Safer ICUs: Eliminating CLABSI Collaborative
PROJECT MANAGEMENT - TASK LIST

Task #	Tasks	Start Date	Duration (days)	End Date
	Assemble an ICU Safety Team - Indentify Roles, Responsibilities and Project Communication			
1	Review, and update if needed the Hospital ICU CLABSI Project Team List to include: a. Unit Champion (Project Leader) b. Nurse Manager c. Physician Champion d. Anyone else who is an integral part of the unit e. Coach (optional) f. Patient Safety Coordinator/Patient Safety Officer If changes or additions to current list please submit to llegrant@ncha.org Please use attached **CLABSI Team Form (CLABS ProjectTeamV4.doc).**	6/29/2009	14	7/13/2009
2	Identify senior executive (VP or Higher) to serve in executive sponsor role. Must be available to round once a month for one hour and must be approachable	6/29/2009	14	7/13/2009
3	Set date for monthly rounding with senior executive	7/1/2009	30	7/31/2009
4	Post ICU CLABSI Project Team List in Unit	6/29/2009	14	7/13/2009
5	Set-up regularly scheduled ICU CLABSI Project Team meetings (at least monthly)	6/29/2009	14	7/13/2009
6	Identify the key stakeholder groups that will need regular project communication and a ICU CLABSI Project Team member responsible for communicating to that stakeholder group	6/29/2009	14	7/13/2009

Task #	Tasks	Start Date	Duration (days)	End Date
7	ICU CLABSI Project Team member - Communicate to key stakeholder groups	7/1/2009	30	7/31/2009
	Review Materials and Tools Currently in use in the ICU			
8	Perform a CLABSI Tool Inventory by checking Collaborative CLASBI Toolkit against what you are using). You may use the **Table of Contents** from the **CLABSI Toolkit** available on the HRET Website, **http://www.hret.org/hret/programs/cusp/manuals.html** , to do this.	6/29/2009	32	7/31/2009
9	Review CUSP Tool Inventory with ICU CLABSI Team. You may use the **Table of Contents** from the **CUSP Manual** available on the HRET Website, **http://www.hret.org/hret/programs/cusp/manuals.html** , to do this.	7/1/2009	30	7/31/2009
	Staff Safety Training			
10	ICU CLABSI Project Team identify a safety event that had occurred on unit, include what led to the event.	6/29/2009	14	7/13/2009

Task #	Tasks	Start Date	Duration (days)	End Date
11	Set up one hour session(s) for ICU Unit Safety Training for all staff members (physicians, nurses, RTs, unit clerks,etc.). Content to include: 1. Science of Safety video (32 minutes) available at **http://www.hret.org/hret/programs/cusp/manuals.html** 2. Discuss with audience: a. Important concepts in the video b. A safety event on the unit and what led to the event c. How principles of safe design could have prevented this event d. How could teams improve communication 3. Ask each participant to complete a **Staff Safety Assessment (Identifying Defects) CUSP Tool-Appendix C** and turn it in to ICU CLABSI Team Use **Science of Safety Attendance Sheet (Appendix B)**	7/1/2009	30	7/31/2009
12	ICU CLABSI Team review all completed **Staff Safety Assessment (Identifying Defects) CUSP Tool-Appendix C**. 1. Collate and categorize into common defects, such as medication process, communication, patient falls, patient identification, supplies,etc. 2. Prioritize the defects using the following criteria: a. Likelihood of harming a patient b. Severity of harm c. How common is it d. Likelihood it can be avoided in daily work	7/31/2009	15	8/15/2009
	Measurement			

PROJECT MANAGEMENT - TASK LIST

Task #	Tasks	Start Date	Duration (days)	End Date
13	ICU CLABSI Project Team complete Exposure Survey baseline **(https://www.surveymonkey.com/s.aspx?sm=dh2cyGWEL4gwAhXA4PYKNA_3d_3d)**	6/29/2009	14	7/13/2009
14	Administer to the entire ICU Staff (physicians, nurses, RTs, unit clerks,etc.) a **baseline** AHRQ Hospital Survey of Patient Safety Culture for all ICUs (website and log in information to follow)	9/8/2009	28	10/6/2009
15	Submit **baseline** (Oct 2008 to Mar 2009) ICU CLABSI rates to SHIM	5/15/2009	45	6/29/2009
16	Submit **monthly ICU CLABSI rates** to SHIM by the **15th of each month** (For example June 2009 data due July 15, 2009)	6/15/2009	548	12/15/2010
17	Submit **monthly completed Teamcheck In Tool** by the **15th of the month** (Available on the MHA website - login information sent individually to each ICU.	7/15/2009	518	12/15/2010

On the CUSP: Stop BSI

Manual for Regional/State Project Directors

Prepared for:
Agency for Healthcare Research and Quality (AHRQ)
U. S. Department of Health and Human Services (HHS)

Contract Number: HHSA290200600022; Task Order # 7

Contract Title:
National Implementation of the Comprehensive Unit-based Safety Program (CUSP) to Reduce Central Line-Associated Blood Stream Infections (CLABSI) in the ICU

Contractor:
Health Research & Educational Trust, Chicago, IL

Prepared by:
Johns Hopkins Quality and Safety Research Group
Michigan Health and Hospital Association Keystone Center for Patient Safety & Quality

May 2009

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How to Use This Manual

This manual is designed to provide context for the work you are about to undertake. It should be viewed as one resource, not as the definitive guidebook to every aspect of this ICU improvement initiative.

Your role as project director transcends unit level challenges. As the individual at the state or cohort level who is the primary liaison with the project leadership team: the Health Research & Educational Trust (HRET), the Johns Hopkins Quality & Safety Research Group (JHU QSRG) and the Michigan Health & Hospital Association's Keystone Center for Patient Safety & Quality (MHA Keystone Center), you oversee the global project. This manual is for you.

As project director, you have several key responsibilities including project management, engaging executives, coaching teams, and measurement and reporting. We have organized this manual to help you address each of those duties.

We provide tools to help with each project director responsibility. Where appropriate, those tools are organized using a model we developed to support transformational change. This model includes 4 stages that answer the following questions:

1. **Engage:** How will this make the world a better place?
2. **Educate:** What do we need to know?
3. **Execute:** What do we need to do?
4. **Evaluate:** How will we know we made a difference?

Each ICU team will be expected to have a team leader who oversees local implementation. The team leader is aided by physician and executive champions as well as a complement of staff who aid with various dimensions of the project. The ICU team leader will have a unit level project manual.

Beyond the general guidance we provide for your individual responsibilities as project director, we also provide explicit guidance for team activities. We give you the tools your teams will use to implement the interventions.

In addition, the toolkits include data collection forms, data element definitions, abstraction guides or instructions for completing the data collection forms, and a timeline outlining when data are due.

The toolkits on the Comprehensive Unit-based Safety Program (CUSP) & eliminating Central Line-Associated Blood Stream Infections (CLABSI) contain detailed suggestions on how to implement each of these interventions using the Engage, Educate, Execute, and Evaluate model.

As project director you must become very familiar with all of the toolkits, since teams will come to you with their questions. We will work with you to understand the toolkit and to understand both your responsibilities and your team's responsibilities for the intervention. We will also provide suggestions in response to your requests and will help you answer team questions throughout the project.

Conference calls, workshops, hospital-based team meetings, and additional tools developed by and shared among project participants will enhance what we provide.

As project director you will become the local expert on all that is contained here, and you will be the official project liaison to HRET, the MHA Keystone Center, and JHU QSRG. This may sound overwhelming, but we know from other project directors that once systems are in place, the time required for project management is very reasonable.

Background

Intensive care units (ICU) are one of the largest and most expensive aspects of U.S. health care. Over 5 million people are admitted to ICUs annually in the U.S., consuming approximately 30% of acute care costs or $180 billion annually. In addition to consuming health care costs, these patients suffer preventable morbidity and mortality. Previous studies suggest that nearly every one of the 5 million patients admitted to an ICU suffer a potentially life threatening adverse event (Andrews, Donchin).

The AHRQ's evidence report/technology assessment, *Making Healthcare Safer: A Critical Analysis of Patient Safety Practices*, identified several interventions that can reduce mortality in ICU patients. The following are among the recommended interventions: reporting adverse events, staffing ICUs with physicians trained in critical care, improving the culture of safety and communication among caregivers, and reducing central line-associated blood stream infections (CLABSI).

In a groundbreaking project, JHU QSRG, the MHA Keystone Center, and 127 ICU teams from Michigan hospitals and health care systems dramatically reduced CLABSI. Those teams used the same collaborative interventions and techniques that we will use in this project. Within 3 months after implementation of these practices, the median rate of infection in the participating ICUs was 0. This rate was sustained throughout the remaining 15 months of follow-up (Pronovost 2006) and appears to have been sustained in the two years since that project formally ended.

Nationally and internationally there is widespread interest in replicating the MHA Keystone Center project in expectation that similar improvements may be realized broadly. As a result, we have embarked on a number of large scale collaborative projects to share what we have learned and to bring these interventions and practices to hospitals and ICUs that share our commitment to improvement. Our approach is to focus on each practice or therapy through explicit interventions and rigorous measurement.

Purpose of the Collaborative

This project is designed to improve the culture of safety and specific clinical outcomes in intensive care units. The collaboration will leverage the experience of the JHU QSRG, the MHA Keystone Center, HRET, and a group of ten states over three years. The specific program components include implementation of the Comprehensive Unit-based Safety Program (CUSP) and specific activities to measure and reduce central line-associated blood stream infections (CLABSI). Participants will have access to tools and resources for planning, implementation, evaluation, and networking during the collaborative.

Responsibilities and Deliverables

Project Leadership Team Responsibilities and Deliverables

The Johns Hopkins University Quality & Safety Research Group

- Assignment of a QSRG liaison to the project for monthly communication (conference call) between the collaborative sponsor and JHU faculty
- Intervention Toolkits
- Content for action phase of collaborative (improvement tools, measurement and data collection tools, and networking opportunities with other participants)
- Faculty leadership on ICU team conference calls

MHA Keystone Center for Patient Safety & Quality

- Assignment of an MHA Keystone Center liaison to the project for monthly communication (conference call) between the collaborative sponsor and JHU faculty
- Project manual for hospital/unit project coordinator
- Web-based system for unit level data collection that is compliant with HIPAA and State health care confidentiality requirements
- Performance reports based on submitted performance data; unit level and aggregate that is compliant with HIPAA and State health care confidentiality requirements
- Ongoing support for state project directors and ICU team leaders.
- Management of annual unit level HSOPS culture survey
- Support of data collection and reporting using the MHA Care Counts Web based data collection system.

State/Regional Sponsor Responsibilities and Deliverables

- Assignment of designated project coordinator to work directly with MHA Keystone Center liaison
- Recruitment of participants (signed team commitment form for each hospital and unit prior to launch)
- All direct operational contact with teams
- Scheduling, financial support, and facilitation of team conference calls.
- Arrangement, financial support, operational support and facilitation of workshops (project launch, end of year one, and end of year two)

This Collaborative has two components: rigorous measurement and interventions to improve both culture and clinical outcomes.

Project Focus Areas

- Year 1: Elimination of Central Line-Associated Blood Stream Infections (CLABSI) (goal: 0 CLABSI for 3 months during first year of project)
- Year 1: Facilitate activities to improve ICU teamwork and communication
- Year 1: Introduce model for leading change—applies in ICU and throughout the hospital
- Year 2: Sustain CLABSI rates (goal: median of zero CLABSI for participating ICUs)
- Year 2: Facilitate activities to improve ICU teamwork and communication
- Year 2: Enhance use of change model

Project Overview

Your role as project director of this ICU improvement initiative is an important one. Participating teams will be implementing evidence-based interventions that have proven effective in ICUs of all sizes and complexities across the entire country. We provide the tools, the evidence, and guidance for the work ahead, but your teams will look to you as the local project expert. Therefore, your role is critically important, not only as the link to resources at HRET, MHA Keystone Center, and JHU QSRG, but also as the primary link to each of your teams.

We expect to learn from each other as the project evolves. Our new relationship as partners will involve not only what we give you, but what you give us. As a focal point for local implementation we provide what we have learned from our experience working with hundreds of ICU teams. You are expected to share with us feedback from your teams and lessons you are learning as you lead this important work.

While each hospital and each state or region has its unique characteristics, there are also many similarities to others. Thus what we learn from our work together may provide important additions to the growing body of knowledge regarding improving quality and patient safety in the ICU. We look forward to working with you during the next year.

Project Management

The Effective Project Director

As project director you coordinate the components—motivated and committed teams and tried and true resources—to achieve project success. You organize the specific timing of activities, provide constructive feedback to individual teams, and motivate the teams to work together for a common goal. We assist you with these activities, but our primary involvement is behind the scenes. We try to make certain you have all the pieces you need. By learning to work together and sharing our knowledge, we move quality and safety forward. Patients and their families benefit from explicit, goal-directed communication, patient-centered teamwork and evidence-

based care. They experience improved outcomes. ICU staff experience the emotional satisfaction of knowing they are minimizing harm and delivering the level of care they would want for themselves or those they love. The culture of safety in the ICU is improved. Teams identify additional opportunities to improve. They become eager to address other quality and safety issues.

This is challenging work, and your role is pivotal. Your responsibilities for project management include logistical, technical, and leadership activities. All must be done well for the project to succeed. You will have frustrations along the way, but as your partner we are here to help you succeed.

Leadership Responsibilities

It is perhaps not surprising that in most highly effective organizations leaders have a strong emotional bond with employees, the mission is clear to all, and individual staff members understand at a personal level their role in company success. Jim Collins wrote about it as the hedgehog concept in *From Good to Great,* John Kotter wrote about it in *The Heart of Change,* and we see it in our own work with ICU teams. Partnership projects that have demonstrated the greatest success are guided by leaders who are passionate about the work, skilled at communicating the vision, relentless in efforts to build relationships, undaunted by setbacks, and most importantly, perceptive listeners.

Your passion and dedication to this project will be reflected by those who walk in your shadow. Two specific groups will particularly benefit from your leadership: individual team leaders and the executives with whom they work. We will share strategies we have seen succeed with each group, and will help you develop new strategies if you encounter unique challenges in your ICU project.

Logistical Responsibilities

Your primary responsibility as project director is to organize this work and keep it moving forward. We understand this is no small task. You create and facilitate all direct communication with teams. We work through you and serve as a resource. Thus, you and your staff must do the following:

- Create and maintain accurate lists of team members and their contact information.
    - It is critical to ensure that the correct person or people are getting the necessary information. Ideally, a project contact will disseminate information internally, but it is suggested that there be at least one additional contact who receives information as a back-up.
- Host monthly conference calls to review intervention content and assess team progress.
    - Operator assisted calls are ideal when there is a presentation planned for the call, but these can be expensive. If it is not an option to use operator assisted calls, instructions to participants should be sent ahead of time to mute their lines either by using the mute function or pressing certain keys on their keypads. These instructions should be repeated at the beginning of all calls to minimize disruption. An example of instructions is included in Appendix A.
- Plan, facilitate, and host face-to-face team workshops twice a year. See Appendix B for suggestions on how to plan for the face-to-face workshops.
- Coordinate annual HSOPS Survey administration (Hospital Survey on Patient Safety)

- Supervise the monthly data collection from each team, review individual and aggregate data summary reports, and work with us to discern what the data are showing.
- Determine the best ways to communicate with your teams on a continual basis, and build on the trust they have in your leadership.

Communication will likely take place through a variety of means: e-mail, Web bulletin boards, phone calls, or other mechanisms that you identify. An "ideal" high level time and task list is included in Appendix C along with a list of project coordinator responsibilities in Appendix D.

Once teams achieve basic familiarity with expectations, they tend to run with the project. We have found that the most effective project directors don't "over direct" or try to micromanage the initiative. Your teams are bright professionals who can only succeed if they make this work their own. They are more than capable. Once you have provided the tools and set the context for collaboration, you step to the sidelines. You become the coach and engineer of project structure, but the teams design and pace their own implementation tactics. This will take some trial and error on your part, but experience tells us that once you have your internal processes established, project management is very rewarding and not overly burdensome. We will help you. In addition to providing written tools to help you get started, we also provide a consistent project liaison. Your MHA Keystone Center liaison will help direct specific questions you may have to the most appropriate JHU QSRG team member for resolution and will be a resource as you guide your teams.

Preparing Well for Project Launch

Once the decision to pursue an ICU collaborative has been made, it typically takes at least 2-3 months for team recruitment, internal process development and infrastructure development within your agency to support project responsibilities. We urge partners not to rush this stage of the activity. Having a solid foundation in place before you begin will make a huge difference in your effectiveness (and stress level) moving forward. When you are ready to begin, coordinate with us to line up faculty, and then schedule your first team conference call.

On the first conference call we will welcome the teams, provide an overview of the project, and the broad timeline for the work. You will review why and how your organization intends to support the teams. You will lay out a schedule of what teams can expect during the immersion phase. This is a period of project preparation over the initial 6-8 weeks and includes a welcoming call and weekly conference calls. These "immersion calls" will feature presentations by Hopkins staff on the core content for each intervention and the topic of data collection and measurement. We emphasize that teams should participate in these calls together if possible and begin formulating a series of questions about what they are hearing. The primary purpose of these calls is to give teams something to think about and begin considering before the first workshop. All content is reviewed at the workshop and great detail is spent on data collection and measurement, since these tend to be the most anxiety-provoking facets of the project at the outset.

The first workshop is one day long, so there is adequate time for teams to process what they are learning, get all their questions answered, and network with other teams and the collaborative partners. The first workshop takes place before any clinical implementation activities. The content calls, preparation for the first workshop, and the first workshop itself are scripted fairly tightly for all new partnerships. This immersion strategy leading up to launch has repeatedly been effective, so unless there are compelling reasons to deviate, we maintain the model. Subsequent workshops are much more malleable to region/agency-specific goals.

Technical Responsibilities

The ICU improvement collaborative requires implementation of evidence-based interventions and data collection to track progress. It is in this technical realm of our work that rigor and standardized implementation are most critical. Unless otherwise indicated, refinement of official data collection tools and processes is an iterative process and the sole purview of the project leadership team. We monitor emerging scientific evidence, assess the experience of the teams with whom we partner, and evaluate the outcomes of their work. Your responsibility for development of measures or data submission tools is limited to informing the project leadership team if teams encounter difficulty using what we provide.

Detailed data collection guidelines and definitions are included in the individual intervention toolkits such as the BSI Toolkit. You will want to review this toolkit very carefully before project launch. Although we have extensive experience with this work, we know that our tools and processes are new to you. We will help you understand this aspect of the initiative. We encourage you to ask us questions and speak up if you need explanations repeated or rephrased. Data reliability and validity are critical to accurately demonstrate project impact, and we are diligent about working with you and your teams on any data issues that may surface.

We will provide a Web-based mechanism to allow access to content, recordings of calls, and sharing of team-generated materials. We encourage all partners to develop their own dedicated Web space where resource materials may be provided for the teams, tools may be shared among participants, and blinded data may be shared.

Once you are clear on the task ahead, we partner with you to help your teams get comfortable with what is expected of them. Together we focus on this at launch and throughout the entire two year initiative.

Executive Engagement

We know from our work with other ICUs that the role of executive champions is extremely important to team success. It is so important that we require identification of an assigned executive for each participating ICU as part of the commitment to participate in this collaborative. Identifying an executive champion is only the beginning, however. Executives need support to become actively engaged in the project and to sustain their involvement. This support will come from local teams, but it must also come from you.

Three questions are particularly pertinent as you develop methods to work with the project executives.

1. What does executive commitment really mean?
2. What is the executive's role in this initiative?
3. How do you maximize executive involvement over the life of this ICU improvement collaborative?

What Does Executive Commitment Really Mean?

We know that initial motivation to participate in this work varies across hospitals and across ICUs within hospitals. We also know that the form and substance of executive commitment varies as well. Your job is to discover what the initial expectations and motivations were and

then help all executives understand what is expected of them and what they can expect in return.

Executives who were inspired to participate by the promise of improved ICU culture may look at a different barometer of success than the executive who hoped to stem ICU nurse turnover, decrease length of stay, or improve clinical outcomes. Some executives may be participating because of peer pressure or concern about loss of competitive advantage if they don't participate. In hospitals with multiple ICUs, we have occasionally encountered executives who were assigned to an ICU without any individual understanding of the project or their role. You can support engagement by making certain each executive understands the project fully. Conversely, you must also understand and respect their motivations to participate. This will allow you to respond to them in a meaningful way throughout the initiative.

In the most successful ICUs, executive champions realize they must be an active member of the improvement team. They understand and adhere to the commitment of their own time and the team time required doing this work. You reinforce their efforts. Put more succinctly: your goal should be to help all executive champions understand the value of the work and the importance of their role.

<u>What is the Role of the Executive?</u>

Basic expectations for executives are spelled out in the Comprehensive Unit-based Safety Program (CUSP) toolkit and in the article, "Senior Executive Adopt-a-Unit." The executive assigned to the ICU should be visible in the unit on a routine basis, encourage safety dialogue with all staff, ("What is likely to harm the next patient?") and meet regularly with the ICU improvement team to review project data and facilitate needed changes. The executive champion is also expected to facilitate opportunities for the ICU team to share highlights of their work, including the results they are achieving. Ideally this includes presentations to leadership, management, and board level committees. It should include appropriate newsletter/media attention so that non-ICU staff and physicians throughout the facility can become acquainted with the project. Our experience is that once the initiative begins, a curiosity develops in the rest of the hospital about "what is happening in the ICU." The executive helps spread the word and advocates for the initiative in all his/her spheres of influence.

Occasionally executives are asked to facilitate specific administrative tasks (e.g. make certain chlorhexidine is available for skin prep, line carts are purchased for each ICU, and full barrier drapes are integrated into line insertion kits).

Once you are clear about executive expectations for the project and they are clear about what their teams expect of them, you can work directly with teams and begin to make it happen!

<u>How Do You Support Long Term Engagement?</u>

In most organizations executives have strategic and leadership functions that have kept them far from the bedside. Thus, this active role in one of the most complex care units in the hospital may be a little uncomfortable at first. We have found that assigning executives explicit tasks is an effective way to support their initial engagement and sustain it over time.

Initially, the format for executive engagement involves making rounds, talking to staff, and asking the safety questions. ("How is the next patient likely to be harmed?" and "What might we do to prevent that harm from occurring?") As teams begin to implement interventions, the

executive is expected to review data and help marshal the resources necessary to achieve strategic improvements. These activities should continue throughout the initiative.

Once the novelty wears off, however, ICU teams face the risk of busy executives becoming less personally involved in the work. At these junctures, or at points when there is important news to share, we partner with you to communicate directly with executive champions. Examples of this might include co-signing letters you send to CEOs and executive champions. Each of these letters is copied to the ICU project leads. The letters may report aggregate progress to date (being careful to address the various motivations for participation). At other times we may address a barrier identified by teams and ask for explicit executive help in removing the barrier. Often we ask not only that executive champions carry out an explicit task, but that they report back when they have done so. This feedback loop reinforces the importance of the executive role. Copying the ICU project leads on the letter strengthens the message: the executive is part of a team that is expecting his/her involvement. These letters often precipitate re-engagement.

We provide examples of letters we have used to help with executive engagement. The tempo of each project is different, and the barriers encountered are not universal. Through close contact with your teams you will learn of the barriers they encounter. We want you to bring to our attention times when you feel a letter would be helpful, and we will help you craft a request for executive action.

As project director you are expected to convene a meeting of executive champions from each ICU no less than once a year to discuss the project and review outcomes. In lieu of a special meeting the project may be an agenda item at an existing executive forum.

We welcome your ideas on other ways to keep executives actively involved in the project over time.

Leading and Coaching Teams

The Technical and Adaptive Work of Change

In *Leadership Without Easy Answers,* Ronald Heifitz discusses the challenge of technical and adaptive work. Simply put, technical challenges are those that can be solved by existing science or technology. Adaptive work, on the other hand, requires us to change our values, attitudes or beliefs. In the work you are about to undertake, the toolkits represent the *technical side* of change. These are the procedures and processes that, if followed, will result in decreased—if not eliminated—CLABSI. The *adaptive* side of change represents the changes that must take place within our selves and our colleagues that lead to the adoption and implementation of the evidence-based tools. Much of the work of leading and coaching is facilitating the adaptive work of change among the ICU teams. Project success is highly dependent on ensuring a balance between technical and adaptive work.

We begin every collaborative initiative with the perspective that each team has limited familiarity with the methods and tools they will use, collaborative leadership, and the teams from other hospitals. Thus, coaching the teams is another important task of the project director. Each team must have a solid command of the content of the interventions. The health care market may require competition between hospitals, but the collaborative teams need to understand that the real “win” comes when they share with and learn from other teams. They must be reminded that small tests of change will be required in order to develop an effective implementation specific to

their organization. They must be willing and able to effectively collect and submit data so that an accurate measure of change can be kept.

Coaching the 4E's

Engage: How will this make the world a better place?

Throughout this initiative and all the related work that follows, teams should expect to receive many requests to explain (and sometimes justify) the project. Each of those requests should be viewed as an opportunity to clarify, refine, and reframe the importance of the work. As new employees join the organization at the executive, medical staff, or unit level, they should proactively be oriented to the project so they know what this project is all about and why the ICU is participating. We have seen that emotional engagement happens most quickly when patient and caregiver stories are used to paint the urgent picture. If there are institution-specific stories that can be shared, those are best. We suggest that engagement tools be reviewed with all project team staff initially, then with all ICU staff and other interested stakeholders as the project evolves. The Josie King video works well with all groups. As with any emotionally laden topic, it is important to structure time for conversation around the tools. Individuals and teams should be provided facilitated time to view or listen, reflect, and share their thoughts about patient safety challenges and opportunities. Once a personal connection has been made, the door is open for engagement. What can be done to rapidly and effectively improve care?

Educate: How can this be done?

It is important that teams have a firm foundation in the project. As the urgency of the patient safety challenge becomes visible, it is likely that at least some team members will want to rush to action. The Johns Hopkins Patient Safety Partnership framework is based on implementation of evidence-based interventions using structures and processes that work. The initial educational activity for all project participants is an overview of the science of safety. Team participation in project conference calls and workshops is an important educational opportunity that should not be missed. As project director, encourage teams to start with education of the defined ICU project team (including executive leader), then expand to include other staff who work in the ICU, medical staff who admit to the ICU, ancillary ICU staff, and other interested individuals throughout your organization. As the project gains momentum, teams will be expected to present the project to leadership groups within their organization. The executive assigned to the team will be asked to facilitate this opportunity, but encourage teams to draw on the project overview as a standardized starting point for their presentation.

Execute: What do I need to do?

Even the most skilled and dedicated project leader cannot single-handedly transform ICU care. As project director you will likely be called to counsel team leaders who "can't get it all done." You will need to coach them in methods of shared team responsibility. Executing the interventions successfully will require that key components of the project are assigned to various individuals with whom the project leader works. Together they will be able to meet project objectives. It is important that all staff understand their role in the ICU improvement effort. We suggest you encourage team leaders to use Project Management tools such as a Gantt chart as a way to keep project implementation on track. Tell them to add tasks to the chart based on their local implementation plan. They should consider posting the Gantt chart and outcomes reports in a highly visible place where staff members are likely to notice them. Leaders should be prompted to promote the project relentlessly and make sure it is a topic at

every staff meeting. Keeping the project "in front" of staff through unit signage, fact sheets in the staff lounge, and bulletin board or poster presentations is an effective way to make project execution a priority.

Evaluate: How will we know we have made a difference?

Broad methods of evaluating impact will draw their value in part based on the initial motivations to join the project. Teams that joined because they wanted improved clinical outcomes are likely to look to those results first when assessing whether they have made a difference. Teams that wanted to improve the culture are likely to look to those trends first as they assess project impact. In reality, ICU care is complex, and identifying whether and how a difference has been made will be unique to each ICU. In your role as project director you can encourage team leaders to take a broad view of project evaluation. Informal methods can be simple and direct. Some ideas: on a weekly basis ask staff if they know about the project, and if so, what they know. Keep track of the number of staff who complete the basic science of safety education. Consider making completion of the educational components a requirement for unit staff. During project team meetings discuss ways to enhance awareness of the project throughout the unit; note interest by the number of team members participating in project conference calls. Give regular feedback to staff and demonstrate how you have responded to their ideas. Be certain to highlight the impact on patient outcomes.

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APPENDICES

Appendix A

"Ideal" High Level Time & Task List

Prework: 3-4 months prior to intended launch

- **Sponsoring Agency Will – Establish Need/Make the Case**
  - Determine Urgency/Importance
  - Assemble the Evidence
  - Clarify Project Aims
  - Develop Preliminary Project Plan: Timeline, Resources, Roles

- **Engage**
  - Letters to executives inviting participation: clear, concise, complete
    - Explain role definitions: teams
    - Commitment: cost/benefit
    - Leadership responsibility
  - Informational Calls with potential participants: establish relationships
    - Succinctly restate the case and project aims
    - Provide explicit timeframe for commitment to participate
    - Review broad parameters of commitment (financial, human resource, intellectual, etc.)
    - Define clear timeline for start and finish of project
      - Share generic overview of project process
    - Q&A
    - Celebrate early commitments

Launch: Months 1-3 — establishing relationships and expectations/start up time

- **Educate**
  - "content calls" with teams – ideally as precursor to face-to-face launch
    - value r/t establishing relationships
    - provides teams time to contemplate the expectations/formulate questions
    - "rules of engagement" – working together
  - establish expectations, format, process for data collection
    - firm timeline for baseline data collection and submission
    - clear expectations re: report generation, data analysis, feedback to individual teams re: monthly data submissions
  - conduct baseline culture of safety survey (Hospital Survey on Patient Safety)

Months 3-5

- **Execute**
  - Initiate conference calls
    - (project director coaching three times per month: Hopkins content once monthly)
  - Initiate data collection (monthly with defined due date)
  - Initiate use of project tracking tool
  - Teams begin internal team meetings/building relationships
  - Executive adopt-a-team

- **Educate**
    - Face-to-face workshop with teams during month 4

Months 3-5 will typically be “heaviest” in need for team support from project directors. These months will also typically demand the greatest infrastructure refinement as data begins coming in, team issues begin to arise, and “project support” takes on local meaning.

Months 6-12 — continue cycling interventions, begin concrete data assessment and feedback

- **Evaluate**
    - Clinical Data
    - HSOPS Results
    - Team Processes

- **Educate**
    - Continue face-to-face workshops with teams two times per year

During months 6-12 project support will likely include multiple feedback loops to executives and teams as we implement the transformational change model of “engage, educate, execute and evaluate.”

Appendix B

On the CUSP: Stop BSI Conference Call Schedule Jan-June 2009

- **Content calls** are operator assisted. Your phone line is automatically put on mute.
- The operator will give instructions on how to signal to ask a question
- **Coaching Calls** are **NOT** operator assisted. You must mute your own phone line. Press [insert instruction specific to your system] to mute your line. *If your phone line is not on mute, everyone on the line can hear talking, chairs moving, intercoms, and other background noise.*
- Do **NOT** place your line on HOLD. *Everyone on the line will hear your hold music or marketing material*.
- When you are ready to ask a question or provide a comment, press [insert instruction specific to your system] again to unmute your phone, introduce yourself, and then proceed.

Following these instructions will help facilitate our calls and hopefully make these calls more user-friendly for all teams.

Date and Time	Topic	Dial-In Number	Call Title Confirmation #

Appendix C

On the CUSP: Stop BSI
Meeting Planning Guide

General Instructions:

Registration: Set up outside of the room with name badges and any additional handout materials. Have materials handy for creating extra name badges. Staff should be in the registration area at least 15 minutes prior to registration.

Room Set-up: Set up crescent rounds of no more than 8, with water on table, note pads, pens, and any additional hand out materials, if not at registration. Additional items may be a give-away such as hand sanitizers and state association promotional items.

A/V: Set up two screens in front, podium on riser with conference monitor, 2 lavaliere mics (one for presenter, one for getting the next person ready) and 2 hand held mics for Q/A. Provide high-lumen projector (depending on size of the room), loaded presentations on laptop prior to event, slide advancer for speaker, and A/V tech in room all day. Entire workshop is audio-recorded for website playback. Wireless internet available.

Continental Breakfast: Serve 1 hour prior to start time
Available all day: Water
Morning Break: Soda, coffee, and tea
Lunch: Suggest plated lunch in nearby room.

Sample Agenda:

7:00	Registration
8:30	Introductory Comments
9:00-9:30	Who Are We and Where Are We Going?
9:30-10:00	Leading Change
10:10:30	CUSP
10:30-11:00	Break
11:00-11:30	BSI
11:30-12:00	Measurement & Data Collection
12:00-1:00	Lunch
1:00-1:45	Pre-mortem Discussion & Debrief
1:45-2:30	Project Management
2:30-3:30	Team Time
3:30-4:00	Team Report Outs
4:00-4:15	You're Not in Kansas Anymore--Adjourn

Appendix D

On the CUSP: Stop BSI
ICU PROJECT COORDINATOR RESPONSIBILITIES
(Including, but not limited to the following):

- Correspondence with ICU teams
    - Creating and maintaining team contact information
    - Answering phone and email questions – requires communication with faculty, staff, or tracking down information before responding
    - Providing resources, articles, presentations, etc. via email
    - Preparing & sending email announcements

- Data management
    - Process – All data should be entered into MHA Care Counts
        - Monitoring Data Status Reports in MHA Care Counts
        - Sending emails to the Project Contact at facility that is missing one or more data pieces

    - Analysis & Report Generation
        - Running collaborative level reports on a regular basis to evaluate statewide progress

- Hospital Survey on Patient Safety management
    - Identifying Hospital and/or ICU coordinators for the survey process
    - Sending emails to coordinators
        - Enter tracking information
        - Survey links
        - Reminders with tracking updates
        - Survey administration end

- Conference calls
    - Preparing and sending email announcements and handouts for conference calls
    - Preparing and distributing conference call schedules
    - Participating in conference calls