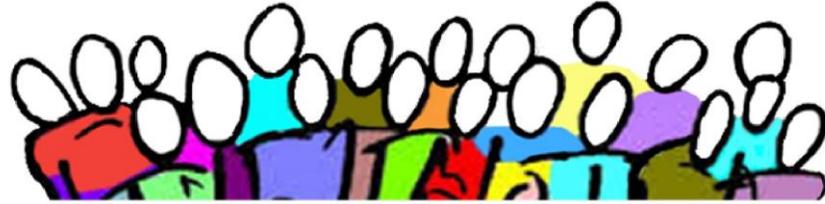




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QPS TalkTime

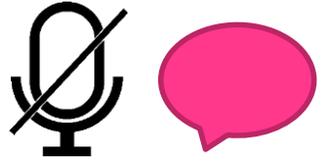


A community of quality and patient safety improvers

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

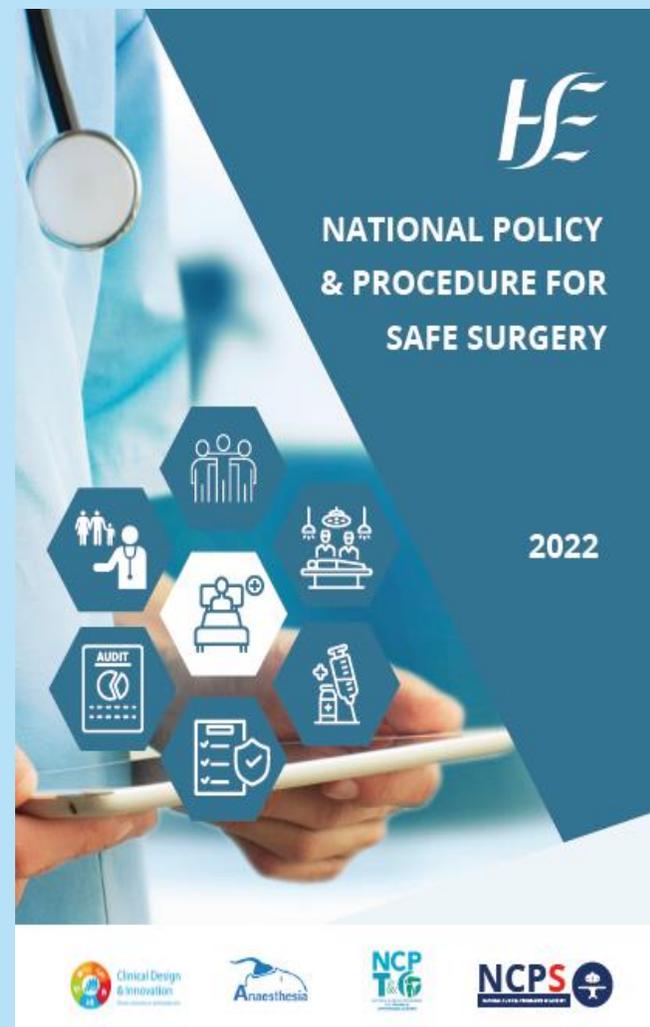
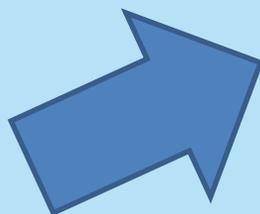
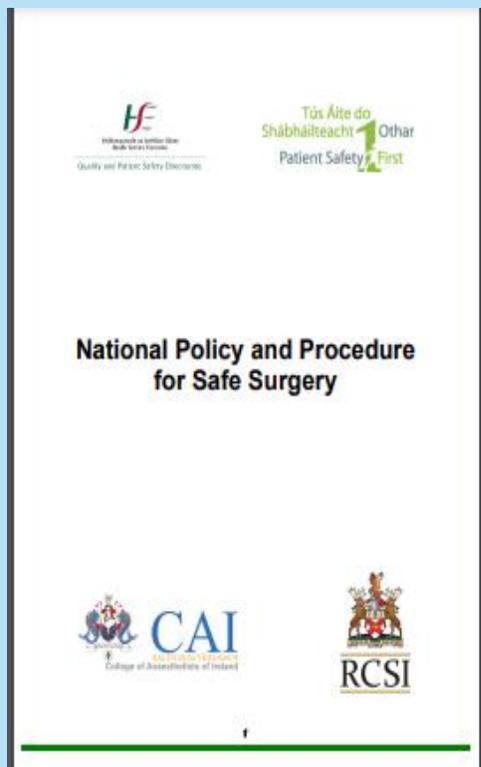
Ms Aileen O'Brien



Nurse Lead

*National Clinical Programme for
Anaesthesia*





WHO Guidelines for Safe Surgery 2009

Safe Surgery Saves Lives



WORLD ALLIANCE FOR PATIENT SAFETY

SAFE SURGERY SAVES LIVES

SECOND GLOBAL PATIENT SAFETY CHALLENGE



World Health Organization

Patient Safety Strategy 2019-2024



Seirbhís Sláinte
Níox Foiréann
& Forbairt | Building
Better H
Service

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

Independent report by the
Healthcare Safety Investigation Branch (2020/006)

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

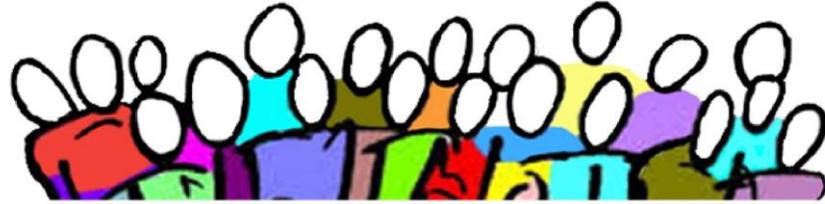
aobrien@coa.ie

Thank You





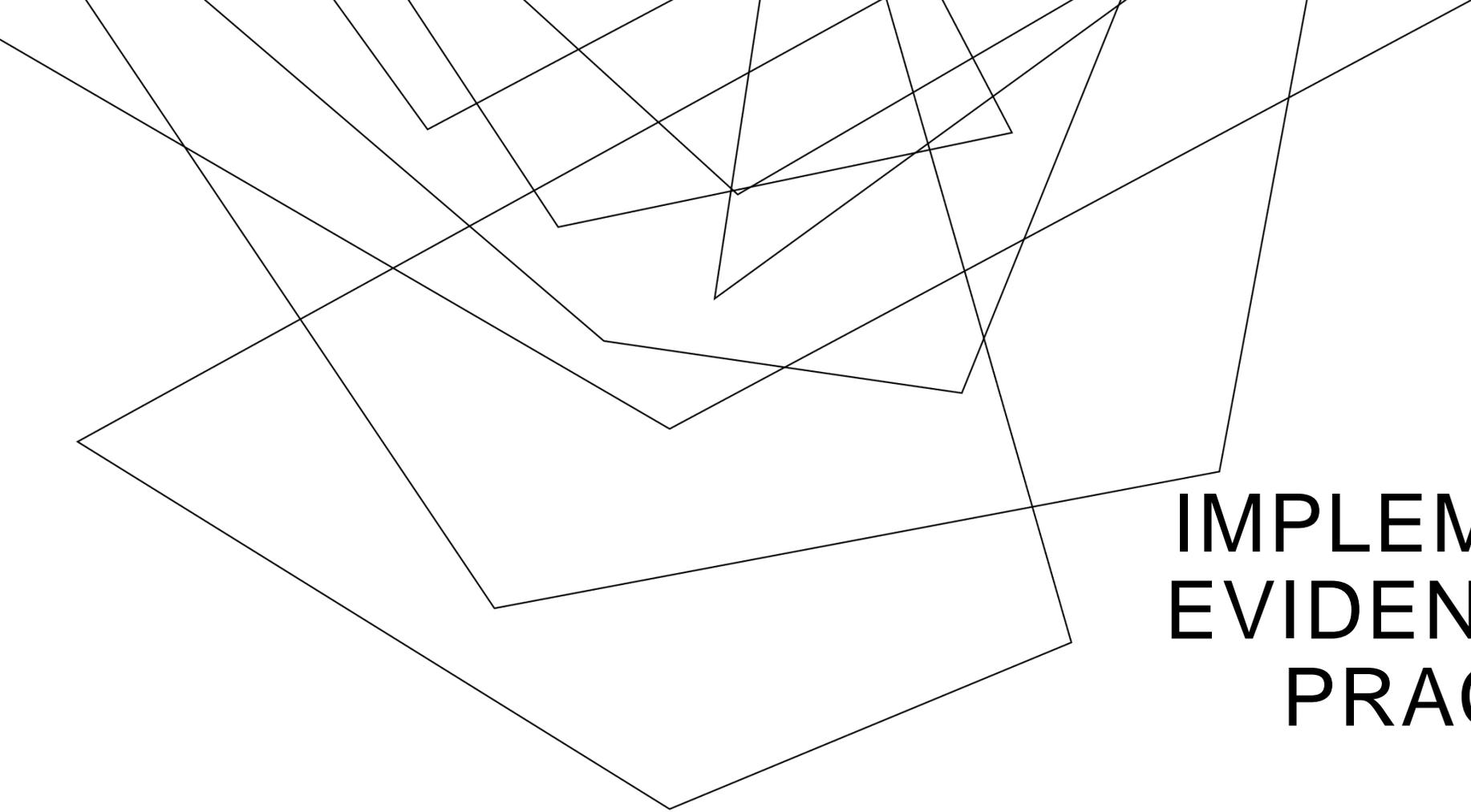
QPS TalkTime



A community of quality and patient safety improvers

18th April, 2022

Safer Surgeries...steps to reduce risk of harm

The top left corner of the page features a complex, abstract graphic composed of several thin, black, overlapping lines that form various geometric shapes and polygons, creating a sense of movement and structure.

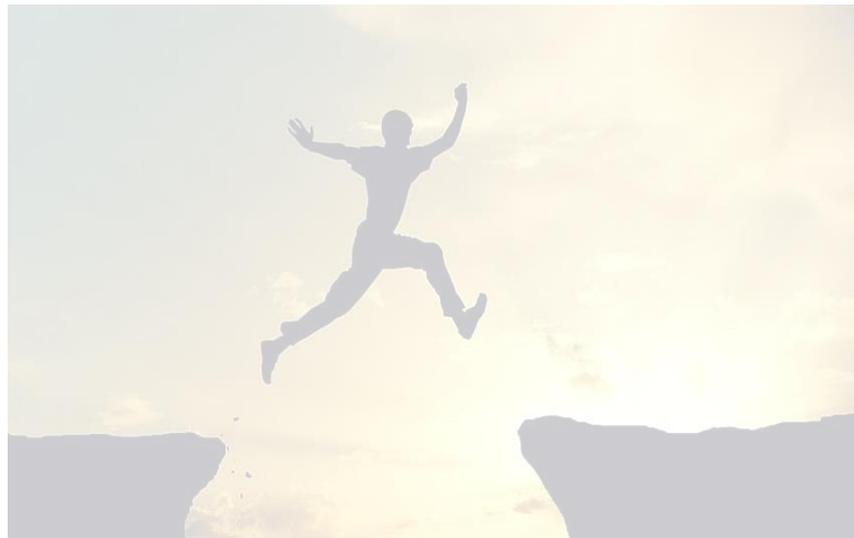
IMPLEMENTING EVIDENCE INTO PRACTICE

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]

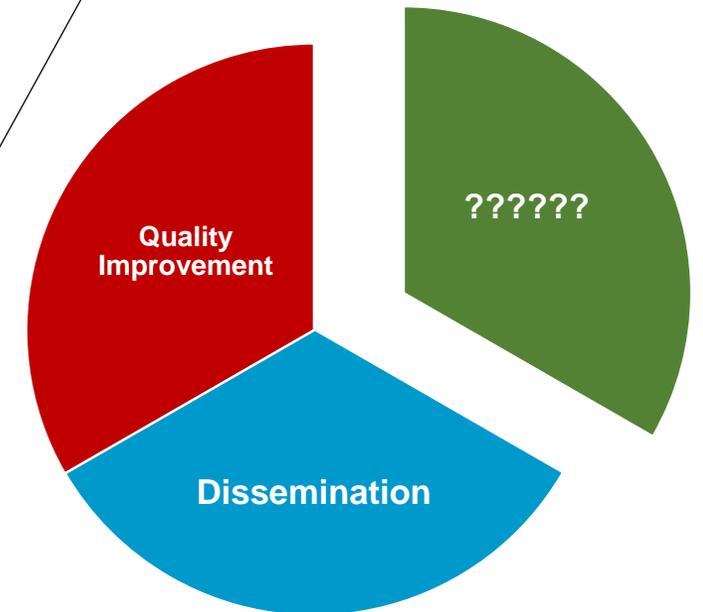
ACHIEVING THE GOAL OF IMPROVING THE QUALITY OF HEALTHCARE.

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

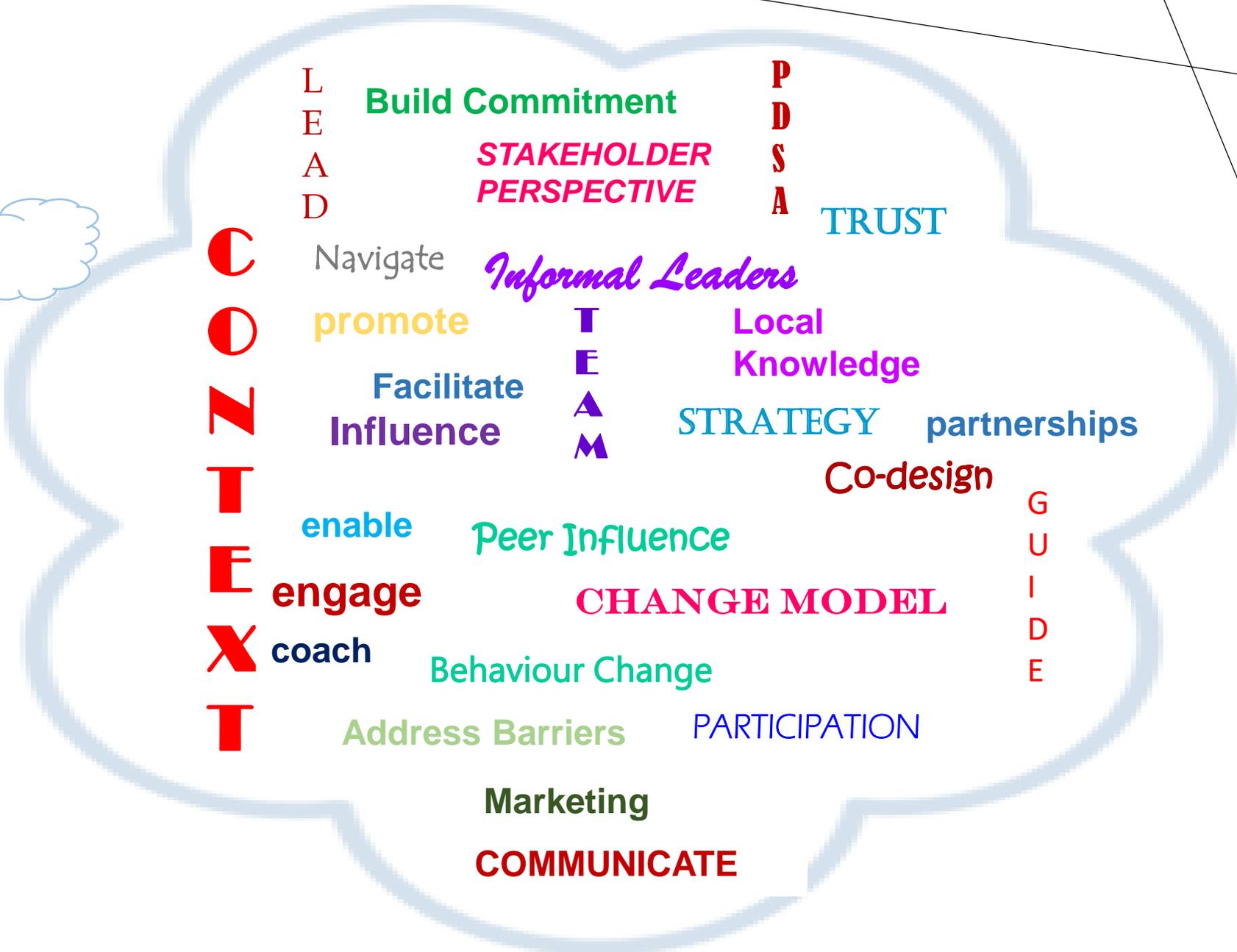
Implementation science is “the scientific study of methods to promote the systematic uptake of research findings and other EBPs into routine practice.” [2]

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



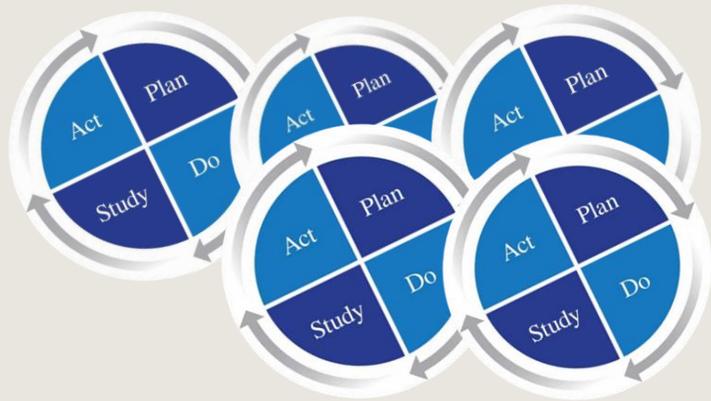


Framework for Improving Quality in our Health Service [5]



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**.

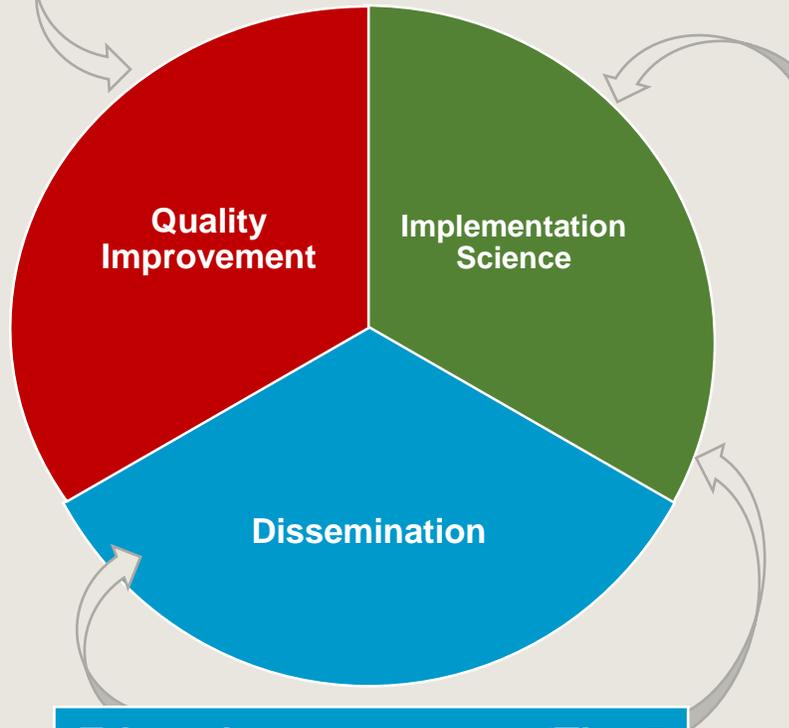
RESULTS: Consensus on the importance of the process with views expressed that it should be rolled out to all areas. **Some local informal leaders** emerged to drive implementation

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

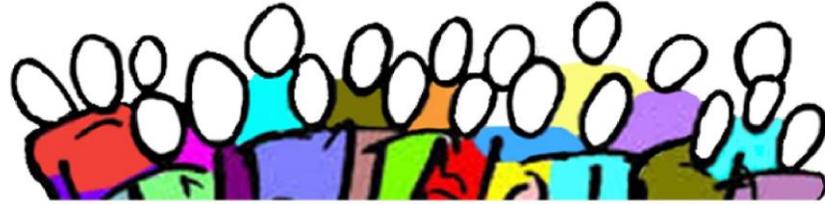
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4. Leeman, J., Rohweder, C., Lee, M. et al. Aligning implementation science with improvement practice: a call to action. (2021) *Implement Science Communications* 2, 99 <https://doi.org/10.1186/s43058-021-00201-1>
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8.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



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18th April, 2022

Safer Surgeries...steps to reduce risk of harm

QPS TalkTime



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Safer Surgeries...Steps to reduce risk of harm

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**

UNEXPECTED ADULT INTRA-OPERATIVE LIFE THREATENING HAEMORRHAGE PROTOCOL



CLINICAL CONCERN FOR LIFE THREATENING BLEEDING
THEN ACTIVATE **CODE RED IMMEDIATELY**



SENIOR CLINICIAN
STATE - I am activating the Life Threatening Haemorrhage Protocol, **CODE RED**

IDENTIFY EMERGENCY COORDINATOR
Co-ordinator function, Delegate & assign roles, Mobilise resources

STOP THE BLEEDING

- › Identify bleed
- › Source instruments
- › Midline laparotomy
- › Damage Control via
 - Direct Pressure
 - Packing
 - Clamping

RESUSCITATE

- Airways/Breathing/Circulation**
- › Large bore IV access
2 x 14 gauge
 - › Supply appropriate f_iO_2 to maintain good oxygenation
 - › Continuous Cardiovascular monitoring
 - › Active/passive warming – environment, fluids, blanket

Identify if anti-coagulated, on anti-platelet meds and discuss reversal with Haematologist

MANAGE METABOLIC RISKS

- Hypoxia, Hypothermia, Hypocalcaemia, Acidosis, Hyperkalaemia

IDENTIFY COMMUNICATION LEAD
- Keep Emergency Coordinator informed
- Identify yourself and your contact number

CALL FOR HELP
State Life Threatening Haemorrhage Protocol activated **CODE RED** in location xxxxx for patient yyyyy

- › Switchboard TEL/EXT: _____
- › Surgeon _____
- › Anaesthesiologist _____
- › Laboratories - Blood Transfusion, Haematology, Biochemistry _____
- › Porter _____
- › Assistant Director Of Nursing _____
- › Haematologist as required _____
- › Additional Support/ External Help if needed (e.g. Vascular surgery or Interventional Radiology) _____

CONTACT TRANSFUSION LAB, PLAN BLOOD SAMPLES AND TRANSFUSION SUPPORT

- › Identify sample requirements and blood component availability
- › Take Bloods and send to laboratory/ Near Patient Testing (NPT)
 - Blood group & antibody screen, FBC, U&E, Calcium, Coag screen inc. fibrinogen, lactate, ABG

PAUSE AND REVIEW

REPEAT BLOODS
› Repeat FBC, U&E, calcium (Ca), coag screen, fibrinogen at 30 mins then hourly
› Inform laboratory of NPT results

STAND DOWN
Inform Lab / Return unused components / Complete traceability & documentation / Start thromboprophylaxis / Plan de-brief

INITIAL EMPIRIC BLOOD MANAGEMENT

TRANEXAMIC ACID - 1g IV bolus over 10 mins
Consider Cell salvage - if in regular use

IMMEDIATE RED CELL TRANSFUSION
TRANSFUSE Emergency Group O (or patient specific blood order if available) from nearby blood fridge/ transporter

EMPIRIC BLOOD MANAGEMENT (THEN TRANSFUSE GUIDED BY LABORATORY/NEAR PATIENT TESTING)

ORDER MASSIVE HAEMORRHAGE PACK
4 units of red cells
4 units of Plasma

ORDER 4g fibrinogen for every blood volume loss

REQUEST PLATELETS TO BE AVAILABLE ON STANDBY - TRANSFUSE 1 UNIT (ADULT DOSE) OF PLATELETS FOR 1.5 BLOOD VOLUME LOSS OR GUIDED BY PLATELET COUNT TO KEEP PLATELETS > 50x10⁹/L

PAUSE AND REVIEW

IF BLEEDING CONTINUES REASSESS AND CONTACT HAEMATOLOGIST

Consider 10 mls 10% Calcium gluconate

Order additional Massive Haemorrhage Packs/transfuse guided by test results and repeat monitoring until bleeding controlled

TREATMENT TARGETS
Hb 7-9g/dL / Platelets > 50x10⁹/L, PT/APTT < 1.5 x mean control / Fibrinogen >1.5g/L, iCa++ > 1 mmol/L

-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

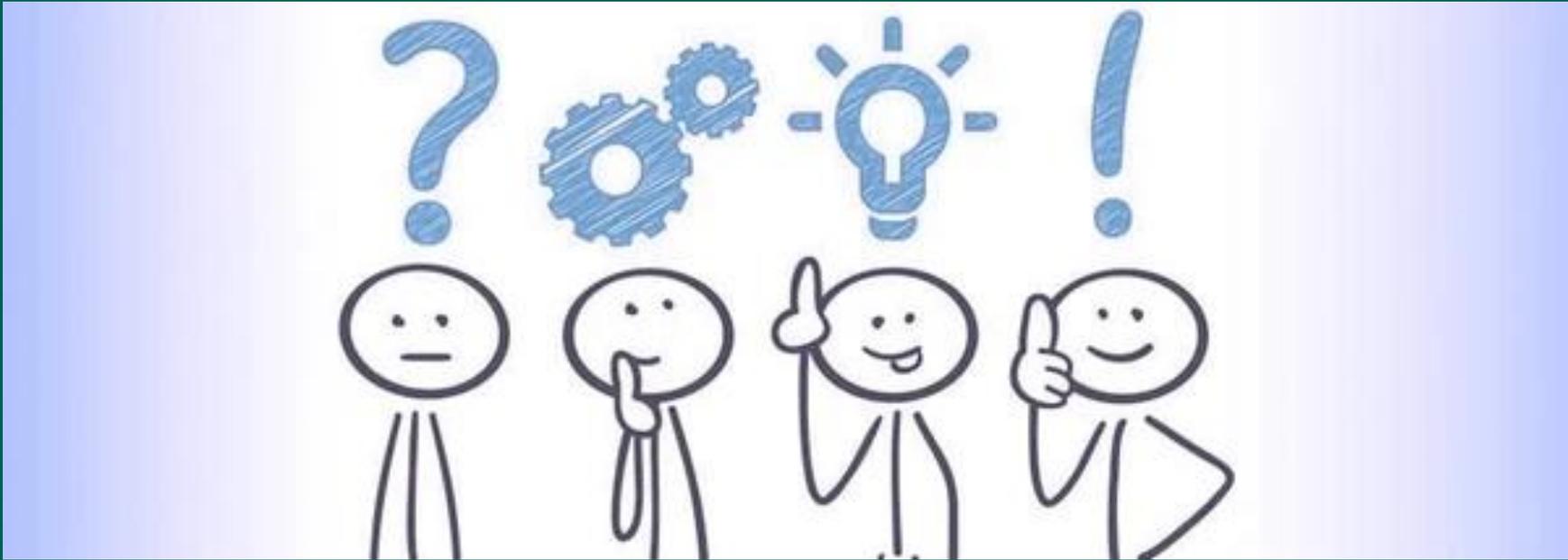
Will be supported by on-line guide, FAQs

VERSION 2, JANUARY 2023

NEAREST EMERGENCY GROUP O	BLOOD FRIDGE/ TRANSPORTER	RED CELL COMPONENTS	PLATELETS	PLASMA	FIBRINOGEN	TRANEXAMIC ACID (TXA)	PROTHROMBIN COMPLEX CONCENTRATE	IDARUCIZUMAB (PRAXBIND)
Location		Time to availability Patient's own group	Location	Location	Location	Location	Location	Location
Minimum contents		Cross matched	Time to availability	Time to availability	Time to availability	Time to availability	Time to availability	Time to availability

Date Hospital Specific Information updated _____

Supplied as Available For Anticoagulated Patient



HEARING YOUR THOUGHTS AND COMMENTS



Quality & Patient Safety Prospectus 2023

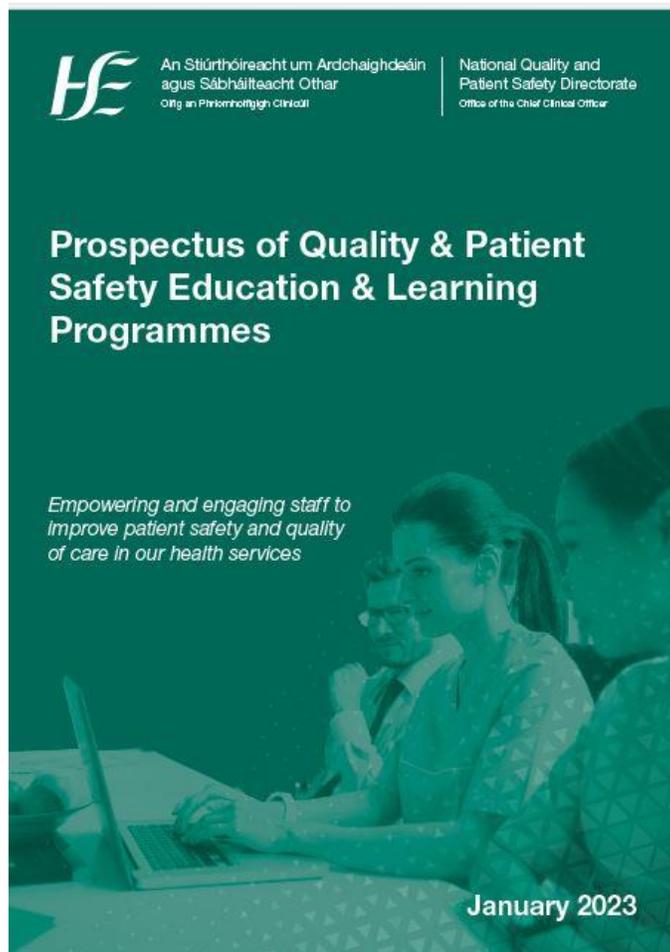


Table of Contents

- Quality Improvement
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- Complaints, Governance & Learning
- Governance & Risk
- Safeguarding
- 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

Introduction to Human Factors

Version 07 last reviewed 13/1/2023

Let's begin

20 min e-learning module available on HSeLand.

Topics

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

hseland.ie
Cúram le Eolas

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

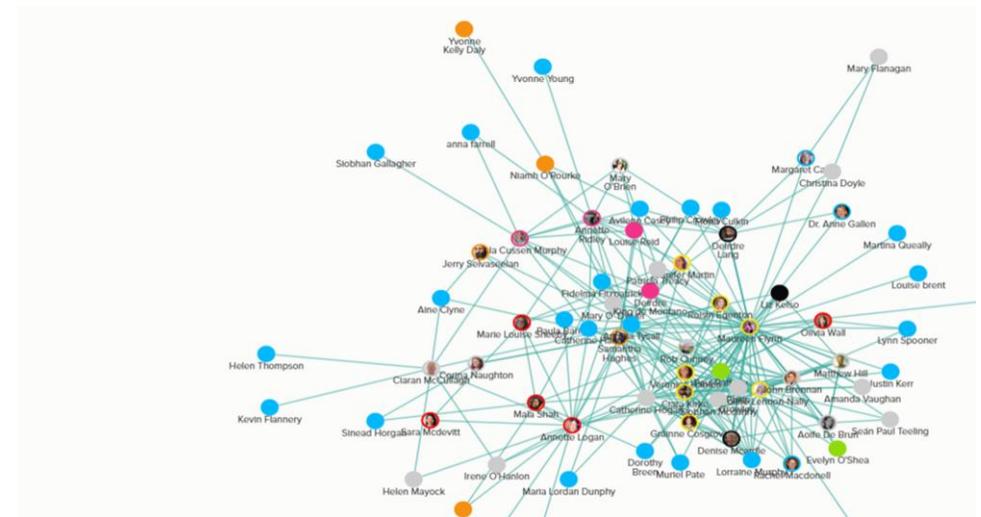
Want to learn more? Contact
QPS.Improvement@hse.ie

The graphic is a dark blue rectangular invitation. At the top left is the Royal College of Physicians of Ireland logo. At the top right is the HSE logo. In the center is a gold circular badge with the text 'YOU'RE INVITED'. Below this is a teal rectangular box containing the event details: 'Situation Awareness For Everyone: Sustain and Spread your Huddle & Deliver National Patient Safety Priorities', '4 May, 2023', '10 AM - 4 PM - 6 CPD awarded', and 'RCPI, No. 6 Kildare Street'. At the bottom is a white box with a gold border containing the text: 'Open to all previous SAFE learners, free of charge. Please join us for a day of shared learning, keynote speakers and a focus on supporting you to sustain your Huddle improvements and spread the changes to other settings. Agenda to follow.'

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



About

We are a community of thousands of people across the UK and Ireland, collaborating to improve the safety and quality of health and care. Q is delivered by the Health Foundation and supported and co-funded by partners across the UK and Ireland.



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

QPS TalkTime



A community of quality and patient safety improvers

QPS TalkTime No. 7

2nd May 2023 | 1pm to 2pm

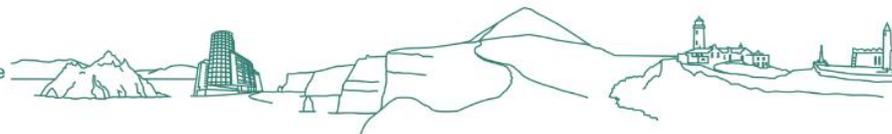
Patient Partnerships

Scan me!



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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.

*Thank
you*

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