Stop blood-stream infection

A report last week on hospitals’ success in reducing blood-stream infections shows how the On the CUSP: Stop BSI project is harnessing the power of partnership to solve some of health care’s thorniest challenges.

The Agency for Healthcare Research and Quality (AHRQ) announced that the CUSP (Comprehensive Unit-based Safety Program) project reduced central line-associated blood-stream infections in adult intensive care units by 40% over four years, saving more than 500 lives and $34 million in health care costs (see the story on page 7). The initiative is led by the AHA’s Health Research & Educational Trust (HRET), with support from AHRQ.

It was implemented in more than 1,100 hospitals in 44 states, the District of Columbia and Puerto Rico to take aim at blood-stream infections associated with so-called central lines, which are catheters used to deliver drugs and other liquids directly into patients’ major veins. The project has helped participating hospitals reduce the rate of central-line blood-stream infections nationally to 1.1 per 1,000 central line days in 2012 from 1.9 in 2009, according to AHRQ.

At CUSP’s heart is a simple concept: Tast the wisdom of your front-line clinicians. CUSP uses a culturally driven approach, a checklist of evidence-based safety practices, staff training and other tools to prevent and reduce infections.

It builds on the success of a project launched in 2003 by the Michigan Health & Hospital Association and Johns Hopkins University in Baltimore to reduce the rate of central-line blood-stream infections in more than 100 Michigan intensive care units. Following its success in Michigan, CUSP was expanded to 10 states and then nationally through an AHRQ contract to HRET to guide the program. The state hospital associations are strong supporters.

Improving care is a never-ending march toward perfection, and even one instance of preventable infection is one too many. But hospitals should be proud of what they have accomplished thus far through CUSP. The program is a powerful example of hospitals’ commitment to reducing healthcare-associated infections and a national model for spreading innovation and making health care safer for patients and families.

For more, visit www.onthecuspstopbsih.org.

2012-2013 Comprehensive Patient Safety Leadership Fellows

Judy A. Boerger, RN
Senior Vice President and Chief Nursing Executive
Parkview Regional Medical Center
Fort Wayne, IN

Project: Excellent Care Every Patient Every Day
Deploy smart systems, new technology and Lean design to improve workflow and patient outcomes related to falls, pressure ulcers and catheter-associated urinary tract infection or CAUTI rates.

Alina D. Bulgar
Coordinator, Medication Regulatory and Accreditation Services, Department of Pharmacy Cleveland (OH) Clinic Project: Develop and Implement Look-Alike/Sound-Alike Medication Policy in an Effort to Reduce Preventable Medication Errors
Develop and implement a fully integrated look-alike/sound-alike medication list, policy and standards of practice throughout the health system.

The new class of Patient Safety Leadership Fellows

During the 2012 AHA and Health Forum Leadership Summit, held July 19-21 in San Francisco, the AHA recognized the 11th class of AHA-NPSF Comprehensive Patient Safety Leadership Fellows. The fellowships are sponsored by the AHA and National Patient Safety Foundation (NPSF).

One of the nation’s foremost leadership development programs in patient safety, the yearlong fellowship helps senior practitioners increase their capacity to lead patient safety improvement initiatives and accelerate positive change in their organizations.

Participants take part in a series of learning retreats and webinars, and design and implement a quality improvement initiative – called an Action Learning Project – to improve processes and spread evidence-based safety practices in their organizations.

The 2012-2013 class of leadership fellows is a collaborative effort of the AHA and NPSF, in partnership with the AHA’s Health Research & Educational Trust (HRET), Health Forum, American Society for Healthcare Risk Management, American Organization of Nurse Executives, and the Society of Hospital Medicine. The fellowships are an HRET program.

The program is designed to help the fellows foster a culture of safety within their organization and put newly acquired skills into practice. Throughout its history, the program has inspired senior health care practitioners and teams to promote breakthroughs in performance excellence.

For more information about the fellowship, visit www.ahafellowships.org or contact (312) 422-2933. Application brochures for the 2013-2014 program will be available later this fall.

“The accelerating pace of delivery system transformation for greater quality and efficiency makes a focus on patient safety improvement absolutely paramount for providers ... the fellowship gives health care leaders the tools, the experience and the network they need to lead patient safety improvement initiatives in their organizations and be at the forefront in the rapidly changing environment.”

— Maulik Joshi, HRET president and the AHA senior vice president of research
Leadership Fellows

Jessica D. Dunn, RN  
Director, Care Coordination and Geriatric Services  
Virginia Mason Medical Center  
Seattle, WA

Alison C. Pyle, RN  
Director, Nephrology, Urology, Neurology Units  
Virginia Mason Medical Center  
Seattle, WA

Karina K. Uldall, M.D.  
Section Head, Inpatient/ED Psychiatry  
Virginia Mason Medical Center  
Seattle, WA  
Project: Prevention of Delirium-Associated Adverse Outcomes in a Hospitalized Patient Population

Develop a delirium bundle to address staff, patient and family education and early interventions that address multiple factors associated with delirium.

Ruth Fanning  
Clinical Assistant Professor  
Stanford (CA) University  
Project: Introduction of a New Anesthesia Information Management System at Stanford University Medical Center - A Systematic Approach to Safe and Effective Implementation

Develop a format for testing and troubleshooting new technologies using high-fidelity simulation and comparing effects of various training techniques.

Brenna M. Farmer, M.D.  
Assistant Professor of Medicine, Attending Physician  
Weill-Cornell Medical Center/New York Presbyterian Hospital  
Project: Develop a Patient Safety and Medication Safety Program in the Emergency Department (ED)

Develop a quality and safety program to address resident physician education within an ED and increase reporting of events.

Henry L. Garvin  
CEO, Patient Safety Officer  
San Luis Valley Regional Medical Center  
Alamosa, CO

Kimberly M. Chacon, RN  
Quality and Safety Nurse  
San Luis Valley Regional Medical Center  
Alamosa, CO

Kelly Gallegos, RN  
Director of Clinical Excellence  
San Luis Valley Regional Medical Center  
Alamosa, CO

Gregory F. McAuliffe, M.D.  
Chief Medical Officer  
San Luis Valley Regional Medical Center  
Alamosa, CO  
Project: Improving the Culture of Safety in Surgical Services

Embed accountability principles, cause analysis on harm events to improve follow-up on events report in a surgical unit.

John L. Ginsburg, M.D.  
Vice President of Medical Affairs  
Evangelical Community Hospital  
Lewisburg, PA  
Project: Emergency Room—Door-to-Floor Time

Decrease door-to-transfer time for ED patients by analyzing work flow, identifying bottlenecks and utilizing staff input in improvement.

Estevan Garcia, M.D.  
Chief Safety and Quality Officer  
Brooklyn, NY  
Project: Enhancing Medical Staff Culture and Peer Review

Study and design new strategies to guide hospital-wide implementation of a systematic peer review process.

Richard T. Griffey, M.D.  
Associate Chief for Quality and Safety, Assistant Professor, Division of Emergency Medicine  
Washington University School of Medicine  
St. Louis, MO  
Project: The Impact of “Push” Notification of Computerized Tomography (CT) Study Count on CT Ordering in the Emergency Department

Identify conditions and patient groups at risk for repeat and multiple imaging and assess physician attitudes related to computerized decision-support data that would impact ordering behavior.

Julie B. Lindower, M.D.  
Clinical Assistant Professor of Pediatrics  
University of Iowa  
Children’s Hospital  
Iowa City, IA  
Project: Patient Handoffs

Develop a standardized handoff process and hazard risk analysis related to care transfers and discharge of patients in the neonatal intensive care unit.

Laurel Grisbach, RN  
Director, Risk Management and Patient Safety  
BETA Healthcare Group  
Glendale, CA

Deanna Tarnow, RN  
Director, Risk Management and Patient Safety  
BETA Healthcare Group  
Alamo, CA  
Project: Lessons Learned from Medical Misadventures

Use stories combined with a gap-analysis tool to identify and reduce the opportunity of error occurrences at multiple facilities.

Lucian R. Jones, M.D.  
Compliance Chair, Anesthesiology  
St. Charles Health System  
Bend, OR  
Project: Administration of Sedation Services

Develop a system-wide quality monitoring process to address sedation policy, assessments and standard of practices in the operating room.

Karen Kovich  
Administrator, Patient Safety  
Adventist Health Care  
Oak Brook, IL  
Project: Developing a Multi-Year Strategic Plan for Patient Safety: Creating a Roadmap to a Culture of High Reliability

Create a three-year strategic plan to provide a shared vision around high reliability and alignment on future safety initiatives.

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“... The Patient Safety Leadership Fellowship is a wonderful opportunity for health care leaders who are committed to the delivery of safe, high-quality care ... the experience is rich, as are the relationships and networks that fellows develop in the process.”

— Diane C. Pinakiewicz, president of the National Patient Safety Foundation