

# Unit-Based Communication Program (John Hopkins)

*Experiences of a critical care  
program in implementing eCUSP*

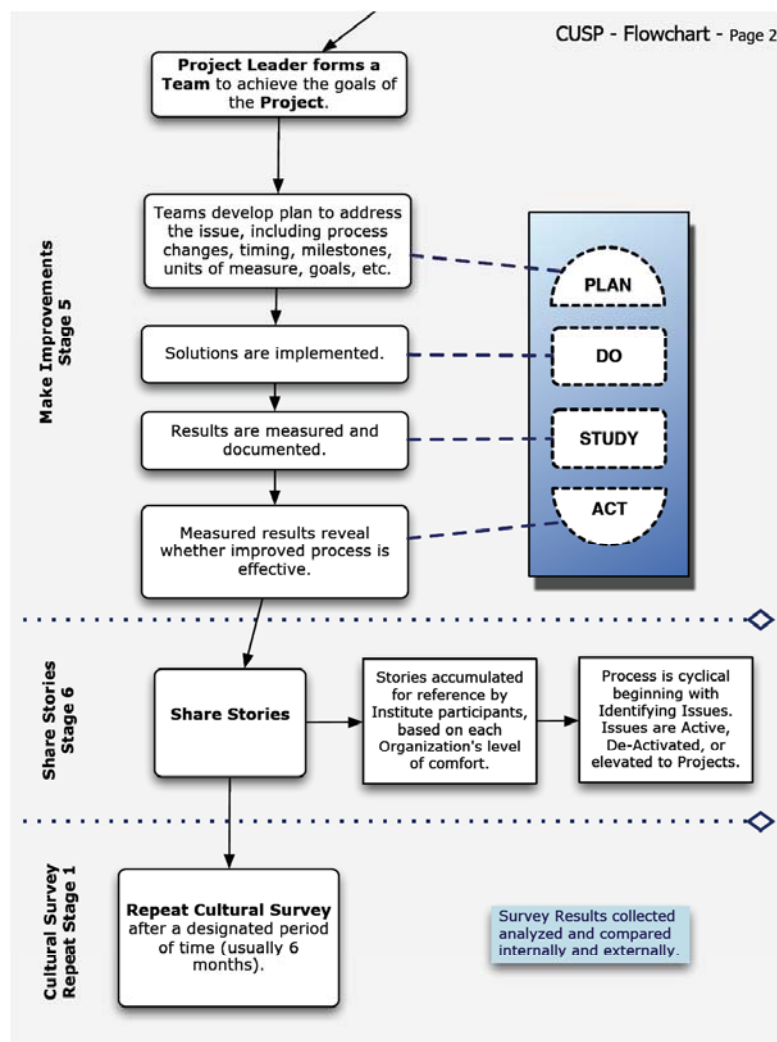
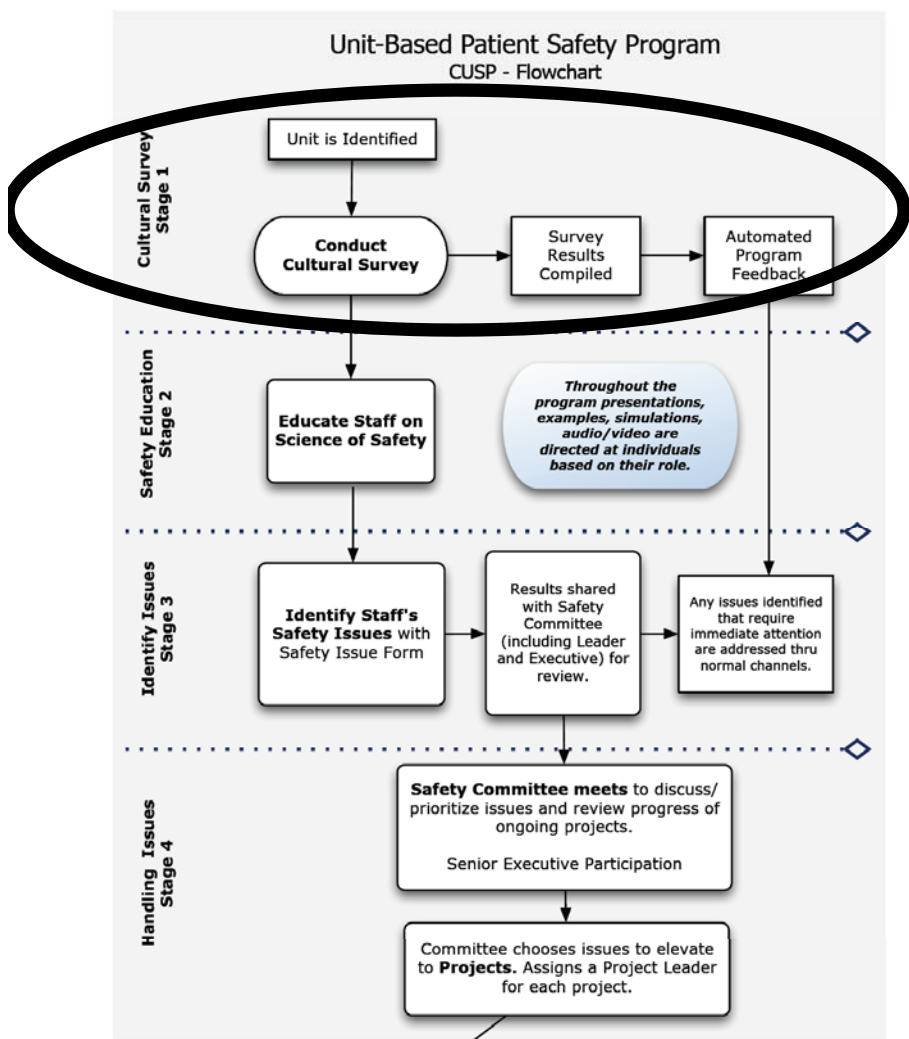
Tracie Northway, RN, MSN, CNCCP(C)  
Pediatric Critical Care, Quality & Safety Leader  
BC Children's Hospital

---

# Background

- History of *reactive* quality improvement in Pediatric Critical Care at BC Children's Hospital
- Health Canada funding through a Healthy Workplace Initiative
- Adoption of patient safety program (PSP) based on John Hopkins' Comprehensive Unit-Based Safety Program (CUSP)
- PCC approached to pilot PSP in partnership with:
  - Quality, Safety & Risk Management Department
  - Infection Control
  - Learning and Development Department

# Patient Safety Group -CUSP





# THE PATIENT SAFETY GROUP

HEALTH CARE ORGANIZATIONS EMPOWERED TO COMMUNICATE, COLLABORATE, IMPROVE & SHARE

Welcome - September 8, 2009

Culture of Safety Survey

## Programs

- eCUSP
- Culture Survey

## Resources

- News
- Health Updates
- Links

## The Group

- About Us
- Testimonials
- Support
- Contact



What can eCUSP do for you?

- account for and

## USER LOGIN

Login:

Password:

LOGIN

[Forgot password or login?](#)

[Do you have a registration key?](#)

Login to access **eCUSP** (*electronic comprehensive unit-based safety program*), or the **Culture Survey**.

## JOSIE'S STORY available nationwide!

Patient Safety Group co-founder, Sorrel King, has published her book *Josie's Story*, through Grove/Atlantic Publishers of New York. In *Josie's Story*, Sorrel writes about the medical errors that led to Josie's death, the family's struggles to deal with their grief, Sorrel's foray into the health care industry as a patient safety advocate, and the safety improvements that have come about in Josie's memory. For more information and where to purchase the book, go to: [The Josie King](#)

## PROGRAMS

### eCUSP

Manage, monitor, record, account for, and share the safety and quality efforts undertaken in specific units and throughout the organization. Improve your culture of safety with this intuitive quality improvement solution.

- [More Info...](#)
- [Contact us to learn more...](#)
- [View the Project Management tutorial...](#)

### AHRQ HOSPITAL CULTURE SURVEY

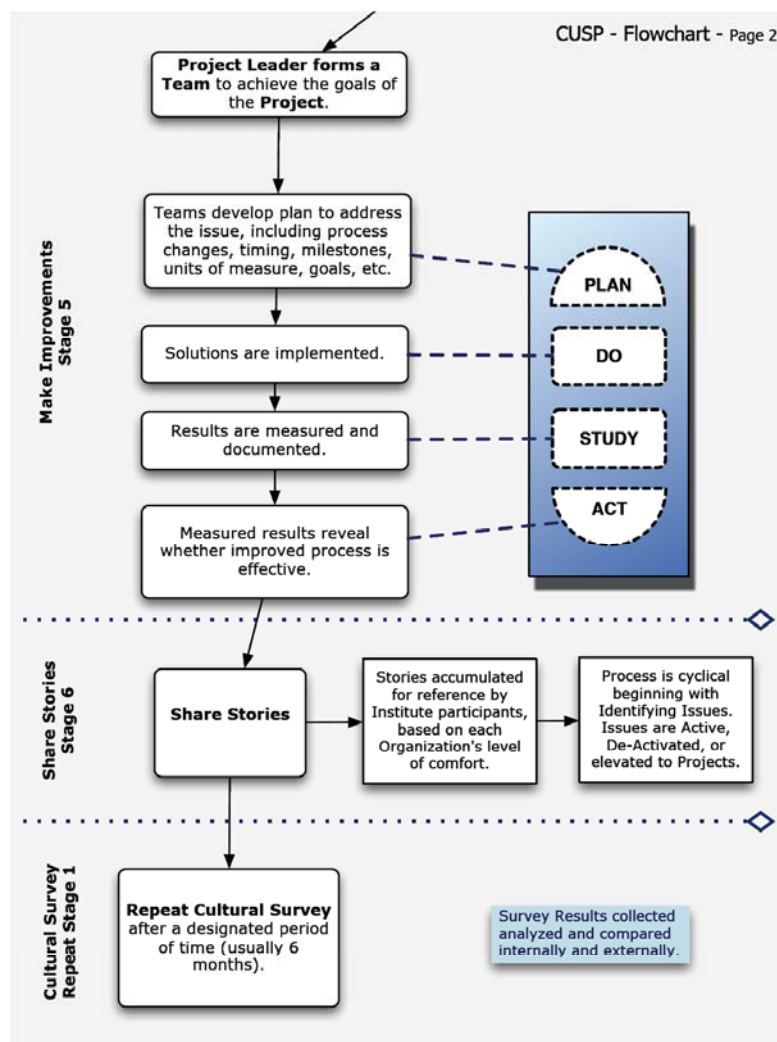
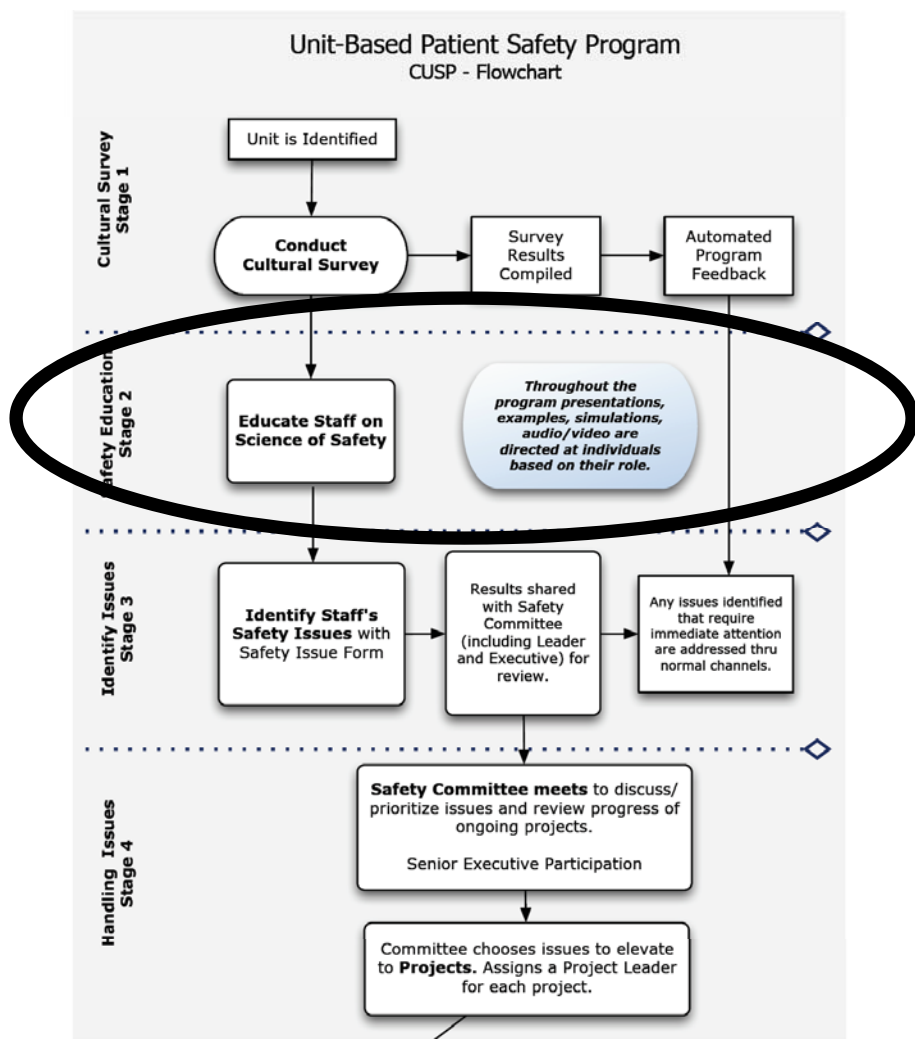
Affordable, easy to setup, easy to take survey. Reports are instant, robust and can be compared to the latest AHRQ 2009 benchmark. Joint Commission required. Much easier than using Excel™ and more efficient than current methods in place. Check out the just released Survey Checklist, a step-by-step implementation plan for the survey.

- [More Info...](#)
- [Survey Checklist](#)
- [Contact us to learn more...](#)

### AHRQ MEDICAL OFFICE CULTURE SURVEY

Affordable, easy to setup, easy to take survey. Reports are instant, robust and can be compared to the 2008

# Patient Safety Group -CUSP



Programs

- eCUSP
- Reports

Resources

- News
- Health Updates
- Links

The Group

- About Us
- Testimonials
- Support
- Contact

Personal

- My Profile

My Page

Leader : eCUSP : Septe

Current Program: BCCH Pediatric Critical Care

Welcome, Tracie Northway. Submit safety or quality issues by clicking "Enter a New Issue". Complete the assignments required of a Leader in this program. If you have questions, contact your Program Leaders:

Tracie Northway, . The BC Patient Safety & Learning system (BC PSLs) is where all safety hazards, near misses, and adverse events should be reported.

program

**BCCH Pediatric Critical Care** (Status, Schedule, Users) Mar-15-2005

Activity Reports

assignments

- Enter a New Issue** Sep-08-2009
- Handle Issues - Elevate/Review/Edit/Resolve** Oct-13-2007
- Handle Projects - Review/Edit Setup** Apr-12-2005

projects

- Dislodgement of lines / catheters / transducers** May-18-2005  
Role: Project Team Member  
Assigned Tasks: 7
- Access and flow issues create potential delay in treatment** Aug-15-2005  
Role: Project Team Member
- Urinary tract infection** May-19-2005  
Role: Project Team Member  
Assigned Tasks: 12
- Medication Delivery Systems: Critical Care Infusions, Pyxis, Transcription & Ordering Errors** Jun-08-2005  
Role: Project Leader

i would like to...

- Enter a New Issue**
- View our Issues**
- View our Resolved Issues**
- View our Projects (16)**
- View Shared Stories**

presentations...

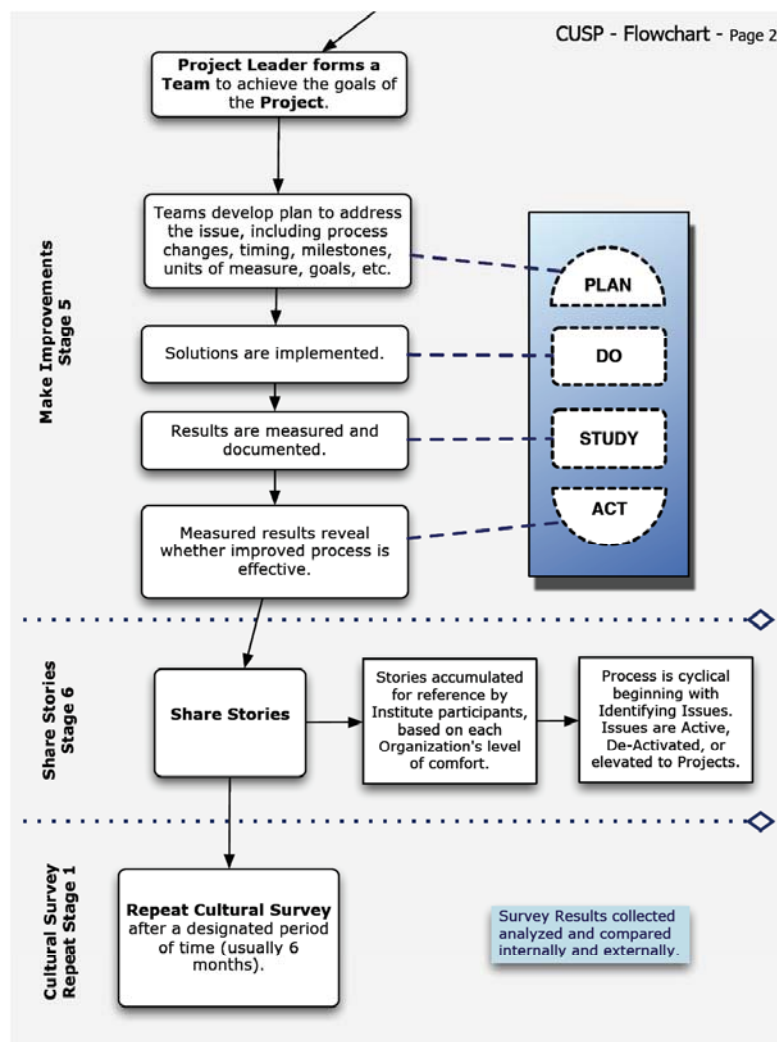
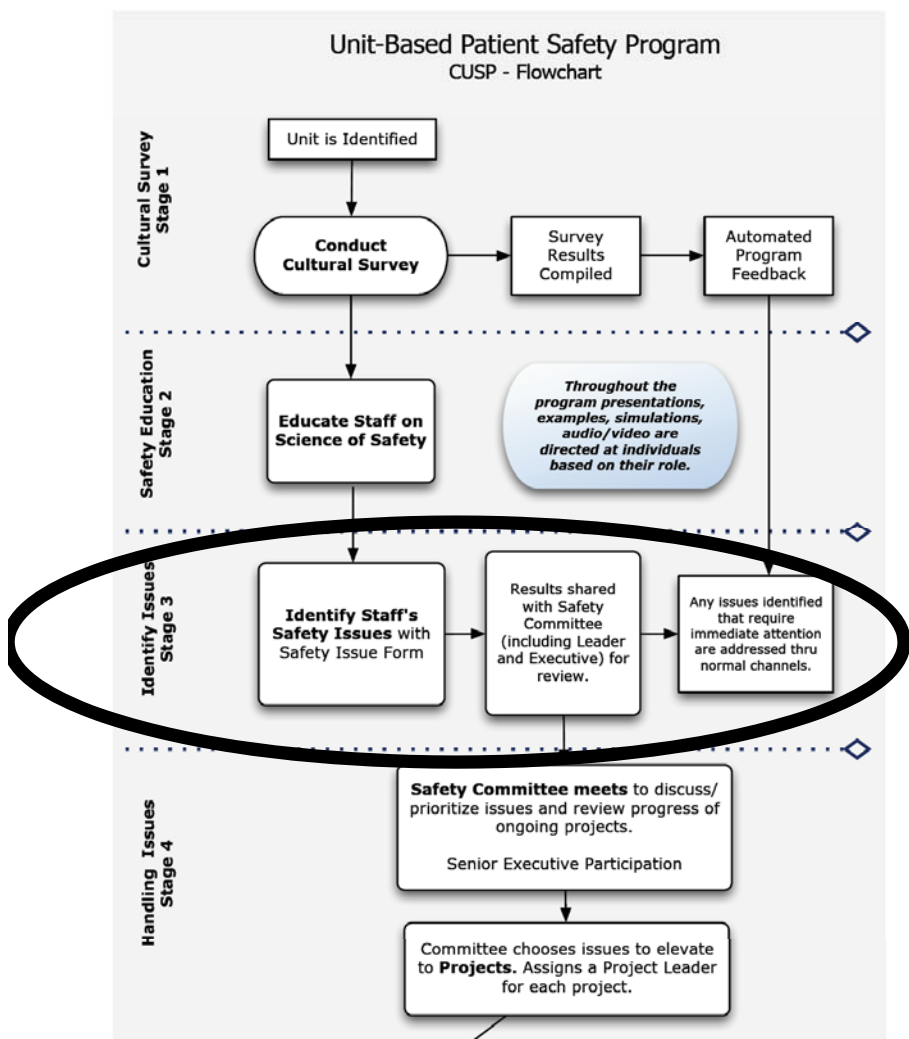
- Improving Patient Safety**  
Normal View  
View Full-Screen
- The Science of Safety**  
Normal View  
View Full-Screen
- Josie's Story**  
Normal View  
View Full-Screen
- Executive Adopt-a-Unit / Walkrounds**  
Normal View  
View Full-Screen

Be a member in more than one program

Online education

Tailored to your profile

# Patient Safety Group -CUSP



Programs

- eCUSP
- Reports

Resources

- News
- Health Updates
- Links

The Group

- About Us
- Testimonials
- Support

Personal

- My Page
- My Profile

My Page

Leader : eCUSP : Septe

Current Program: BCCH Pediatric Critical Care

Welcome, Tracie Northway. Submit safety or quality issues by clicking "Enter a New Issue". Complete the assignments required of a Leader in this program. If you have questions, contact your Program Leaders:

Tracie Northway, . The BC Patient Safety Learning system (BC PSLs) is where all safety hazards, near misses, and adverse events should be reported

program

**BCCH Pediatric Critical Care** (Status, Schedule, Users) Mar-15-2005

Activity Reports

assignments

- Enter a New Issue** Sep-08-2009
- Handle Issues - Elevate/Review/Edit/Resolve** Oct-13-2007
- Handle Projects - Review/Edit Setup** Apr-12-2005

projects

- Dislodgement of lines / catheters / transducers** May-18-2005  
Role: Project Team Member  
Assigned Tasks: 7
- Access and flow issues create potential delay in treatment** Aug-15-2005  
Role: Project Team Member
- Urinary tract infection** May-19-2005  
Role: Project Team Member  
Assigned Tasks: 12
- Medication Delivery Systems: Critical Care Infusions, Pyxis, Transcription & Ordering Errors** Jun-08-2005  
Role: Project Leader

i would like to...

- Enter a New Issue**
- View our Issues**
- View our Resolved Issues**
- View our Projects (16)**
- View Shared Stories**

presentations...

- Improving Patient Safety**  
Normal View  
View Full-Screen
- The Science of Safety**  
Normal View  
View Full-Screen
- Josie's Story**  
Normal View  
View Full-Screen
- Executive Adopt-a-Unit / Walkrounds**  
Normal View  
View Full-Screen

Be a member in more than one program

Quick access to enter events and view your programs

Online education

Tailored to your profile

Direct links to your projects



# Entering a Safety Issue

The Patient Safety Group - Windows Internet Explorer

https://www.patientsafetygroup.org/program/step3b.cfm

File Edit View Favorites Tools Help

The Patient Safety Group

- Enter a New Issue
- View All Issues
- Handle Issues
- Projects
- Share Stories
- Reports

**Resources**

- News
- Health Updates
- Links

**The Group**

- About Us
- Testimonials
- Support
- Contact

**Personal**

- My Page
- My Profile

**Create a HEADING for this Issue.**

Potential for cross contamination related inconsistent isolation procedures

**DESCRIBE (in detail) the Issue:** (ex. how might the next patient in your work area be harmed?)

Transferring teams from various areas within and external to hospital are not observing Level 2 isolation procedures when transferring suspected H1N1 patients. Concerned about cross contamination from staff to staff and to other patients.

**Provide a SUGGESTION/SOLUTION for this Issue:** (ex. how we can prevent this harm?)

Partner with infection control to support transferring teams in best practice. Education around best transferring practices with heightened isolation precautions. Expand Toolbar

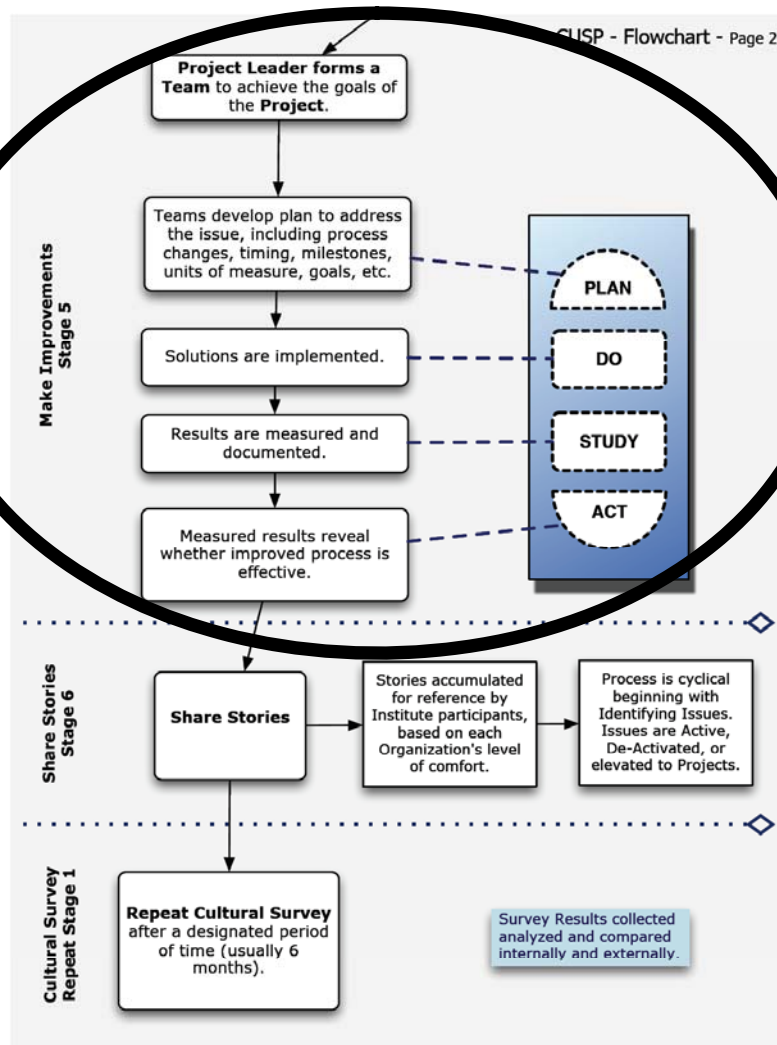
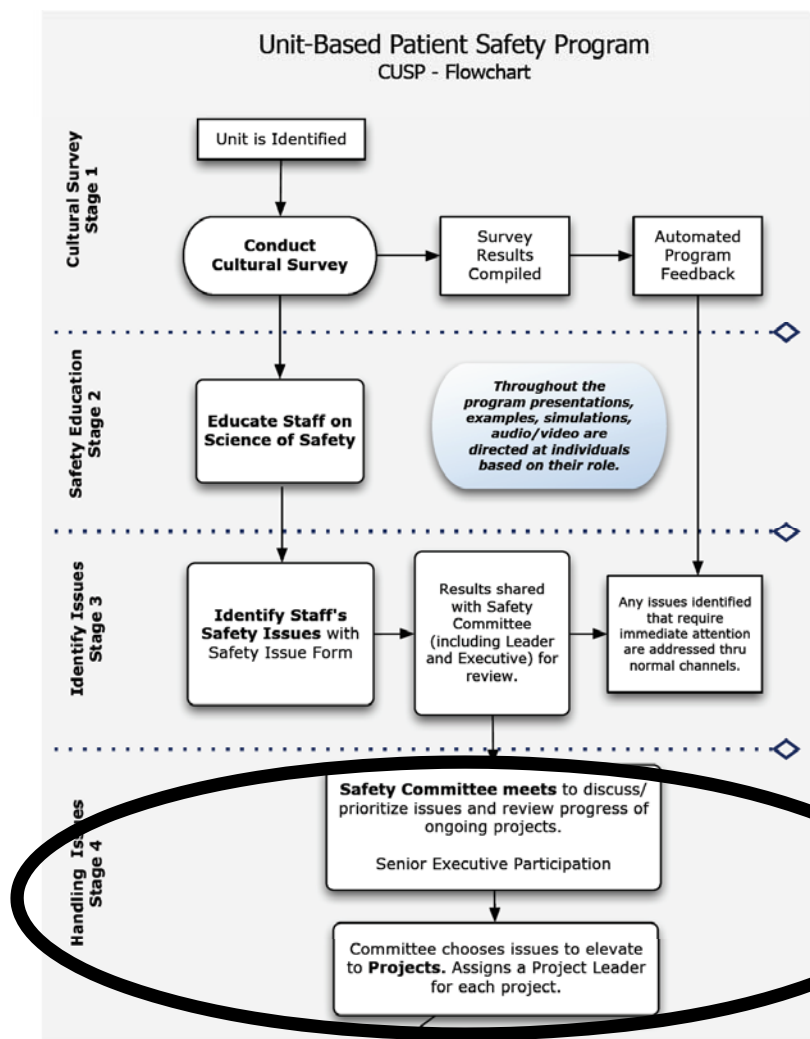
**Identify yourself as the individual submitting this issue.**

Thank you for helping improve quality and safety in your workplace!

Submit Issue

Internet 100%

# Patient Safety Group -CUSP



### Programs

- eCUSP
- Introduction
- How eCUSP Works
- Assess Culture
- Safety Education
- Identify Issues
- ▼ Handle Issues
  - Introduction
  - Review
- Projects
- Share Stories
- Reports

### Resources

- News
- Health Updates
- Links

### The Group

- About Us
- Testimonials
- Support
- Contact

### Personal

- My Page

## Review Issues & Projects > Edit Project

**The project has been updated.**

<b>Project Title:</b>	<b>Start Date:</b>
Standardizing care for patients with disruption in skin integrity.	Oct-06-2005

**Description of the Issue:**  
Inconsistencies in site wide skin care from prevention to wound management for both surgical and non-surgical cases.

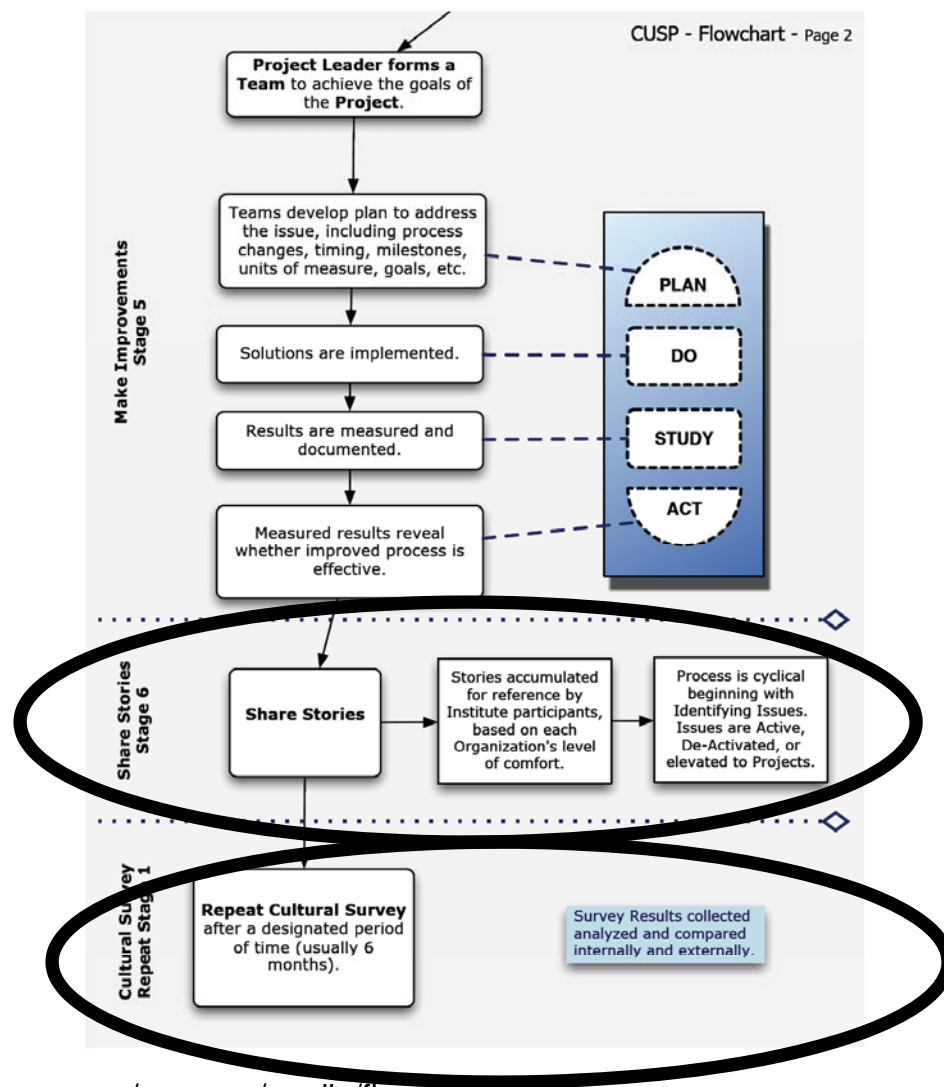
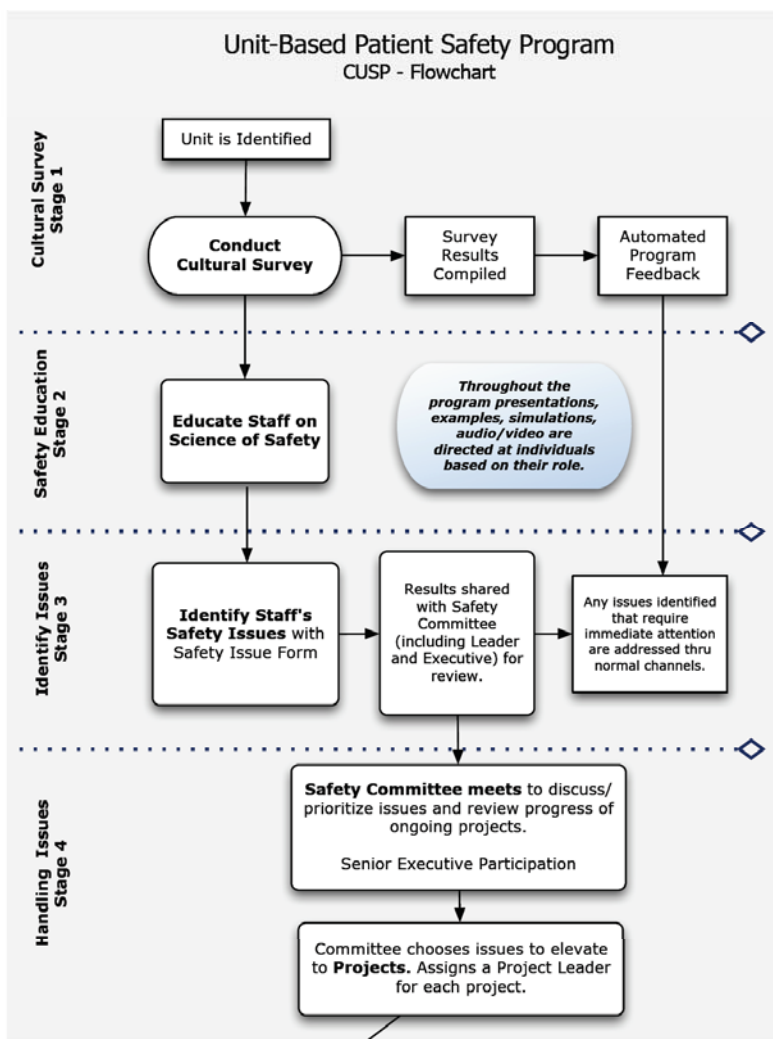
**Project Suggestion/Solution:**  
Standardize care based on best practice for patients with a disruption in skin integrity (e.g., post-operative sites, burns, traumas, pressure sores)

**Project Goal:**  
To provide:  
Consistency in disruption of skin integrity care will be achieved within 12 months.  
Report a decrease of 25% in operative site skin infections within the next 12 months.

Leader	Duration	Reporting Cycle
<a href="#">Caroline Kohlberg</a>	3 Years	1 Month

Project Updates:	Created:
<a href="#">Implementation of tools</a>	09/08/2009
<a href="#">Partnering with HPA</a>	09/08/2009
<a href="#">Late summer/Early fall update</a>	10/13/2007
<a href="#">Spring Update 2007</a>	05/15/2007

# Patient Safety Group -CUSP



# Lessons Learned

- Ensure the key players are at the table; obtain Administrative support
- Re- or establish partnerships with other programs and departments (e.g., Infection Control, Quality, Safety & Risk Management, Emergency, Operating Suites)
- Break out of your silo to move towards standardized care
- Communication through 1:1 discussions is often logistically challenging but well worth it
- Have your evidence
- An effective orientation is important but ongoing orientation and support with actual PSP electronic database is essential



# Lessons Learned (cont'd)

---

- **Be curious**; listen (even if you don't like what you hear); utilize a Coach Approach to conversations
  - Commit to one electronic patient safety database
  - eCUSP superb for site-wide collaborative projects
  - It is another computer program... with reminders... by email
  - Create a dynasty; encourage and support staff to identify patient safety issues and be involved in improvement initiatives
  - Acknowledge wins and losses; Celebrate the wins (Usually involves food!)
-



# For Further Information

---

Tracie Northway

[tnorthway@cw.bc.ca](mailto:tnorthway@cw.bc.ca)

Patient Safety Group

[info@patientsafetygroup.org](mailto:info@patientsafetygroup.org)

Patient Safety Group Site

<https://www.patientsafetygroup.org>

---