Improving Care for People in Scotland, A Focus on Deterioration: Prevention, Recognition and Response

Healthcare Associated Infections

Chair – Shaun Maher
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Free wi-fi available
Wi-fi network: delegate
Password: haymarket
### Agenda

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<td>Catherine Stokoe, Diane Stark, Helen Call</td>
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IMPROVING CARE FOR PEOPLE IN SCOTLAND, A FOCUS ON DETERIORATION: PREVENTION, RECOGNITION AND RESPONSE

PVC Prevention & Management
Our Improvement Journey Cardiology (Ward 21/23)
Agenda

- Why Cardiology?
- SAB Impact
- Project Specifics
- What Was happening? The Challenges
- Areas of Non-Compliance
- Raising Awareness
- Learning, What Went Well
- Where Are We Now?
- Next Steps
Why Cardiology?
How did the staff feel?

It was likened to a grief reaction...
The Model For Improvement

When you combine the 3 questions with the …

PDSA cycle, you get …

… the Model for Improvement
High level aim: (OUTCOME MEASURE)
Reach 300 days without having a PVC related SAB.

Low level aim: (PROCESS MEASURE)
To achieve and sustain 95% compliance of the PVC care bundle (insertion, maintenance & removal) to prevent PVC related SAB’s by 29\textsuperscript{th} July 2016.
What Was Happening Weekly?

Scottish Patient Safety Programme
Measure PVC1 - PVC Optimal Care - weekly
Ward 23 Cardiac Care Unit, VHK
Goal Line=95%

Week
What Was Happening Daily?

This pareto chart indicates the number of PVC non-compliance indicated through PVC audits conducted from 13th June for a 5 week period.

The key areas of non-compliance are identified within the 80% percentile (red box).

Indicates the 5 SPSP audit/reporting requirements.

****All Findings
Key Areas Of Non-Compliance

Insertion date & time
Bionector attached & tubing taped down
Dressing intact

We all have a part to play in PVC care & compliance – for our patients sake!

IT’S EVERYONE’S BUSINESS

#SPSConf16
How?

Raising Awareness With Staff
“Making it easy for everyone to do the right thing”
How?

Raising Awareness With Patients, Relatives & Carers

- Implemented prompt posters
- Testing prompt handout cards
- Point prevalence audit
- Patient information leaflets laminated & displayed at bed sides

#SPSPCONF16
PVC Point Prevalence Audit:
02.09.16

**AIM**: To determine the number of PVC devices in use, and of those PVCs in place how many were required using clinical judgment, what category using **DRIFT** criteria and how many used in preceding 24 hours.

The audit reviewed 393 adult inpatients:
- 123 patients had a PVC (31%)
- 125 PVCs in situ (2 patients with 2 PVCs).

- 123 (98.4%) clinically appropriate
- 116 (92.8%) complied with the DRIFT criteria
- 113 (90.4%) used in the past 24 hours (2 X R)

Maternity Ward: 3 PVCs – **100%** in all criteria.

**CELEBRATE GOOD PRACTICE:**
The audit provided assurance that PVC use in the majority of cases is clinically appropriate, actively being used when in situ and reflected compliance with the DRIFT criteria.
Shared Learning & What Went Well

• Through safety huddles & teamwork
• Charge Nurse meetings
• Heightened awareness
• Focus at staff induction (Medical & Nursing)
Next Steps

- Focus effort on 2 key non-compliance areas & test new change ideas
- Continue to raise awareness at every opportunity (MDT approach)
Next Steps – Phase 2

- Explore Visual Infusion Phlebitis (VIP) score system further & agree version, content & escalation plan.

- Review care plan content.

- Introduce PVC insertion & maintenance bundles into patientrack – electronic prompt, compliance and compliance audit!

- Explore front door approach to PVC care and potential change ideas.

- Commit to 6 monthly PVC use point prevalence audits to provide ongoing quality assurance.

- Promote DRIFT to all areas, and include in PVC insertion bundles.
Where Are We Now?

Scottish Patient Safety Programme
Monthly PVC Optimal Care Compliance
Cardiology, VHK
Goal Line=95%

Scottish Patient Safety Programme
Weekly PVC Optimal Care Compliance
Ward 23 Cardiac Care Unit, VHK
Goal Line=95%

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Days Between PVC Related SAB In Cardiology

Interval chart showing Days between Hospital Onset (>48 hrs in NHS Fife)
PVC related Staphylococcus aureus Bloodstream (SAB) Infections
on The Cardiology Unit (Wards 21 & 23 VH M) : NHS Fife
Last updated 26/10/2016

Days since last infection

Days between SABs

183 Days
Since last Hospital Onset
(>48 hrs admission
NHS Fife)
PVC related SAB.
Learning Summary

For NHS Fife:

✓ Insertion date & time clearly detailed

✓ Bionector attached & tubing taped down

✓ Dressing intact

✓ Project phase 2 – build on the learning, raise awareness & compliance

PVC CARE	EVERYONE’S BUSINESS

BUNDLE	COMPLIANCE
easy to do the right thing, every time

Thank you
IMPROVING CARE FOR PEOPLE IN SCOTLAND, A FOCUS ON DETERIORATION:
PREVENTION, RECOGNITION AND RESPONSE

A New Concept in Auditing
Diane Stark, Helen Call, Catherine Stokoe
Agenda

• To give an overview of SICPs
• Pilot sites and project teams
• Current audit process
• New concept in auditing
• Successes of the project
• Challenges of project
• Summary
What are SICPs?

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agent from both recognised and unrecognised sources of infection.

NIPCM, September 2016
What are SICPs?

1. Hand Hygiene
2. Personal Protective Equipment (PPE)
3. Safe Management of Linen
4. Safe Disposal of Waste (including sharps)
5. Safe Management of Care Equipment
6. Safe Management of Care Environment
7. Patient Placement/Assessment of IPC risk
9. Respiratory and cough hygiene
10. Safe Management of Blood and Body Fluid Spillages
Pilot Sites and Project Teams
What happened?

- Different interpretations of the tool depending on who is auditing
- Some areas self audit, others have external auditors
- Variation between SICPs scoring carried out at ward level and QA from IPCT
- Lack of reliable process
What does the picture tell us?

**Bed of roses** is an expression, which means an easy and peaceful life. Most likely based on a rose representing happiness and love.
Time for a Change
## New Concept in Auditing

### Bed Making whilst bed in use

**Hand Hygiene**
- Opportunities taken?
  - After stripping bed
  - When leaving patients environment
- Correct Technique?
  - No jewellery (except wedding band) or bare below elbows
  - All surfaces of hands covered as per 6 steps
  - Hands dried using paper towels
  - Paper towels disposed of as domestic waste
  - No recontamination of hands after disposal of paper towels

**PPE**
- **Aprons** should always be worn during bed making and changed between tasks
- **Gloves** should be worn when exposure to B/BF’s suspected
  - Well fitted?
  - Changed immediately after each person or task complete?
  - Changed if perforated?
- **Eye/face protection** suspected risk of splashing from B/BF’s
- **Remove PPE** Dispose of as clinical waste

**Linen Management**
- **Used** Linen handled appropriately
  - Laundry receptacle at point of use (or alginate bag)
    - Do not place linen on floor, lockers, tables
    - Linen should not be shaken
    - Bag not overfilled
- **Infectious linen** (known or suspected infection or contaminated with B/BF)
  - Same criteria as used linen
  - Securely placed directly into a water soluble alginate bag, then in a clear bag and placed in a red cloth bag

### Key Points
- **B/BF = Blood or Body Fluids**
- **PPE** = Correct use of PPE when worn
- **Compliance with ALL Elements**

### Risk Assessment
- **No suspected contact with B/BF** - No gloves
- **Suspected contact with B/BF** with no risk of splash?
  - Gloves needed
- **Suspected contact with B/BF** risk of splash? - Gloves and eye/face protection

### Tip:
- Gather your kit before you start the task e.g. linen buggy/clean linen. Do you remove PPE?
  - Dispose of as clinical waste

### Observation Numbers

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<th>Hand Hygiene</th>
<th>Key Moment</th>
<th>Staff Group</th>
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Education, Training & Testing

KEEP CALM AND P.D.S.A.
Finding out the issues testing where to put the PPE…

Or where not to put it!
Run Chart SICPs Bed Making Overall Compliance
2016

Following HIS demo,
PPE in room

% compliance

Jun 16  Jul 16  Aug 16  Sep 16  Oct 16

#SPSCon16
Successes!

• Ward Staff keen to be part of the project on most of the pilot sites
• Building relationships between the wards and the IPCT
• Seeing first hand the barriers to compliance frontline staff face daily and working with them to help resolve
• Support from QIF
• Staff ownership of audits
• Learning together as we progress
• Completely different way of auditing
Challenges

• Competing priorities for ward staff and IPCT
• SICPs seen as something extra to do not fully integrated into daily patient care
• Testing out custom and practice and busting the myths
• Staffing shortages and project members on sick leave for a number of weeks
• Completely different way of auditing using episodes of care
What next?

• Reliable implementation of SICPs is vital for patient safety and looking at SICPs as part of patient care helps staff understand the ‘why’ as well as the ‘how’
• Need to understand the challenges faced by frontline HCWs and what the barriers to compliance are
• Provide support for each other in doing this – IPCTs, senior managers, national bodies and frontline staff
• Reliable and robust data
• Develop and test new ‘episode of care’ audit tools
Improving Care for People in Scotland, A Focus on Deterioration: Prevention, Recognition and Response

Our Improvement Journey with Peripheral Venous Cannulation (PVC)

Katy Currie, Senior Charge Nurse, Emergency Department, RHSC, NHS Lothian
Agenda

• Reason for Change
• Introduction
• Communication
• Monitoring
• Ongoing Assessment
Mapping our Journey

• Recognised need for change
• Develop a more functional bundle
Starting Point

• Monthly data review
• Points captured
  • Hand hygiene
  • Gloves worn
  • 70% isopropyl alcohol wipe used
  • Trans semi-permeable dressing used & reflects date & time
“Old Bundle”
My Involvement

• Senior Team Leader
• Take Ownership
• Development of the Bundle
• Direct involvement - planning, assessment, implementation & review
# PVC Insertion Bundle

**PILOT ONLY: RHSC A&E Department**

## PVC INSERTION BUNDLE RECORD

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**OPERATOR NAME**

(print and sign)

**SPECIALITY**
Informing Others of the Journey

- The Emergency Department (ED) team
  - Communication
  - Used a “plan, do, study, act” (PDSA) approach
  - Review
  - Launch
- The wider team

Get everybody on board...
Reviewing the Journey - monthly data review

Before
• Collect 20 samples
  • Time consuming to find the data
• Didn’t record case notes that had no data

Now
• Collect 20 samples
  • All samples have the data
• All relevant case notes have data
  • Audit in Aug/Sept 2016 = 100%
Reflection

• Promote transparency
• Audit using peer review
• Identified areas of improvement
  • Ability to highlight reason for deviation
  • Access to appropriate dressing
The Road Ahead

• Ongoing evolving process
• Data
  • Is it capturing data required?
  • Is the bundle user friendly?
• Global role-out
• Ongoing audit
• Future development
  • System that highlights deviations
  • Become “paper-lite”
Thank you

- obrigado
- Dank U
- Merci
- mahalo
- Közsi
- nacubo
- Grazie
- Thank you
- mauruuru
- Takk
- Gracias
- Dziękuje
- Děkuju
- danke
- Kiitos
Coming next

Panel debate – Safety is sorted; it’s time to move on to another dimension of quality

Pentland Suite – Level 3