How Health Care Organizations Foster Peer Collaboration to Improve Safety Culture

Article in new issue of The Joint Commission Journal on Quality and Patient Safety

(Oak Brook, Ill., March 30, 2015) Joint Commission Resources today released the April 2015 issue of The Joint Commission Journal on Quality and Patient Safety. The issue features an article on how collaborative improvement networks facilitate peer-to-peer learning, coaching and local adoption. The article, “A Collaborative Learning Network Approach to Improvement: The CUSP Learning Network,” by Sallie J. Weaver, Ph.D., and colleagues, includes case studies from four organizations in the Comprehensive Unit-based Safety Program (CUSP) Learning Network.

The CUSP Learning Network is a multi-institutional collaborative network that has demonstrated effectiveness in improving perceptions of safety culture, as well as care processes and outcome measures. Member organizations have implemented all or part of the CUSP methodology to improve organizational safety culture, patient safety and quality of care. The methodology focuses on empowering frontline care providers to take ownership of unit-level improvement efforts, and also strongly encourages participation by executive leaders in improvement activities.

In the article, these four organizations describe the impact of participation in the learning network in terms of three levels of analysis (unit, hospital and health system):

- Rochester General Health System, Rochester, New York: “Use Storytelling to Inspire Commitment and Spread”
- Einstein Medical Center Philadelphia: “Integrate CUSP as an Organizational Habit”
• North Mississippi Medical Center, Tupelo, Mississippi: “Build Internal Capacity to Speed Intervention Spread”
• Johns Hopkins Hospital, Baltimore: “Construct Core Values Around CUSP”

Common themes among these case studies suggest that member organizations found value in collaborative learning and sharing improvement strategies. The authors state that the CUSP Learning Network “may offer a way to develop an infrastructure for longer-term support of improvement efforts and to more quickly diffuse creative sustainability strategies across organizations.”

Additional articles in the April 2015 issue are as follows:

**Reporting Systems**

**Incident Learning in Pursuit of High Reliability: Implementing a Comprehensive, Low-Threshold Reporting Program in a Large, Multisite Radiation Oncology Department**

*Peter E. Gabriel, M.D., M.S.E.; Edna Volz, M.S., ASQ MQ/OE, CSSGB; Howard W. Bergendahl, J.D., M.S., CPPS; Sean V. Burke, J.D.; Timothy D. Solberg, Ph.D.; Amit Maity, M.D., Ph.D.; Stephen M. Hahn, M.D.*

A large, multisite radiation oncology department designed a comprehensive condition reporting program, with use of a low reporting threshold to focus on precursors to adverse events. In a 46-month period, 8,504 conditions were reported, with 77.9 percent of clinical staff members reporting at least one condition. Ninety-eight percent of conditions were classified in the lowest two of four severity levels, providing the opportunity to address conditions before they contribute to adverse events.

**Performance Measures**

**A Qualitative Analysis of Hospital Leaders’ Opinions About Publicly Reported Measures of Health Care Quality**

*Sarah L. Goff, M.D.; Tara Lagu, M.D., M.P.H.; Penelope S. Pekow, Ph.D.; Nicholas S. Hannon, B.A.; Kristen L. Hinchey; Talia A. Jackowitz; Patrick J. Tolosky; Peter K. Lindenauer, M.D., M.Sc.*
Little is known about how hospital leaders view quality performance measures. Leaders at 131 hospitals across the United States responded to an open-ended prompt that was part of a 21-item questionnaire about publicly reported quality measures. Although some of the hospital leaders supported the concept of measuring quality, the majority criticized the validity and utility of current quality measures. The ability of such measures to stimulate improvement may be limited without greater buy-in from hospital leaders.

**Patient and Family Engagement**

**Bringing Central Line–Associated Bloodstream Infection Prevention Home: Catheter Maintenance Practices and Beliefs of Pediatric Oncology Patients and Families**

*Michael L. Rinke, M.D., Ph.D.; Allen R. Chen, M.D., Ph.D., M.H.S.; Aaron M. Milstone, M.D., M.H.S.; Lindsay C. Hebert, M.S.P.H.; David G. Bundy, M.D., M.P.H.; Elizabeth Colantuoni, Ph.D.; Lisa Fratino, M.S.N., RN; Cynthia Herpst, RN; Michelle Kokoszka, B.S.N., RN; Marlene R. Miller, M.D., M.Sc.*

A survey was conducted regarding pediatric oncology patients' and families' use of and beliefs about best-practice central line maintenance practices. Of 110 invited patients and caregivers, 105 participated (95 percent response rate). Dressing change practices were the most difficult with which to comply. Interventions to reduce ambulatory central line–associated bloodstream infections should target appropriate educational experiences for adult caregivers and patients and identify ways to improve compliance with best-practice care.

**Department**

**Rapid Response Systems: Deployment of Rapid Response Teams by 31 Hospitals in a Statewide Collaborative**

*Deonni P. Stolldorf, Ph.D., RN; Cheryl B. Jones, Ph.D., RN, FAAN*

A 17-item survey examined the components of rapid response teams (RRTs) in all 56 hospitals that participated in a nine-month RRT collaborative in a southeastern state of
the United States. Responses, provided by administrators or their designees at 31 of the hospitals (55 percent response rate), showed that the hospitals were successful in addressing the afferent and efferent limbs of their rapid response systems. However, hospital policies may need to be enacted to ensure that safety/process improvement and oversight processes are addressed.

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