



# Comprehensive Unit-based Safety Program or CUSP

## Sustaining Safe Care: The Penguin Project

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*Adapted from "On the CUSP: Stop HAI"*



# Lessons Learned from the Field ~

## Why CUSP Is Important



For improvement projects to succeed equal attention must be given to the technical work ( science, evidenced-based practices) and socio-adaptive work (culture, communication, teamwork)



Differences in unit culture should be considered during project development and implementation



Team members must be held accountable for evidenced-based practice compliance



Teamwork must replace a hierarchical culture

# Key Concepts

- Culture is local
  - Implement in a few units, adapt and spread
  - Include frontline staff on improvement team
- Not linear process
  - Iterative cycles
  - Takes time to improve culture
- Couple with clinical focus
  - No success improving culture alone
  - CUSP alone viewed as 'soft'
  - Lubricant for clinical change

# Learning from Penguins

*"Our Iceberg Is Melting: Changing and Succeeding Under Any Conditions" is a simple fable about successfully responding to change in an ever-changing world, based on the award-winning work of Harvard's Dr. John P. Kotter.*

- A group of beautiful emperor penguins live as they have for many years in Antarctica. Then, one curious bird discovers a potentially devastating problem threatening their home, and when he raises the issue, no one listens to him.
- The characters in the story, Fred, Alice, Louis, Buddy, the Professor, and NoNo, are like people we recognize — even ourselves. Their tale is one of resistance to change and heroic action, seemingly intractable obstacles, and the most clever tactics for dealing with those obstacles.
- It's a story that is occurring in different forms all around us today — but the penguins handle the very real challenges a great deal better than most of us.

# CUSP Supports Kotter's Eight Steps of Change

Kotter	CUSP Toolkit Modules
Step 1: Create a sense of urgency	Understand the Science of Safety
Step 2: Create a guiding coalition	<ul style="list-style-type: none"> <li>• Assemble the Team</li> <li>• Engage the Senior Executive</li> </ul>
Step 3: Develop a shared vision	Identify Defects
Step 4: Communicate the vision	<ul style="list-style-type: none"> <li>• Understand the Science of Safety</li> <li>• Identify Defects</li> </ul>

# CUSP Supports Kotter's Eight Steps of Change, *continued*

Kotter	CUSP Toolkit Modules
Step 5: Empower others to act	<ul style="list-style-type: none"> <li>• Assemble the Team</li> <li>• Identify Defects</li> <li>• Implement Teamwork and Communication</li> </ul>
Step 6: Generate short term wins	Implement Teamwork and Communication
Step 7: Consolidate gains and produce more change	Identify Defects
Step 8: Anchor new approaches in culture	<ul style="list-style-type: none"> <li>• Understand the Science of Safety</li> <li>• Implement Teamwork and Communication</li> </ul>

# The CUSP Model

- Created through a collaborative effort of the Agency for Healthcare Research and Quality (AHRQ) and state and national-level innovators in patient safety
- Supported by a range of quality and safety improvement models
- Utilized a wide range of safety tools and approaches
- Based on the understanding that all culture is local, and that work to improve culture must be owned at the unit level
- Rooted in the belief that harm is not an acceptable “cost of doing business”



# Is Your Hospital Safe?

- Would you want a loved one to be a patient at your hospital? Your unit?
- Would you want to be a patient in the unit where you work?
- Can you say with 100 percent certainty that you believe that your hospital does everything it can to protect its patients?

# “Just Culture”

A system that:

- Holds itself accountable
- Holds staff members accountable
- Has staff members who hold themselves accountable

# Understanding Risk and Human Behavior

- Human Error: Inadvertently completing the wrong action; slip, lapse, mistake
- At-Risk Behavior: Choosing to behave in a way that increases risk where risk is not recognized, or is mistakenly believed to be justified
- Reckless Behavior: Choosing to consciously disregard a substantial and unjustifiable risk

# CUSP Results

- Heightens engagement of staff and senior leaders
- Improves communication among care team members
- Shares mental models
- Expands knowledge of potential hazards and barriers to safety
- Creates a collaborative focus on systems of care

# Summary

- A Just Culture is a system that holds itself accountable, holds staff members accountable, and has staff members who hold themselves accountable
- A Just Culture environment is ruled by both transparency and accountability and supports improved outcomes by emphasizing both robust systems and appropriate behaviors
- Use the Just Culture principles along with the CUSP principles when assembling the team, engaging the senior executive, identifying defects and employing teamwork and communication

[www.ahrq.gov/cusptoolkit](http://www.ahrq.gov/cusptoolkit)



# Questions?

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