An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

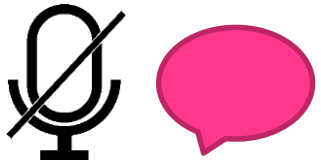
QPS TalkTime

A community of quality and patient safety improvers

18th April, 2022

Safer Surgeries…steps to reduce risk of harm

How we are running today's session



- You will be muted but the chat is open throughout - please post any questions or comments there and we will address them after the presentation.

- If your tech fails, don't worry – we're recording it so you can watch back on the NQPSD YouTube channel and access the slides at your convenience.

- Audio is available via your PC or dial in:

  Telephone no: Irish: 01-5260058 / UK: +44-20-7660-8149

  Event number: 2733 032 9086#

- Please feel free to continue the discussion on Twitter: **@QPSTALKTIME**

  @mapflynn | @Dervlahogan | @annejon24065844 | @Aileen_OBrien1 | @surgeryIreland

  @NationalQPS | #QIreland | #patientsafety

- Please help us to improve our QPS TalkTime Webinars by completing a short feedback form (pop up window before you log out)

- You will receive an email from QPS TalkTime confirming your attendance

- **To get started … we invite you to**

Share using the chat box

- Your name, work and where you are joining us from …

- Finish this statement:

How do you play your part in Safer Surgery…

Speakers today

Anne Jones
Nurse Lead for Quality and Patient Safety Improvement, Ireland East Hospital Group

Dr. Joan Power
Consultant Haematologist

Aileen O Brien
Assistant Director of Nursing, National Clinical Programme for Anaesthesia

In conversation with

Dr. Maureen Flynn, Director of Nursing, QPS Connect Lead with the National Quality and Patient Safety Directorate

Dr. Dervla Hogan, Programme Manager (Operations), QPS Improvement, HSE National Quality and Patient Safety Directorate

Joined in conversation with

Ciara Hughes
Programme Manager, National Clinical Programme in Surgery

Miriam Kennedy
Guideline Development group project Manager

Ms Aileen O'Brien

Nurse Lead

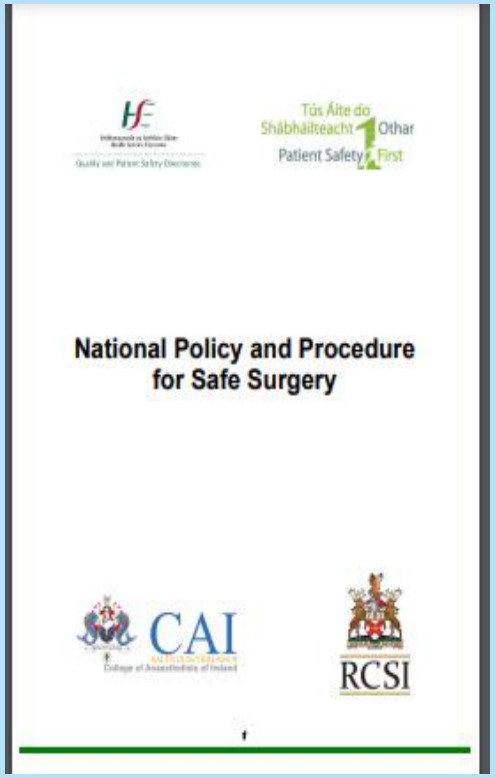
National Clinical Programme for Anaesthesia

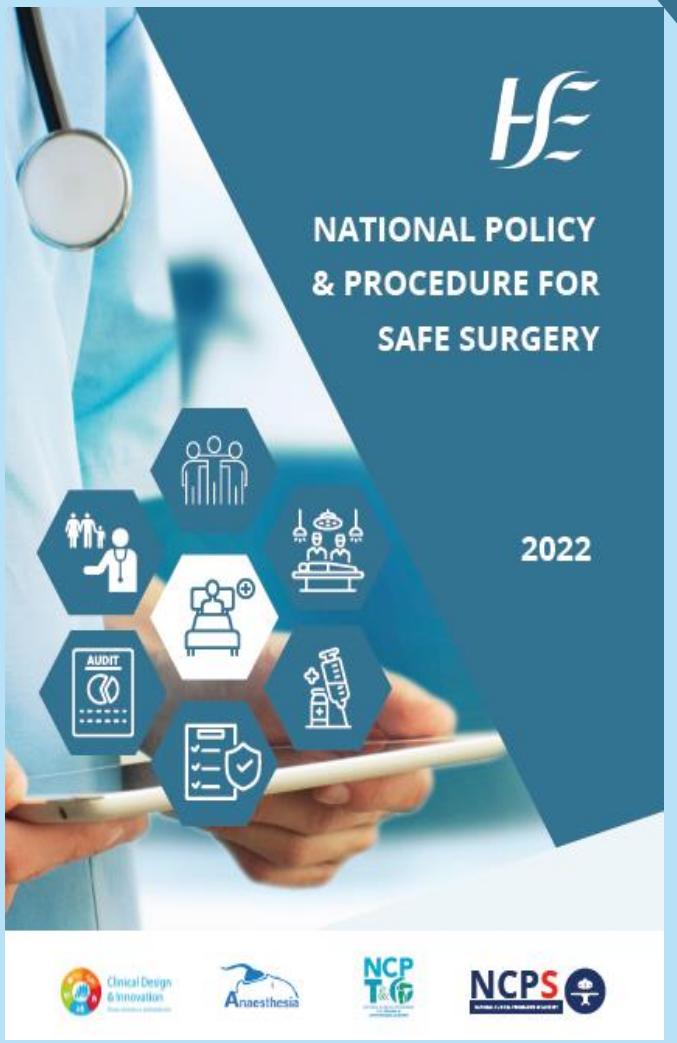
Clinical Design & Innovation
Person-centred, co-ordinated care

Anaesthesia

NCP T&O
NATIONAL CLINICAL PROGRAMME FOR TRAUMA & ORTHOPAEDIC SURGERY

NCPS
NATIONAL CLINICAL PROGRAMME IN SURGERY





Clinical Design & Innovation
Person-centred, co-ordinated care

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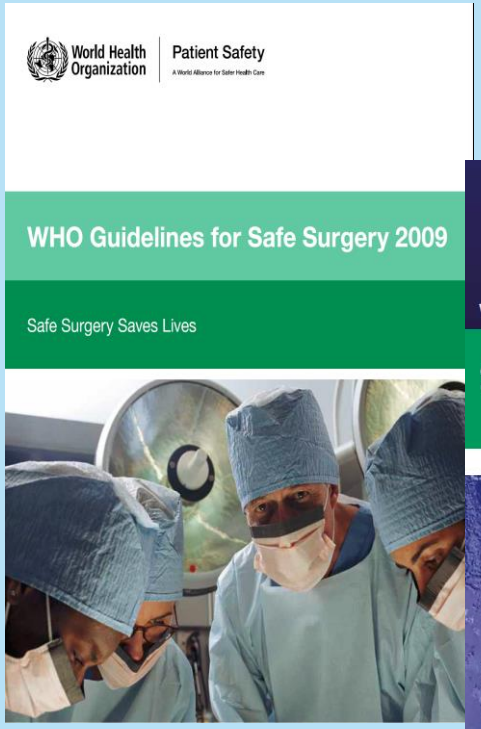

World Health Organization
Patient Safety
WHO Guidelines for Safe Surgery 2009
Safe Surgery Saves Lives


WORLD ALLIANCE FOR PATIENT SAFETY
SAFE SURGERY SAVES LIVES


Patient Safety Strategy
2019-2024


HSIB
National Learning Report
Never Events: analysis of HSIB's national investigations
January 2021

What is New?

Two New Stages

- Briefing
- Debriefing

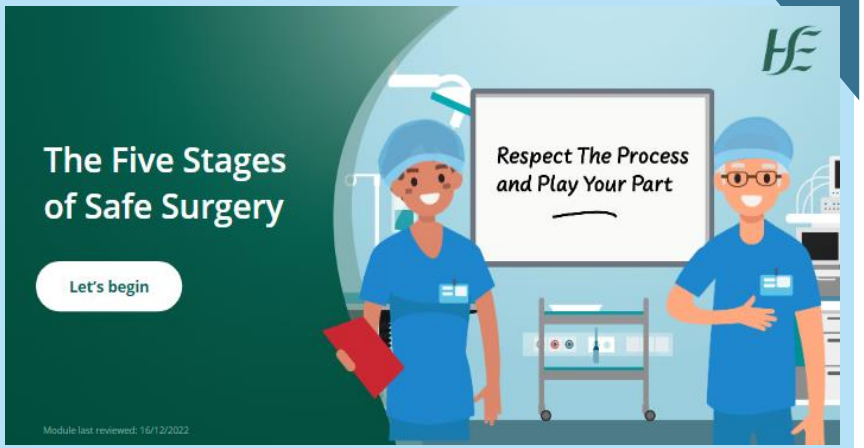
Minimum Safety Checks

Human Factors –Teamwork, Communication

Variations

HSE Land E Learning Module

- Due for Launch - April 26th 2023
- Takes approximately 45 minutes
- Doesn't have to be completed in one sitting
- Knowledge checks as you progress with 5 minute assessment at the end
- Will have CPD points
- Transferrable between hospitals
- Key messages – Respect the Process and Play Your Part



Clinical Audit

- Bi Annual audit
- Audit tool- structures and processes
- Retrospective & Concurrent Observational

  70/30%
- Sample size 20-50 cases
- Analysis, Reporting & Implementation of QI
- 100% Compliance

Ms. Aileen O'Brien

National Clinical Programme for Anaesthesia

aobrien@coa.ie

Thank You

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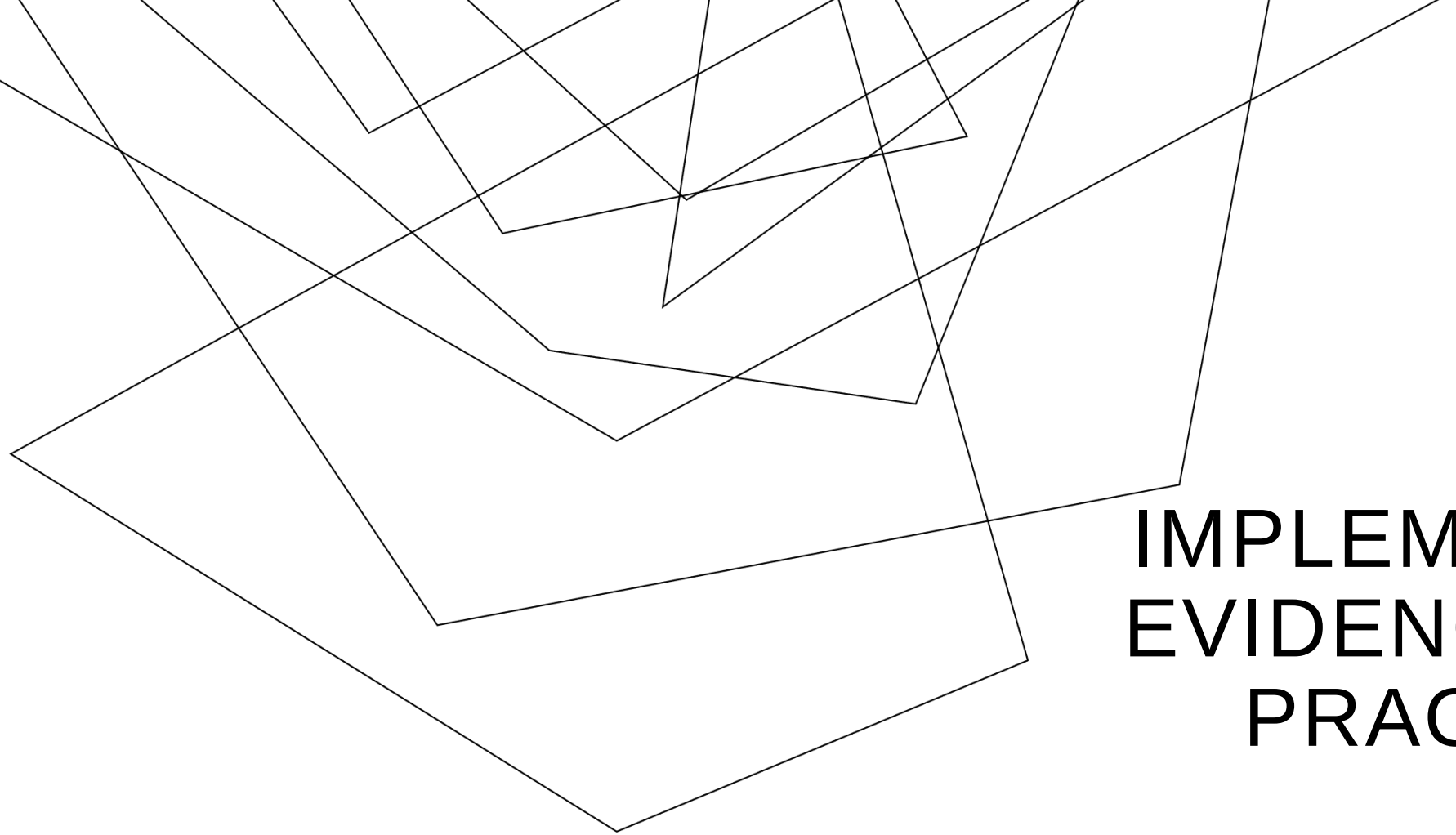


IMPLEMENTING EVIDENCE INTO PRACTICE

Anne Jones
Nurse Lead for Quality and Patient Safety Improvement
Ireland East Hospital Group
April 2023

HOW DO WE GET THERE

It is widely reported in the literature that evidence-based practices (EBPs) take an average of 17 years to be incorporated into routine general practice in health care

and

Only about half of EBPs ever reach widespread clinical usage [1]

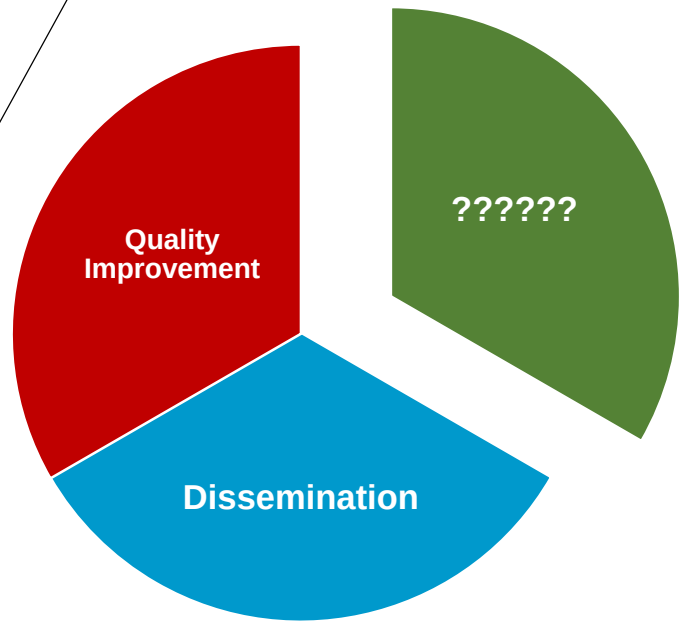
ACHIEVING THE GOAL OF IMPROVING THE QUALITY OF HEALTHCARE.

Dissemination, refers to the spread of information about an intervention; verbal+/- electronic communication, provision of hard copies, launch events, often assisted by educational efforts

Quality Improvement Frequently when we identify a specific problem in a specific healthcare system, we employ QI methods to design and trial strategies to improve the specific problem for that specific healthcare system, e.g. system or process redesign

But

How do we ensure engagement, buy-in, adoption, implementation, commitment, sustainability



IMPLEMENTATION SCIENCE

Implementation science is “the scientific study of methods to promote the systematic uptake of research findings and other EBPs into routine practice.” [2]

Implementation science is distinct from, but shares characteristics with, both quality improvement and dissemination methods. [3,4]

Framework for Improving Quality in our Health Service [5]

LEAD

Build Commitment

STAKEHOLDER PERSPECTIVE

PDSA

TRUST

Navigate

Informal Leaders

promote

TEAM

Local Knowledge

Facilitate

Influence

STRATEGY

partnerships

Co-design

CONTEXT

enable

Peer Influence

GUIDE

engage

CHANGE MODEL

coach

Behaviour Change

Address Barriers

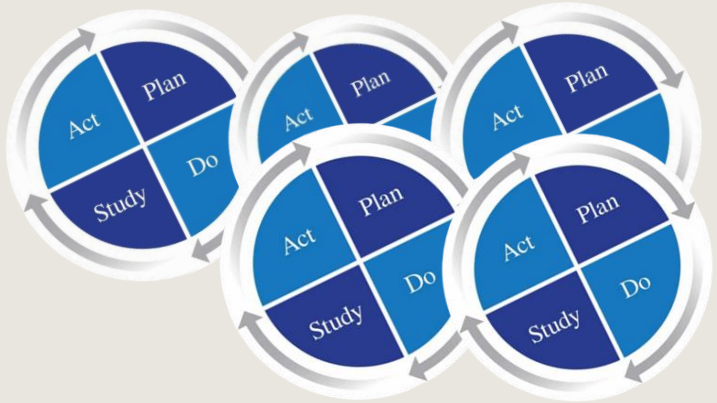
PARTICIPATION

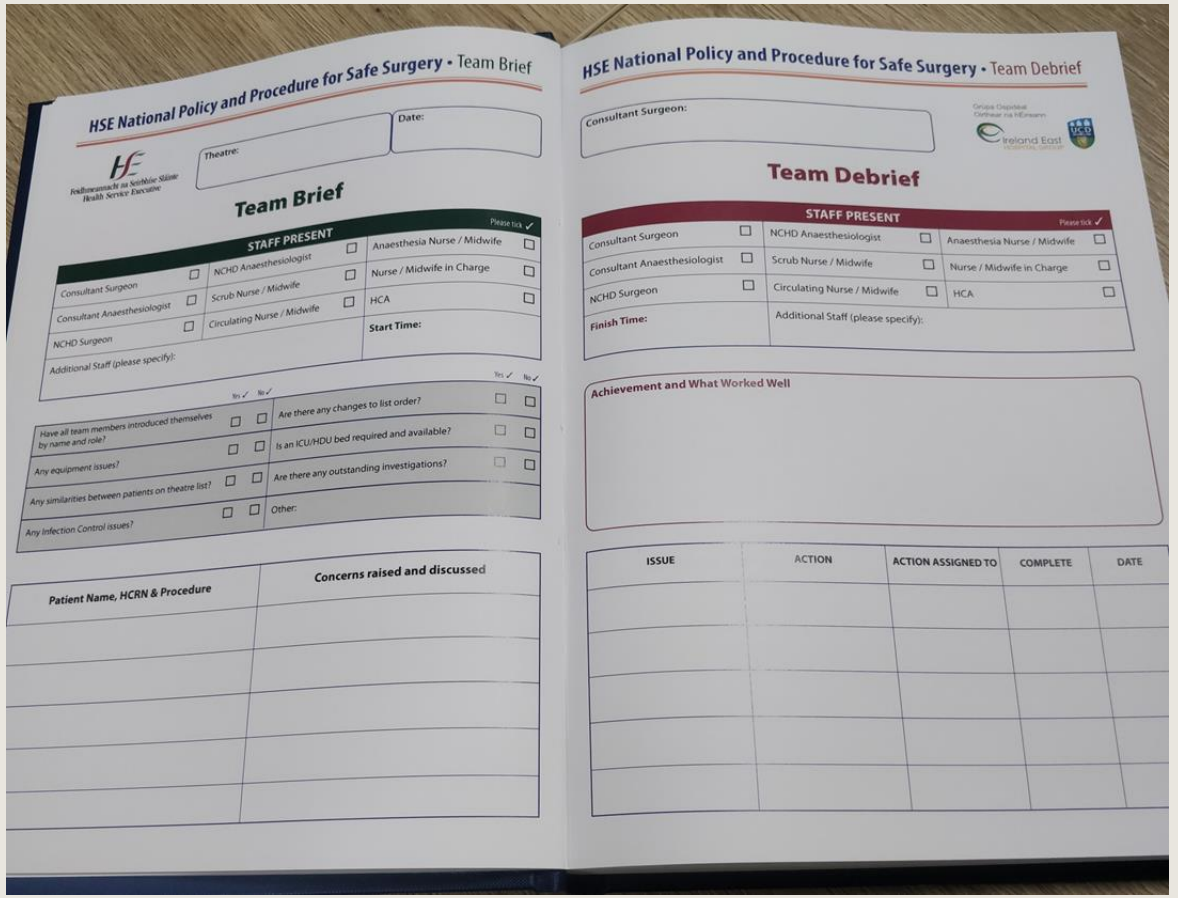
Marketing

COMMUNICATE

INTRODUCTION OF BRIEF & DEBRIEF PROCESSES TO IEHG OPERATING THEATRES

A sub-group was established to design and pilot a process for implementation of the WHO Guidance, which advocates for a team Brief and Debrief to take place for **each theatre list** using ‘a **standardised template’** and following a **‘structured’ approach**.





Mirroring advice from Implementation Science research [4,6,7] a combination of interventions were adopted in order to implement the steps to safer surgeries:

- **Partnering** with theatre managers on **co-production of solutions**, availing of **local knowledge** from target population representatives.
- A series of **PDSA cycles** to optimise content of the Brief & Debrief templates, contributing to **ownership** and **engagement**. An overlapping series of PDSA cycles involving the printing company to develop and refine a book-type format
- Implementation of the book with the Brief & Debrief documentation, to act as a

  physical reminder to staff and as a **Forcing Function** within the daily routine
- **Piloting** in 3 sites, **trusting local problem-solving** to **tailor the process to the local context**
- **Facilitating and encouraging feedback** throughout the Pilot phase to **foster ownership and engagement**.

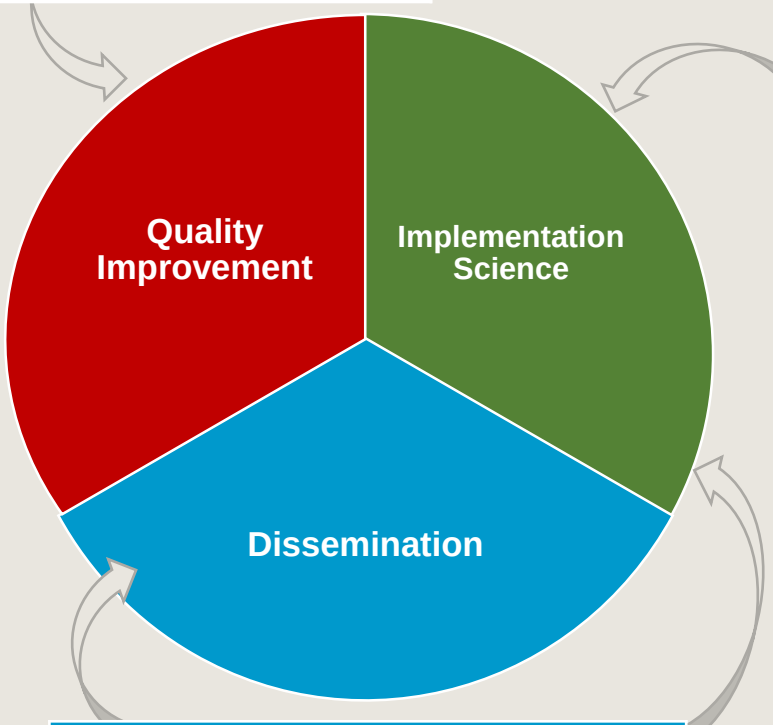
RESULTS: Consensus on the importance of the process with views expressed that it should be rolled out to all areas. **Some local informal leaders** emerged to drive implementation

One site commented that the process implemented surpassed expectations.

LEARNING: The **need for sustained focus** and drive by leaders throughout the implementation
The importance of continuously engaging all involved.

NEXT STEPS

National Audit Programme



E-learning programme 'The 5 Stages of Safe Surgery'

Engagement with sites to purchase a stock of the books to meet their needs
Engagement with printing company regarding the production of the supply of books, reasonably priced and available in adequate quantities to meet demand
Engagement with Theatre Users for the roll out of the initiative to all theatre areas

- Implementation Science is a necessary component in enabling us to 'continue the job of research' [8] supporting its implementation into practice

THANK YOU

References

1. **1. Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. J Roy Soc Med. 2011;104:510–20**

2. **Bauer, MS, Damschroder L, Hagedorn H, Smith J, Kilbourne AM. An introduction to implementation science for the non-specialist. (2015) BMC Psychology: 16;3(1):32.**

3. **Handley, MA et al. "Strategies for implementing implementation science: a methodological overview." (2016) Emergency medicine journal : 33,9: 660-4.**

4. **Leeman, J., Rohweder, C., Lee, M. et al. Aligning implementation science with improvement practice: a call to action. (2021) Implement Science Communications 2, 99 https://doi.org/10.1186/s43058-021-00201-1**

5. **framework-for-improving-quality-2016.pdf (hse.ie)**

6. **O'Cathain, A., Croot, L., Sworn, K. et al. Taxonomy of approaches to developing interventions to improve health: a systematic methods overview. (2019). Pilot and Feasibility Studies 5, 41 https://doi.org/10.1186/s40814-019-0425-6**
7. **Cochrane Effective Practice and Organisation of Care Review Group. Data collection checklist: Cochrane Effective Practice and Organisation of Care, 2002. https://epoc.cochrane.org/sites/epoc.cochrane.org/files/uploads/datacollectionchecklist.pdf**
8. **Bauer, MS., Kirchner, JA. Implementation science: What is it and why should I care? (2020) Psychiatry Research, Volume 283,112376, ISSN 0165-1781, https://doi.org/10.1016/j.psychres.2019.04.025**

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NCEC Clinical Guideline for

gov.ie Departments Consultations Publications

Publication

Unexpected Intraoperative Life Threatening Haemorrhage

From Department of Health
Published on 16 May 2022
Last updated on 17 May 2022

Dr Joan Power MB, FRCPI, FFPath, RCPI Consultant Haematologist

April 18, 2023

QPS Safer Surgeries……Steps to reduce harm

NCEC Clinical Guideline for

Unexpected Intraoperative Life threatening Haemorrhage

Rationale

❑Life threatening haemorrhage-

- **an adverse event of key concern in health**
  - 23% intra-operative, 78% unexpected, 54% OOH **(UK national Comparative Audit, 2018)**
  - Blood loss > 40% blood volume is life threatening (1500-2000ml)
    requires immediate transfusion and management of associated coagulopathy
  - Associated mortality 10 - 11.5% **(UK, RCSI survey 2018)**
  - 32% mortality associated with delay to transfusion in MPH activation
    (UK Haemovigilance system *SHOT*)

- **Ministerial Commission after fatal unexpected intraoperative LTH for National Clinical Effectiveness Committee (NCEC) to develop guideline**

QPS Safer Surgeries……Steps to reduce harm

NCEC Clinical Guideline for

Unexpected Intraoperative Life threatening Haemorrhage

- **Objective and scope**

Develop a National framework for management of adult unexpected intra-operative acute life threatening haemorrhage (excluding obstetrics, trauma, post-op)

across all relevant services and professions in Irish Hospitals,

".. to reduce unnecessary variations in practice and provide an evidence base for the most appropriate healthcare.."

consistent approach to management across all service sites

underpinning structures and processes.

Provide evidence based recommendations for theatre & laboratory staff

guidance to theatre teams and associated healthcare professionals on recommended practices in the following areas -

- Prevention
- Immediate recognition
- Timely response and management

QPS Safer Surgeries……Steps to reduce harm

NCEC Clinical Guideline for

Unexpected Intraoperative Life threatening Haemorrhage

- **Definition**

‘ Anticipatory’ Clinical impact (shock) of on-going major haemorrhage (Vs ‘Retrospective’ Defined blood component use/ blood volume loss over time)

- **activation following rapid identification of actual, or suspected, major haemorrhage, with/ without coagulopathy.**

- **Prompt response like any other resuscitation calls to ensure effective treatment is delivered without any delays to bleeding patients’ ***

Factors contributing to MPH delays *

Poor communication

Delayed Recognition ,unfamiliarity

Delay in Activating and accessing help

Patient movement

Laboratory delays

Blood Transfusion

***S Narayan(Ed),D Poles et al on behalf of SHOT steering group report (2022)**

QPS Safer Surgeries……Steps to reduce harm

NCEC Clinical Guideline for

Unexpected Intraoperative Life threatening Haemorrhage

❑ **management**

➢ **System approach-** Prevention and preparedness
Policies, protocols , communication and documentation

- inc. Safe surgical site, patient transfer protocols,
- Pre-op patient risk assessment and intervention, Surgical checklist individual case

➢ Timely access to transfusion support and appropriate TAT of laboratory testing **Management**

➢ **medical emergency**

- **Activate 'code red'**
- **Control bleeding**
- **Assess and resuscitate (ABC)**
- **Haemostatic resuscitation In defined communication pathway**
With optimal laboratory response , timely release of blood components of
pre-determined red cell: plasma ratios (empiric transfusion- MHP pack)
supported by haemostatic components (without approval of haematologist),

• **Close monitoring of patient** (clinical, cardiac, metabolic , laboratory testing / NPT*) inc. Coagulation , fibrinogen q 30-60 mins

QPS Safer Surgeries……Steps to reduce harm

NCEC Clinical Guideline for

Unexpected Intraoperative Life threatening Haemorrhage

Empiric Transfusion protocols

Support tissue oxygenation, aim to prevent/ reverse coagulopathy early by rapid transfusion in advance of results from blood science testing

Recommendation #12

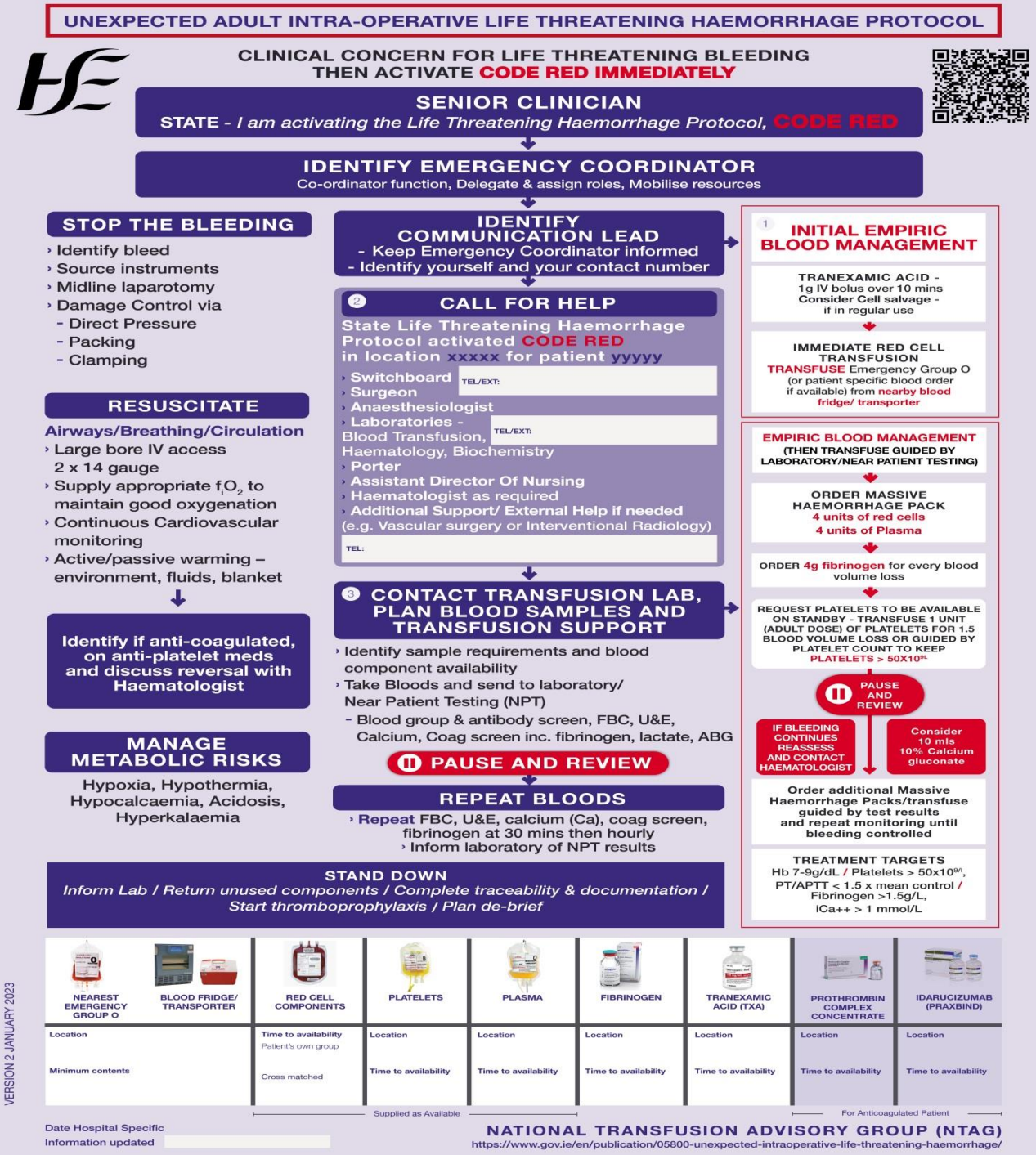
❑ **Transfusion component, derivatives and pharmacological support**

- **Tranexamic acid** Trauma CRASH-2 – reduced mortality
  PPH WOMAN study – reduces bleeding RIP by 1/3, no adverse effects
  (GI HALT-IT study- not indicated for GI bleeding – no reduction RIP , ↑VTE)

- **Red cells** – Provide critical life saving support, tissue oxygenation, assist coagulopathy

- **Plasma** - SD plasma - frozen (reduced coag factors x~ 15 %)
  central role in managing coagulopathy, protective of endothelium
- **Fibrinogen**- Key role for ↓ fibrinogen- early critical event,
  <1g.> 1-1.5bv loss/ replacement.
  insufficient in plasma, ROI Fibrinogen concentrate

- **Platelets**- Consider use for ↓plt- late event > 1.5 bv loss
  but timeline to access variable across hospitals
- **Reversal of anti-coagulation**



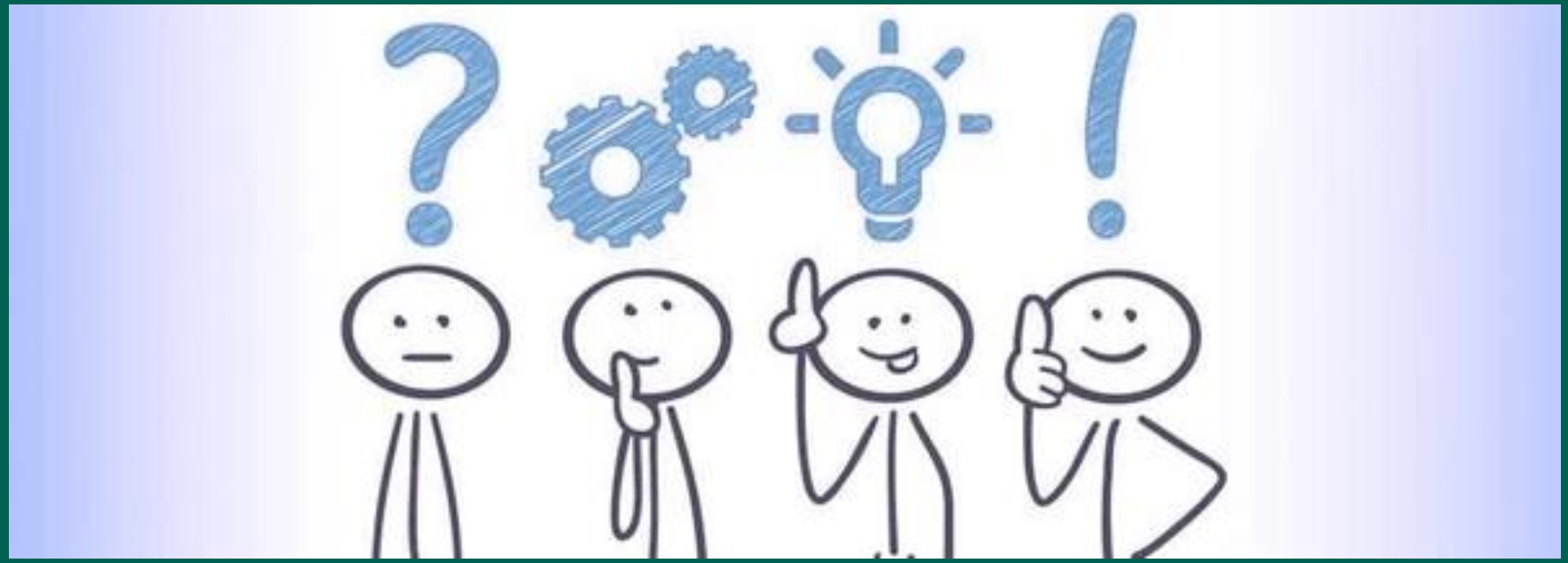
-Communication to hospital Managers/ CEOs to id responsible person lead roll-out at each service site (National Quality & Patient Safety Directorate)

-Circulation of Poster to hospitals

-*Engagement with local stakeholders for Local data capture on Posters*

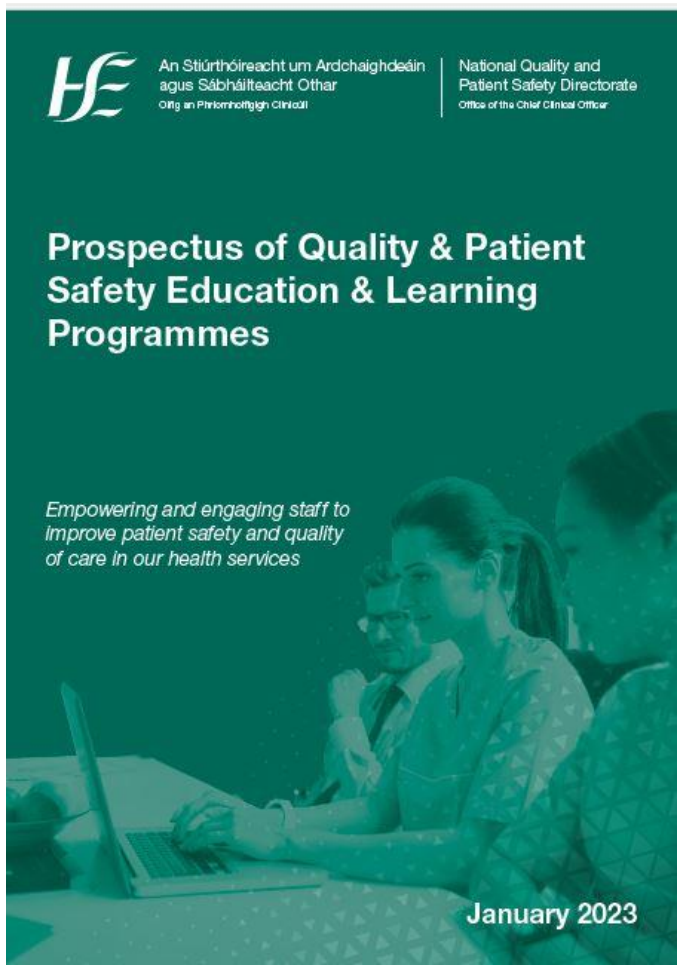
Poster display in each relevant surgical site/room

Will be supported by on-line guide, FAQs



HEARING YOUR THOUGHTS AND COMMENTS

Quality & Patient Safety Prospectus 2023



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- Antimicrobial Resistance & Control (AMRIC)
- Change & Innovation
- Library Services
- Connecting with QPS

https://www.hse.ie/eng/about/who/nqpsd/qps-education/prospectus-of-education-and-learning-programmes.html

Human Factors Learning Programmes

20 min e-learning module available on HSeLanD.

hseland.ie
Cúram le Eolas

Topics

Definition of Human Factors
History of Human Factors
Key factors that impact on performance & wellbeing
Human Factors in practice

COMING SOON

Foundation in Human Factors

1 day workshop for Teams

Topics

Human Factors as a new way of thinking
Factors impacting on human capabilities and limitations
Threat and error management.
Information processing.
Effective decision making and communication.
Non-technical skills assessment using behavioural markers.
Management and leadership.
Human Factors in healthcare.

For further information, qps.education@hse.ie

RCPI SAFE Collaborative

Applications will open shortly for the next cohort of the RCPI SAFE Collaborative, funded by the National QPS Directorate and commencing in Sept 2023

- Multidisciplinary clinical teams of 4 from frontline healthcare
- Improve safety, communicate effectively, heighten recognition & response in your setting

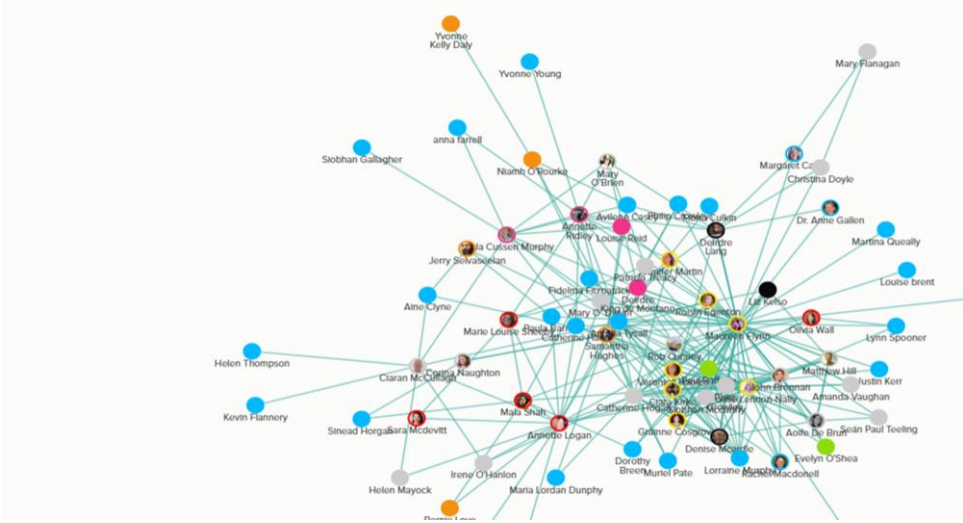
Want to learn more? Contact QPS.Improvement@hse.ie

The QPS Ireland Network Map

To help visualise connections between people interested in quality, safety and improvement across Ireland: https://www.hse.ie/eng/about/who/nqpsd/qps-connect/network-map/

- How to join the map?
  - Visit the HSE website (see link in the chat)
  - Get sent your unique link to the map
  - Enter information about you, your professional characteristics and your interests
  - Log your connections

- How to use the map?
  - Filter the map by role, organisation, interests
  - View individual profiles
  - Connect and collaborate with others



Apply to become a member of

Q-Membership is not needed to join the Patient Safety Community, but we encourage anyone with an interest in quality and patient safety to explore all the supports freely available on the Q Community Website: https://q.health.org.uk/join-q/

For information on how to apply contact:
Mary.lawless@hse.ie / Roisin.Egenton@hse.ie

Upcoming Webinars: Dates for your diary ….

Mila Whelan
Partnering with Patients, Operational Performance & Integration

Nicola Williams
Partnering with People who Use Health Services Programme

Patrick James Power
Member of the HSE National Patient Representative Panel

Brid Ryan
Clinical Lead ePharmacy

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QPS TalkTime No. 7

2nd May 2023 | 1pm to 2pm

Patient Partnerships

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Let us know how we did today ….

Reminder: Short questions (pop up) as you sign off, please help us to improve our QPS TalkTime Webinars by sharing your feedback

We really appreciate your time, thank you.

Contact: Kris.Kavanagh@hse.ie to be included on our mailing list to receive QPS TalkTime invitations