Leaning on the CUSP of Greatness

NorthCrest Medical Center Deploys Hybrid Strategy for Safety

A Six Sigma Green Belt, NorthCrest Medical Center CEO Randy Davis, MBA, readily admits he relishes Lean rapid improvement once a problem has been identified. Chief Clinical Officer Angie Beard, RN, MSN, CCRN, is equally passionate about addressing quality issues but is a fan of AHRQ's detailed Comprehensive Unit-based Safety Program (CUSP).

CEO Randy Davis

"A Lean rapid improvement team is a two-week process. I felt CUSP teams took too long. There was no 'rapid,'" Davis said. However, he continued with a laugh, "What we know is I'm the least capable person to make a clinical decision. The MBA behind my name probably solidifies that observation."

The solution? Deploy a unique compromise.

"I took a formal Lean rapid improvement team, and Angie took clinical CUSP teams, and we merged the two ideas," said Davis.

The blended process has been ideal in addressing HEN quality initiatives. Davis said initially looking at the broad scope of work with the HEN was daunting. "The staff felt each topic was an individual mountain … and jokingly, we all said, 'Yes, and we can die on each one,'" Davis recalled. To create a scalable height, he continued, the group decided to unify all topics by focusing on patient safety as the summit to climb.

"When the Tennessee Hospital Association first introduced the CUSP model to us, the 'unit' was defined as being a physical place," Beard explained. In tweaking the NorthCrest system, she continued, "We identify the 'unit' as being a patient."

That shift accomplished several things: 1) it refocused the mission on the individual; 2) it recognized that a patient isn't stationary in one physical place throughout an episode of care; and 3) it sped up the decision-making timeframe since actions were evaluated by their impact on a specific patient rather than on broad metrics over quarterly and annual reports.

"We really did look at a process and everyone who touched that process," Davis said of the hybrid CUSP/Lean strategy. "We took the lowest level of employee and said you are now empowered to make change. Our mission is the antithesis of 'command and control.'"

While the new system empowered employees, it also required serious forethought and accountability. Before a CUSP team is launched, the interested group must present the issue to be addressed to the hospital's quality coordinator, recruit an executive and physician sponsor, clearly articulate how the CUSP will measure outcomes, and set a start and finish date. "They have to meet every two weeks," Davis said. "There is a CUSP accountability meeting where each team has to send a representative and show new, fresh meeting notes."

He added there also is a monthly Quality Review Committee meeting made up of medical staff members, board members, the administrative team and others where CUSP representatives are asked questions … sometimes really tough questions … about ongoing projects. "And then there is a standing agenda item at the board meeting every month about the QRC meeting. There is no hiding," Davis said of accountability.

He noted each CUSP team has an ending point where they move into sustain and measure mode. "However," Davis added, "you also have to have a trigger measure that reactivates the CUSP."

For example, if the hospital had gone six months with out a facility-acquired pressure ulcer and then two occurred in a short span of time, that CUSP would reactivate. Hitting the predetermined trigger is an indication that adherence to protocols has lapsed and staff needs to be retrained on best practices.

Davis and Beard said there are nearly two dozen CUSP projects currently active. The focus ranges from specific clinical issues such as sepsis, pressure ulcers and early elective deliveries to true processes including patient discharge and physician relations.

A CAUTI Case Study

Beard said the hospital recognized there was an issue with catheter-associated urinary tract infections in the med-surg unit. However, before the patient arrived in the unit, he or she had typically passed through other areas of the hospital including the ER, OR, or ICU. To solve the CAUTI problem, therefore, required the work of more than just the med-surg group.

"We brought all levels of clinicians to the table," Beard said of the interdisciplinary CAUTI CUSP team. "In our drive to reduce catheter-associated urinary tract infections, we recognized early on we needed to decrease indwelling urinary catheter (IUC) usage." She added the goal was to eliminate catheter insertion whenever possible upstream in order to decrease CAUTI downstream. "And that's exactly what has happened," Beard stated.

Davis noted, "Year-to-date, they have shown a 230 percent decrease in IUC days." He added that has led to a 69 percent decrease in CAUTI in 2016 so far.

However, Beard noted getting to this point wasn't as easy as simply reminding people to think before inserting. "We kept trying to decrease IUC usage out of the Emergency Department, but it was met with some resistance … so we took them away," she said of locking the catheters up and requiring info from nurses before freeing them. This action, Davis added, was a direct recommendation from the CUSP team.

"We did not want to take away the tools the clinical team needed to do their job and care for the patient," Beard was quick to say, "but we wanted them to think through the process to make sure they really needed a catheter. We went from inserting 55 a month to just five."

CCO Angie Beard

Another change was to flip the script on catheter removal. Beard said in the midst of everything that has to be addressed on a patient's behalf in the Critical Care Unit, it was easy to forget to order a catheter be removed. Now, the mindset is that it is unusual for an IUC to remain. "It is a hard stop," Beard said. "If the physician does not order the discontinuation of the catheter upon transfer out of the CCU, the nurses are to notify that provider to ensure it wasn't an oversight," she said.

"Now we've even gone one step further," Beard continued. "Every morning at 9 am, we have a bed meeting. One of the things we talk about is who has an IUC and whether or not the patient meets the criteria to still have it. If not, the nurse is charged with going back and getting the order to have it removed," she continued of the constant monitoring of a patient's condition in order to dispense with catheters as soon as it is medically safe.

Davis noted that solving one problem sometimes exacerbates another. "For awhile, our falls spiked because patients were having to get up more to go to the bathroom so the CAUTI CUSP and the Falls CUSP put their heads together, and the result was the 'Four Ps.'"

He said four things must now be checked during hourly rounding: position, potty, personal belongings and pain. Each hour, someone checks to make sure patients are positioned safely, see if bathroom assistance is needed, ensure personal belongings are easily reached and check on pain. This extra measure has brought fall rates back down while continuing to lower CAUTI.

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