Prepare reports to share information relevant to the physician’s perspective that can be shared with other physicians. * Schedule a call with the physician to discuss his or her role in interventions, and listen to and address their concerns. Consider meeting in an area that is most convenient for the physician, which may be his or her office. * Explore opportunities and resources for rewarding physicians (e.g., stipend, gift card, performance goals) by reaching out to the senior executive of the CUSP team.   Remember, too, that almost all physicians share a common goal of providing the best care for each of their patients, so don’t forget to stress information about how the CUSP work can do that as you build your strategy. | Slide 12 |
| Nurse managers hold clinical and administrative roles and should be actively involved in the CUSP team by supporting CUSP activities so that care delivery aligns with the highest quality of care. The nurse manager’s role is also critical to holding staff accountable for standardizing care and implementing infection prevention interventions, including enhancing teamwork and communication. This is done by ensuring survey results and data are shared with staff, educating staff on clinical competencies, and managing local resources so that staff have access to necessary equipment, supplies, tools, policies, and procedures to provide safe care for patients. The nurse manager also establishes processes for staff to be included in analyzing defects and developing plans to address harm.  Nurse managers have to be aware of organizational goals and make sure the ICU’s daily activities are in alignment. To do this, partnering with senior executives is crucial to obtain buy-in and support from leadership. As a result, the nurse manager serves as the decision maker to carry out plans, and inspires staff to participate in initiatives, including CUSP.  Effective nurse managers use multiple forms of communication to obtain and share information with staff, which is important to understand, especially when working with an intergenerational workforce. You may notice that the role of the nurse manager aligns with the ICU CUSP team lead role and often times this role is filled by the nurse manager, but this doesn’t necessarily have to be the case. Many nurse managers also have support from an assistant nurse manager, a clinical nurse specialist, nurse practitioners, or a clinical educator. These support roles may be a great source for a CUSP team lead or team co-lead. | Slide 13 |
| A nurse champion is someone influential and respected by the nursing team and other staff. This person can support the nurse manager and CUSP team lead to meet the goals and expectations of the quality improvement work. A nurse champion engages in patient care and understands the mortality and morbidity associated with CLABSI and CAUTI. This person can be a voice for patients, families, and the nursing team, and can improve patient safety by connecting to CUSP activities.  This person understands how things are actually done at the bedside and what resources are available. The nurse champion knows the accessibility of said resources to help inform practices, processes, and communication among the team and with patients and families. The nurse champion also will be able to follow up with peers on barriers, provide ideas to improve patient safety, and support celebrating successes no matter how small these might be. Also, like the physician champion, the nurse champion can offer feedback to colleagues and be a model for care among their peers.  Another key role the nurse champion plays is assisting in sharing data with bedside nurses, and leading or facilitating defect analysis when an HAI occurs. This role could be filled by a staff nurse, assistant nurse manager, a clinical nurse specialist, or nurse practitioner. | Slide 14 |
| Having diverse perspectives and skill sets in collaboration will support implementation and sustainability. Units often choose to include members of their hospital’s infection prevention and quality or performance improvement teams.  These stakeholders often hold information and resources that you need, such as data to monitor progress toward achieving your goals. They can also help remove barriers and influence change, such as by spreading evidence-based practices to other units or by integrating reminders into electronic health records to determine appropriateness of a catheter.  Should you include these roles in your CUSP team, be sure to include all members in the team’s monthly meetings. It’s also important to acknowledge their skills and defer to their expertise to support interpreting data and monitoring progress, and to inform decision-making and understanding of hospitalwide initiatives in place.  And, don’t forget to consider including medical residents and fellows, environmental services staff, therapists, and members of the transport team; all these perspectives can bring value. | Slide 15 |
| To help you start to build your CUSP team, use this Team Roster that lists some of the team responsibilities. You are encouraged to use this as you think not only about the skills that you need on your team, but also the ways that different team members can contribute. You can also use this tool to talk with potential team members, to review responsibilities and delegate activities. | Slide 16 |
| As you facilitate discussions with your team after sharing the information in this module, consider asking the following questions:   * In your current ICU team, do you have all the roles listed in the Team Roster? * What roles would you like to add? * What challenges do you foresee as you put the team together? * What staff (by role) do you believe it will be easiest to recruit to your CUSP team? * What staff (by role) do you believe it will be most difficult to recruit to your CUSP team? | Slide 17 |
| The [Safety Issues Worksheet for Senior Executive Partnership](https://www.ahrq.gov/hai/cusp/toolkit/safety-checklist.html) is a tool from the AHRQ CUSP toolkit that can help you assess the ICU team’s safety culture. You can use it to identify issues and efficiently and effectively ask for what you need from the CUSP team senior executive. It is linked in the slide and can be found in the materials for Engage the Senior Executive module.  Videos from the CUSP toolkit that reinforce material presented today include [Building Your CUSP Team](https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/02c_build_cusp_team/index.html), [The Role of the Nurse Manager](https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/09a_rolenrsmgr/index.html), [Physician Engagement](https://www.ahrq.gov/hai/cusp/videos/02e-phys-engagement/index.html), and [Engage the Senior Executive](https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/videos/03a_engage_senior_exec/index.html). Finally, the Making it Work Tip Sheet on [Assembling the CUSP Team](http://www.ahrq.gov/sites/default/files/wysiwyg/hai/tools/clabsi-cauti-icu/assembling-cusp-team.pdf) provides additional strategies, a script for conversation starters, and resources to help you build your own CUSP team. | Slide 18 |
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