19TH WORLD STERILIZATION CONGRESS 2018

XIII INTERNATIONAL STERILIZATION CONGRESS AND HOSPITAL DISINFECTION

OCTOBER 31 TO NOVEMBER 3
2018 WORLD TRADE CENTER
MEXICO CITY

SCIENTIFIC PROGRAM

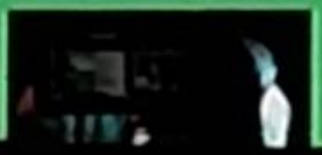
wfhss

btc

Tús Áite do Shábháilteacht Othar
Patient Safety First

Quality Improvement Division



To Err is Human- Building a Culture of Quality Improvement in Decontamination Practice- an Irish Experience WFHSS 2018

November 1999

INSTITUTE OF MEDICINE

Shaping the Future for Health

TO ERR IS HUMAN:
BUILDING A SAFER HEALTH SYSTEM

Health care in the United States is not as safe as it should be—and can be. At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented, according to estimates from two major studies. Even using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.

Medical errors can be defined as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Among the problems that commonly occur during the course of providing health care are adverse drug events and improper transfusions, surgical injuries and wrong-site surgery, suicides, restraint-related injuries or death, falls, burns, pressure ulcers, and mistaken patient identities. High error rates with serious consequences are most likely to occur in intensive care units, operating rooms, and emergency departments.

Beyond their cost in human lives, preventable medical errors exact other significant [illegible] result in total costs (in-

What was happening?

Types of Errors

Diagnostic
- Error or delay in diagnosis
- Failure to employ indicated tests
- Use of outmoded tests or therapy
- Failure to act on results of monitoring or testing

Treatment
- Error in the performance of an operation, procedure, or test
- Error in administering the treatment
- Error in the dose or method of using a drug
- Avoidable delay in treatment or in responding to an abnormal test
- Inappropriate (not indicated) care

Preventive
- Failure to provide prophylactic treatment
- Inadequate monitoring or follow-up of treatment

Other
- Failure of communication
- Equipment failure
- Other system failure

Troyen A., et al. Pre-
1993.

Adverse Events

- "Unintended injuries or complications resulting in death, disability or prolonged hospital stay that arise from health care management".

1 World Health Organization. Baker JL. (2006). *Introduction to Patient Safety Research: Measuring Harm: Retrospective Chart Review*. Available:
http://www.who.int/patientsafety/research/strengthening_capacity/research_classics_baker.ppt#269,1,Introduction

Statistics

2.9%-16% 1 or more AE

10% EU Average

37%-51% Preventable

Most common AE

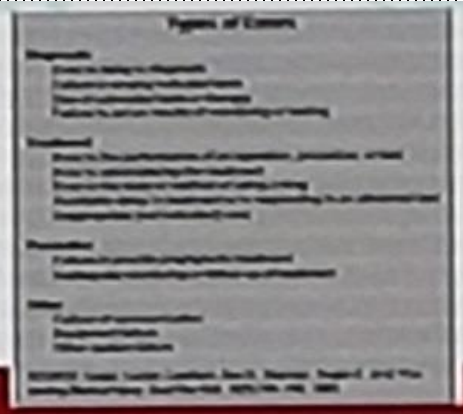
Healthcare-associated infections (HAIs)

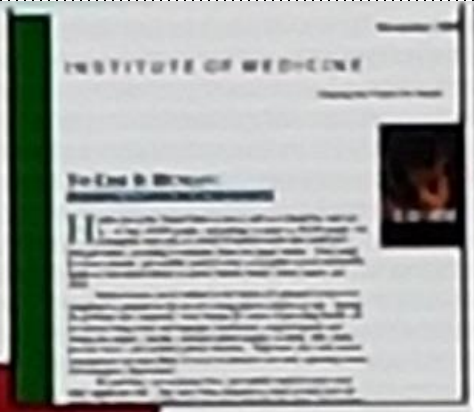
1.4- 1.7 million people affected world wide/ any given time.

Scale and Cost of AE/ Errors

Country	No. of cases/year	No. of deaths/year	Costs/year
UK	100,000	5,000	UK£ 1 billion
USA	2 million	90,000	US$ 4.5 billion
MEXICO	450,000	32/100,000 inhabitants	US$ 1.5 billion
CANADA	220,000	8,000/year	Data not available

16 Years Later





Country	Year	Patients Recalled	Source of Contamination
UK – North Cumbria	2014	357	Machine Failure decontamination failure
USA – Illinois	2014	245	Design of Endoscope presents challenges to the cleaning process- MDR Bacterial Infections
USA – Seattle	2015	135	Design of Endoscope presents challenges to the cleaning process- MDR Bacterial Infections
Ireland	2015	11	Machine Failure

Do we need to change?

Here is Edward Bear coming down the stairs – "bump, bump bump on the back of his head".

He thinks there must be another way of coming down the stairs

If only he could stop bumping for a moment to think of it !

A.A. Milne " Winnie the Pooh" (1926)

Why do we need to do things differently ?

- We keep doing the same things and expect different results?
- Decontamination services reactionary.
- Human Factors- engagement?
- Guide the planning and delivery of services away from crisis management
- and move towards proactive service improvement

(HSE, 2016)

What does Quality Improvement mean for frontline decontamination staff?

"...everyone in healthcare really has two jobs when they come to work – to do their work and to improve it."

Healthcare will not reach its full potential unless quality improvement becomes an intrinsic part of everyone's job, every day, in all parts of the system.

...ntalden and Davidoff 2007

10 Steps to Improving Quality of Healthcare

- Make quality improvement a leadership priority for hospitals.
- Develop the skills and capabilities for improvement.
- Use data effectively.
- Focus on relationships/ engagement and building a quality culture.
- Enable and support frontline staff to engage in quality improvement.
- Work together as a system.

https://www.kingsfund.org.uk/publications/making-case-quality-improvement

Foundation Programme for Quality Improvement in Decontamination Practice

Aim: is to provide an evidence based curriculum that supports the development of QI knowledge and skills

- Working with Decontamination Teams
- 4 days over 5 months
- Project based
- 4 Key Concepts

Concept 1 : Health Service Framework for QI

Concept 2: Method for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

AIM

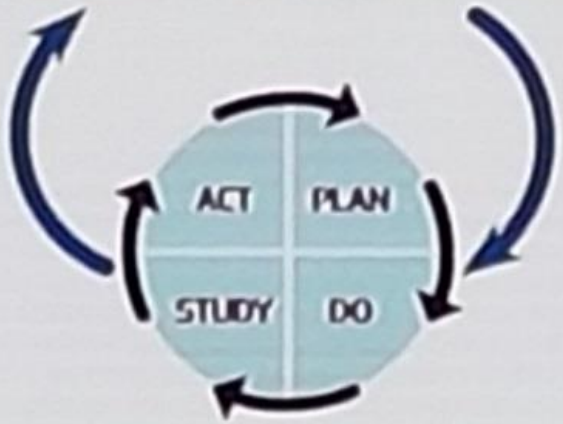
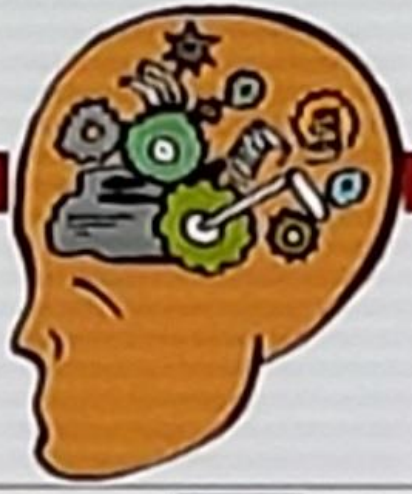


Figure 1: Model for Improvement

Model for Improvement using small tests of change/Plan Do Study Act Cycles
Plan the change, do the change, study / measure to see if there is an improvement – Act on the results and refine if needed.

Concept 3- Measurement



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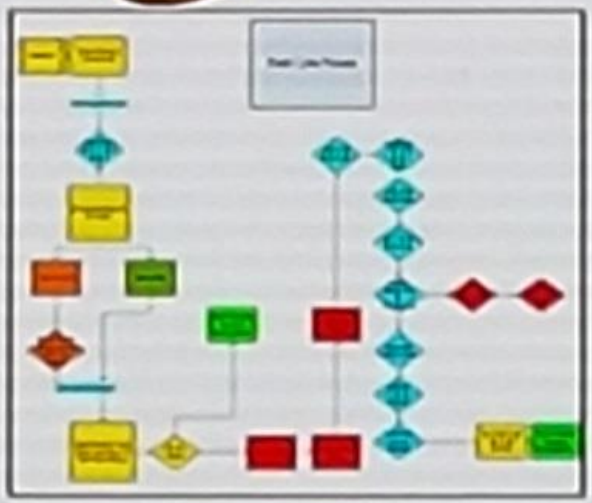
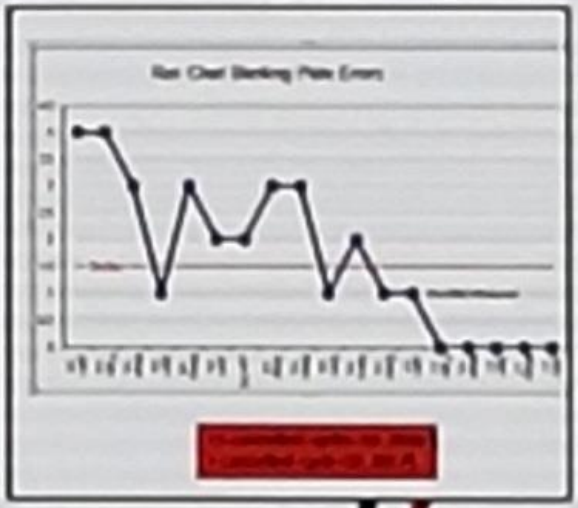
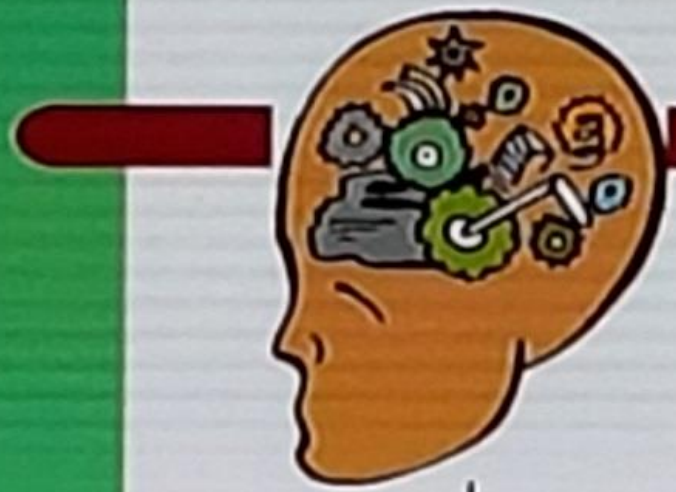




Concept 4 Winning Hearts and Minds for QI



5%

95%

Data analysis

MEASUREMENT FOR QUALITY

Flow analysis

Building the will

STAFF ENGAGEMENT

Stakeholder Management

Communication (planning)

Influencing styles

Basic Tools for Stakeholder Engagement

Stakeholder	Initial support	Level of influence	Key Concerns	Steps to getting buy in
CEO	L	H	Fear / Time / Other Priorities	Get everyone else's buy in 1st – Set up business case – Constant Communication – Data Timeliness of Care -
ADON	L	H	Unaware of data and significance. What the CEO thinks	Decontamination Lead influences her thinking – Data
Decontamination Lead /Committee	H	H	Level of push back from CEO and ADON	Sell it as a Key Quality Requirements, Safe Care, Effective Care, Timely Care
DON	M	H	Level of Push back from ADONS	Get ADONS on board 1st – ensuring business case addresses their concerns – Data Timely Care
Theatre	M	M	Level of noise from other staff in the area Timeliness of Procedure	Key Quality Requirements, Safe Care, Timely Care- support patient throughput – communication and data and ownership
Decontamination Manager	H	H	Lot of staff turnover and changes at present	Work in tandem with newly appointed Supervisor in CDU
Technicians	L	H	Waste is not our responsibility	Allow the frontline staff to come up with ideas and co design the QI constant

How to Win the Hearts?

STAFF ENGAGEMENT

- Involving Team in QI and co- design of the improvement leads to FLO.
- Work with the willing.
- Benefits of Staff Engagement

Positive staff experience

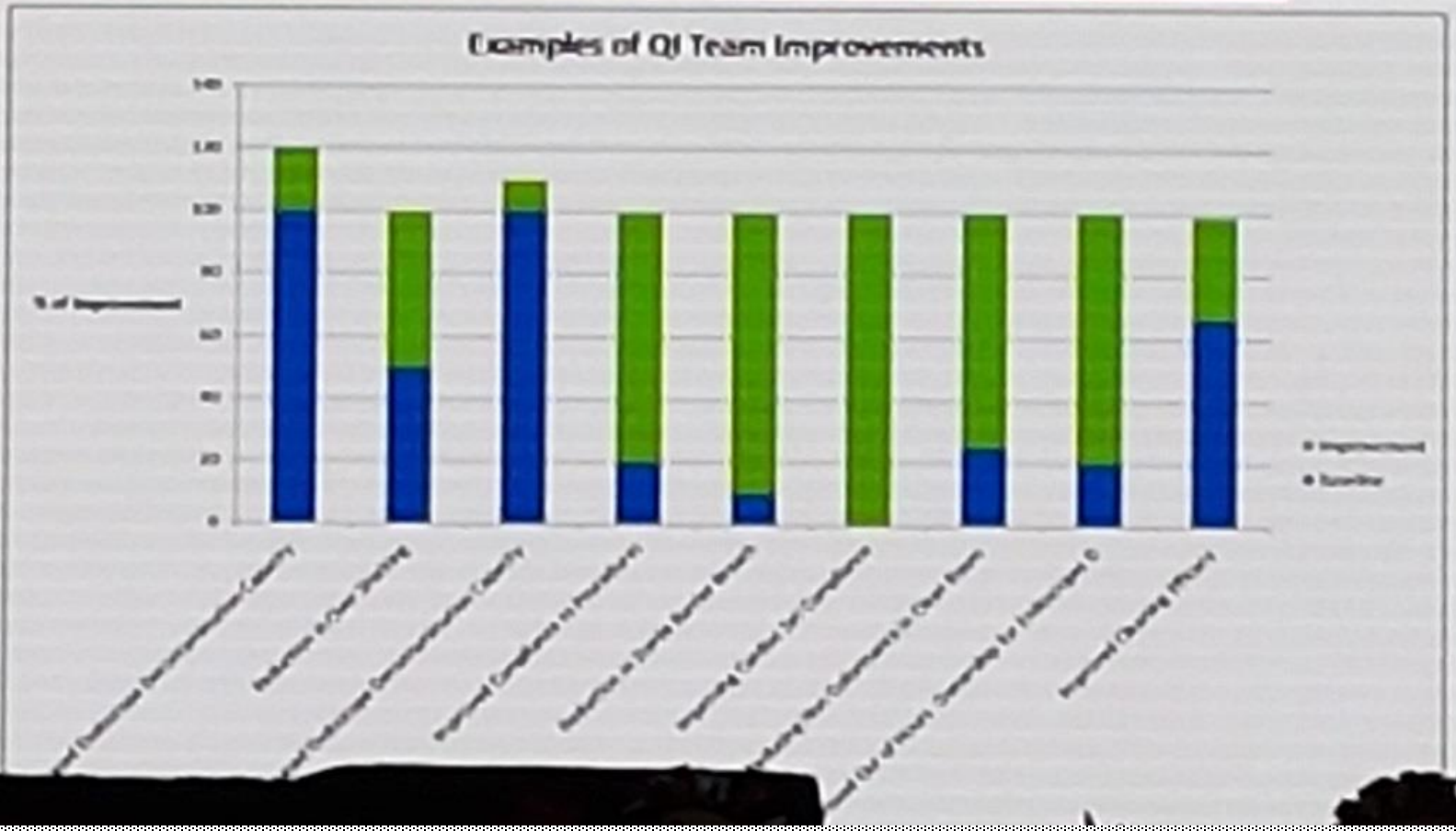
Better patient and service user outcomes

3.5% reduction in Mortality

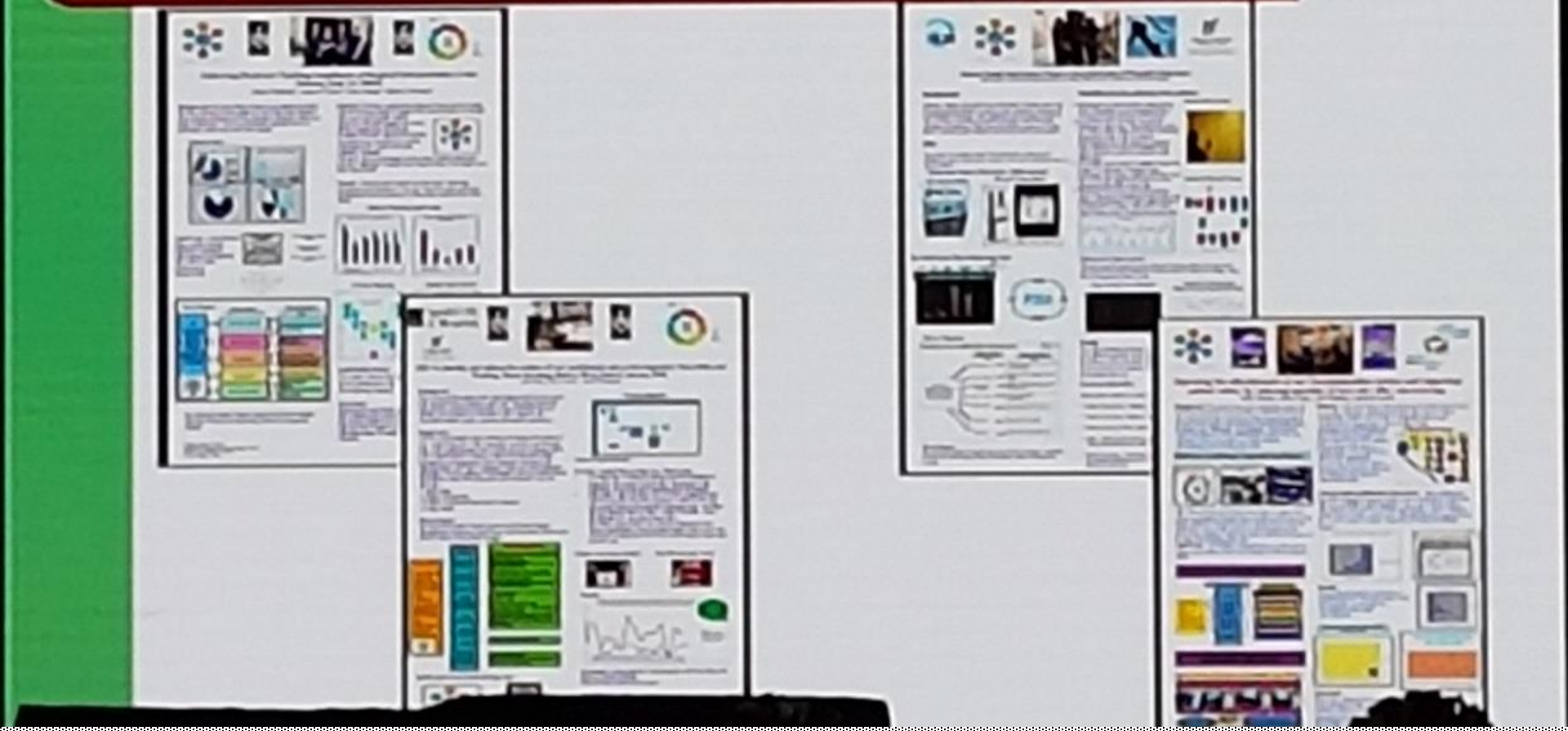
Improve clinical quality and safety

Increased staff productivity (HSE 2018)

Outcomes



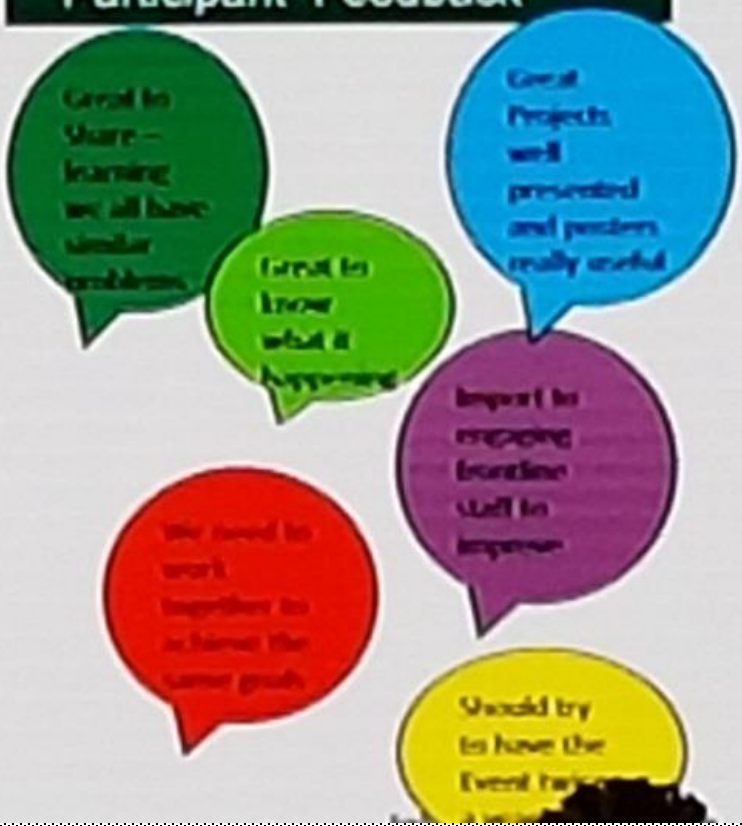
Outcomes



Decontamination Safety Programme Network Event 2018

Spread

Participant Feedback



Next Steps Building and Online Network of Decontamination Improvers

What we have learnt

- We all share the same problems
- Where participants come from different hospitals , but operate the same process e.g. decontamination, they gain as much learning from each other as they do from the course content itself.
- Quality Improvement Programmes , which have traditionally focused on supporting clinical teams, can be successfully adapted to improving decontamination practice.
- Project success has given recognition to our decontamination teams of the complementary

Thank You for Listening !