EXPERIENCE FEED BACK COMMITTEE

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Location of Chambéry
What about Chambéry?

Chambéry, capital of the French Alps

Cradle of Beaufort ...

...and country of Opinel
Chambéry hospital (Fr)

- New Hospital capacity : 671 beds
- Number of operating theatres : 20
- Surgical cases : approximately 20 000 / year
CSSD of Chambéry

- CSSD: team of 24 co-workers
- Open: 7 days a week
- Working hours: 7:00 - 21:00
- Productivity:
  - Large surgical sets: 150/day
  - Medium sets: 350/day
What is experience feedback committee?

- Method for risk management
- Used for security system of civil aviation
- Defines organisation of the team in charge of risk management in healthcare
Experience feedback committee requirements

- Healthcare security depends on medical teams
- Precursors or near misses events shouldn’t be ignored
- Actions to improve security must correct systemic causes and contributory factors of events
Healthcare security

® Medicals errors in US : 44 000 to 98 000 death potentially

§ Medicals injuries in France : 9,2 % by day surgery

® Developpement of security is recommended by the French Health Authority (HAS) using method for risk management
Implementation at CSSD

- Methods coming from industry can be used at CSSD

- Incident Reporting and Analysis System (IRAS)
  - Failures Modes and Effect Analysis (FMEA)
  - Root causes approach
  - ALARM
  - ORION®
© Orion® is a *posteriori* systemic analysis method

© Orion® has been developed by Air France Consulting and it is based on experience acquired in aeronautics

© This method has been transposed to healthcare facilities, first implemented in radiotherapy and later on in other departments
Bird pyramid

- Near Misses (Précursors)
- Accident leading to property damage
- Minor injuries
- Serious Accident
Precursors events...

Concorde accident (july2000)
Why use a systemic method to investigate?

- Humans errors usually blamed
- System approach: human errors are expected even in the best system
- Systemic method permits to identify the causes of the event: contributory factors
Organisation of the committee

- Prospective recording of precursor events
- Opinion on the functioning of the system
- Research for causes of failures
- Proposal and implementation of corrective action
Improvement of committee

- Multidisciplinary team: nurses, operators, surgeons,... volunteers

- Establishing a reporting culture: increase the degree to which members report accident or near misses events

- Learning systemic method

- Appointing a coordinator
  - Collecting data
  - Organizing staff
  - Writing synthesis report
Progress of a session

Duration of the session: from 1 to 1.5 maximum

1. Display by the coordinator of the classified events of the month
2. Discussion and collective choice of the event to be studied
3. Name of the person in charge of the analysis
4. Display of the analysis of the event chosen in the previous committee
5. Choice of the practicable corrective actions with name of the person in charge of the follow-up
6. Follow-up of all the program action
7. Communication
## Chain of the sessions

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<tr>
<th>CREX n°1</th>
<th>CREX n°2</th>
<th>CREX n°3</th>
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<td>1. Listenning of the events of the previous month</td>
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<td>2. Choice of event</td>
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<td>4. Planification of the next meeting</td>
<td>4. Analysis of the event of the previous month</td>
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<td>6. Communication</td>
<td>6. Follow-up of actions decided at M-1</td>
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What method to choose?

- As a formal training and practice are needed to be fully effective, ORION is an easy to learn and easy to use method.

- ORION analyse systemic organisation and not human errors.
Analysis : 6 steps

1. Collecting data
2. Rebuilding the chronology of facts
3. Identifying causes and contributory factors
4. Proposing actions for improvement
5. Writing analysis report
6. Communication
Simple
Easys to complete (1min.)
Everywhere for everybody
Step 1: data collection of the analysis

- **Objectives:** collect all the data on the context of the event (organisational, human, material)

- **Who:** pilot

- **When:** without haste and as close to the event as possible

- **How:** individual interview, collective debriefing
Step 2 : building chronology

- Preserve only the factual elements
  - Exemple : supervisor autoclave

- Build the chronology of the event
  - Before
  - Now
  - After

- Validation of the chronology by the declarers

- Identification of the gap compared to guidelines
Step 3: identifying causes

- Identify causes for each
  - Institutional context
  - Work environment
  - Organisational and management factors
  - Tasks factors
  - Individual (staff) factors
  - Patient factors

- Perform a causes-and-effects analysis

- Examine the contributory factors
Step 4: proposals of correctives actions

- **Objectives**: correct causes rather than effects
- **Who**: pilot
- **How**: precisions
  - How to do?
  - Person in charge
  - Cost or investment

**Characteristics of a successful action**
- Correction of the causes
- Sustainable
- Accepted by co-workers
- Express to be implemented
Step 5: writing of the report

Objectifs: report should be clear and understandable by another person

Who: pilot and co-ordinator

How: list ...

- Event chosen
- Chronology of facts
- Analyse of causes and contributory factors
- Proposed and accepted actions
- Person in charge of implementation
Step 6: communication

- Staff involved in suggested corrective actions should be informed
- Report should be made readily available
- Conclusions should be published
CSSD Experience
Mains events corrected in 2012

- Devices with lumens incorrectly handled during the cleaning
- Fragile instruments non protected during the cleaning: damage, impairment
- Total dumping of a shaver during pretreatment
- Mini hysteroscop faucets not open during cleaning: soils and foreign bodies remains inside
- Paper-filter missing at the time of opening container
Absence of filter paper in containers

Consequences: none

Causes:
- Lack of attention during assembly
- Stress because of intense activity
- New agent in this post
- Lack of training

Suggested corrections:
- Implementation of permanent filter: expensive and long
- Deletion of containers and replacement by non woven wraps: increase of the risks of perforation and of the workload
- New organisation
New organisation to assess quality

Workstation dedicated to the control of containers
- Assembly bottoms and lids
- Complementary drying after cleaning
- Functional control of containers with workflow
- Setting up paper filter
- Recording of control

At least, 2\textsuperscript{nd} control by person in charge of reassembly
Conclusions

- Systemic analysis is an effective tool for the risks management in patient care.
- Sharing experience is one way to improve security and to change practice.
- Designating and training investigator in each CSSD.
Thank you for your attention

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