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 feed back 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 feed back 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 potentally

- Medicals injuries in France : 9,2 ‰ by day surgery

- Developpement of security is recommended by the French Health Autority (HAS) using method for risk management

Implementation at CSSD

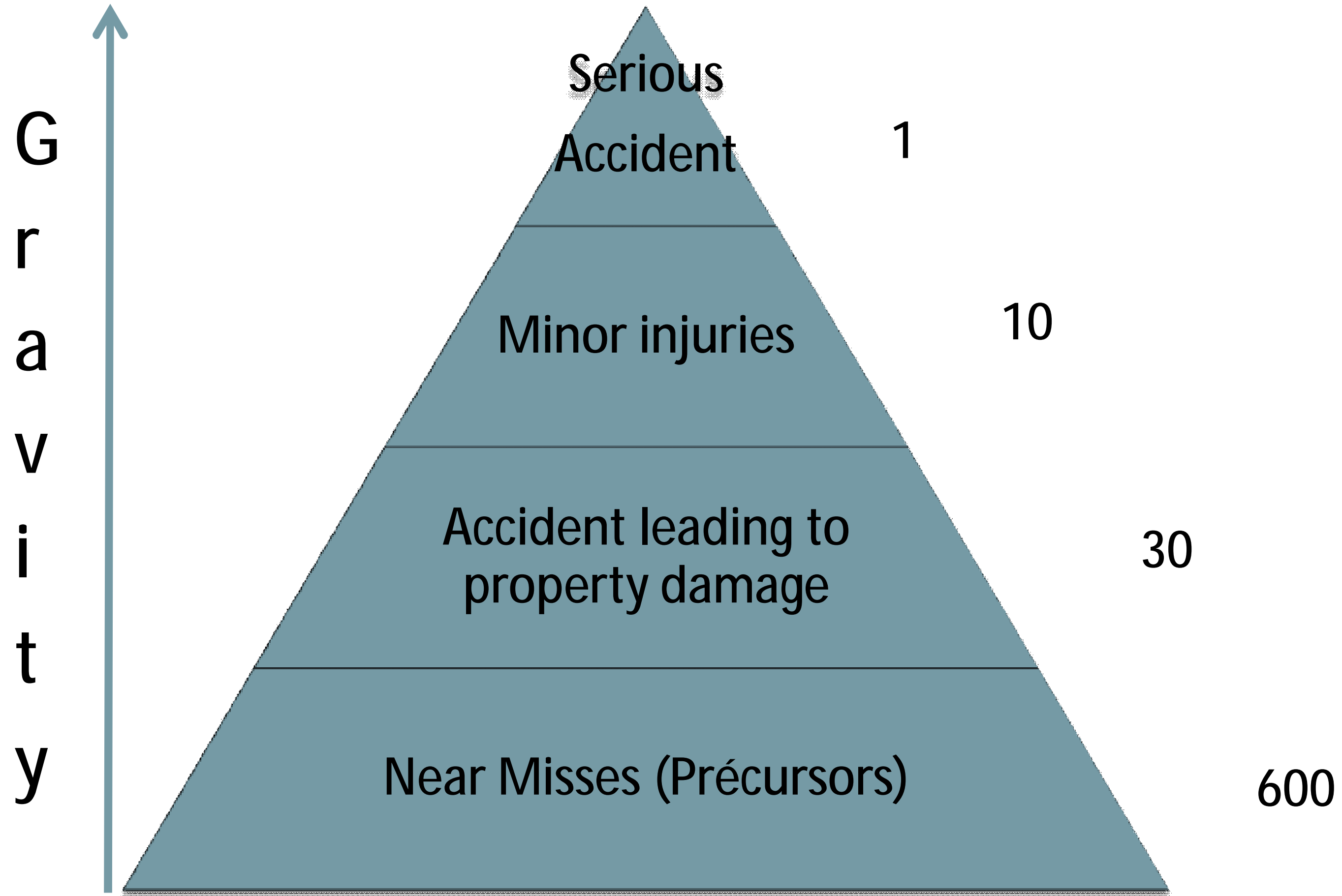
- Methods coming from industry can be used at CSSD

- Incident Reporting and Analysis System (IRAS)
  - Failures Modes and Effect Analysis (FMEA)
  - Root causes approach
  - ALARM
  - ORION®

ORION ®

- Orion® is a *posteriori* systemic analysis method
- Orion® has been developped by Air France Consulting and it is based on experience aquired in aeronautics
- This method has been transposed to healthcare facilities, first implemented in radiotherapy and later on in others departments

Bird pyramid



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

Boss … I've made a mistake !

- 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 wich members report accident or near misses events
- Learning systemic method
- Appointing a coordinator
  - Collecting data
  - Organizing staff
  - Writting synthesis report

Progress of a session

- Duration of the session : from 1 to 1.5 maximum

1. Dysplay 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. Dysplay 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

CREX n°1

1. Listenning of the events of the previous month
2. Choice of event
3. Choice of pilot
4. Planification of the next meeting

CREX n°2

1. .Listenning of the events of the previous month
2. Choice of event
3. Choice of pilot
4. Analysis of the event of the previous month
5. Choice of corrective action
6. Communication
7. Planification of the next meeting

CREX n°3

1. Listenning of the events of the previous month
2. Choice of event
3. Choice of pilot
4. Analysis of the event of the previous month
5. Choice of corrective action
6. Follow-up of actions decided at M-1
7. Communication
8. Planification of the next meeting

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.

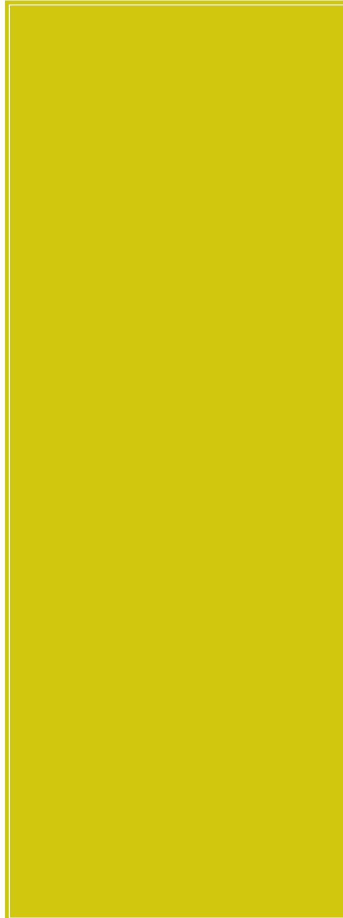
  - ORION analyse systemic organisation and not human errors

METHOD ORION®

Analysis : 6 steps

1. Collecting data
2. Rebuildind the chronology of facts
3. Identifying causes and contributory factors
4. Proposing actions for improvement
5. Writting analysis report
6. Communication

Reporting document



USCC	FICHE DE DECLARATIONS	ModOp Sté N° 89 Annexe II
	EVENEMENT INDESIRABLE USCC	Version : B Du 05/12/12

QUI DECLARE L'EVENEMENT	DATE ET HEURE DE L'EVENEMENT
Nom : .... (facultatif)	Date : ....Heure : ....
Tel :	
OU L'EVENEMENT S'EST-IL PRODUIT ?	
□ LAVAGE	□ CONDITIONNEMENT
□ STOCKAGE/DISTRIBUTION	□ AUTOCLAVE
Nom de l'intervention ou Unités de soins :	
Identification matériel concerné :	
DESCRIPTION DE L'EVENEMENT	

TRANSMETTRE LA FICHE A L'ENCADREMENT

- Simple
- Easys to complete (1min.)
- Everywhere for everybody

Step1 : data collection of the analysis

- Objectives : collect all the data on the context of the event (organisationnal, human, matérial)
- 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 environnement
  - 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
- Caracteristics of a succesful action
  - Correction of the causes
  - Sustainable
  - Accepted by co-workers
  - Express to be implemented

Collective Choice

Step 5 : writting of the report

- Objectifs : report should be clear and understandable by another person
- Who : pilot and coordonnator
- 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

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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 wowen 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, 2nd 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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