



CLABSI/SSI/VAP PEER-to-Peer Learning Session

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The Missouri HEN is a Missouri Hospital Association initiative in collaboration with the Missouri Center for Patient Safety.

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Measures

- Adopt Surgical Safety Checklist
- Antimicrobial Prophylaxis
- Perioperative Skin Antisepsis
- Preadmission Skin Cleansing
- Normothermia in the Operating Room
- Perioperative Glucose Control

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Antimicrobial Prophylaxis

- Develop standardized order sets for each procedure that include antibiotic, timing, dose and discontinuation
- Develop pharmacist and nurse-driven protocols that ensure correct antibiotic selection based on type of surgery and patient characteristics (age, weight, etc)
- Create a process to review all exceptions to protocols.
- Ensure that antibiotics are redosed appropriately in surgeries longer than four hours.

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What are the errors in Surgical Prophylaxis

- When was the 1st dose given?
- Was there sufficient coverage for the duration of the operation?
- Did the patient receive the correct dosage


National (USA) prophylactic error rates can vary from 25% to 40 % depending on the surgical service

Dellinger et al., Am J Surgery 2005; 190:9-15

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Educate Staff

- Educate about the technical aspect
- Turn the evidence into “behavior”
 - Make it the practice in your hospital
 - Make it the process used by your staff during line insertion/maintenance



The image shows four healthcare professionals standing in a row against a plain white background. From left to right: a female nurse in blue scrubs holding a clipboard, a female doctor in a white lab coat, a male doctor in a white lab coat, and another female nurse in blue scrubs holding a clipboard. They are all looking towards the camera.

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Process measurement

- Collect the antibiotic data
 - Preoperative timing
 - Appropriate duration
 - Appropriate drug
- Share the data with OR nurse managers
- Physician champions
 - SURGEON
 - ANESTHESIA

REAL TIME!!! Measurement and Sharing of information

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Empowering Nurses

- Develop scripts for nurses on how to stop a physician if there is a break in protocol
- Educate the physician on what is going to happen if there is a break in protocol
 - Peer to Peer education on expectations
- Educate nurses and physicians in the role of the nurse in the peri operative area
 - Monitor patient
 - Observe for compliance with best practices and stop the procedure if it occurs

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Closed Loop Communication

- State your concern
 - Why you are uncomfortable
 - What is the safety issue you have observed
- Physician educated to repeat back what they heard

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EXECUTE

- Tests of change
 - Development of standardized order set
 - Utilization of surgical checklist
 - Monitoring glucose
- Learn from each SSI/failure to meet the standard
 - Discuss each infection with the care team
 - Timely recognition of SSI or failure in measure

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Learning from Defects

- What happened?
- Why did it happen?
- What could you do to reduce the risk?
- How do you know the risk was reduced?
 - Create policy, process, procedure
 - Ensure staff know the policy
 - Evaluate if the policy is being used correctly

EACH SSI IS A DEFECT LEARN FROM EACH ONE!!!!

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Questions?



A cartoon character with a black body and a white face is looking into an open green box. A green question mark is floating above the character's head. The character has one arm raised. The background is a light blue gradient.