



*The HCAI programme and reducing risks
in the future*

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Sustainable improvement..... Culture, behaviour, reliability

"Staff uninterested
"Don't see it applies to them
"Infection happens
"The IPC team deal with infection
"We are already doing everything we can
"Not enough staff, beds, facilities
"It's all coming in from the community
"Have little data/not shared

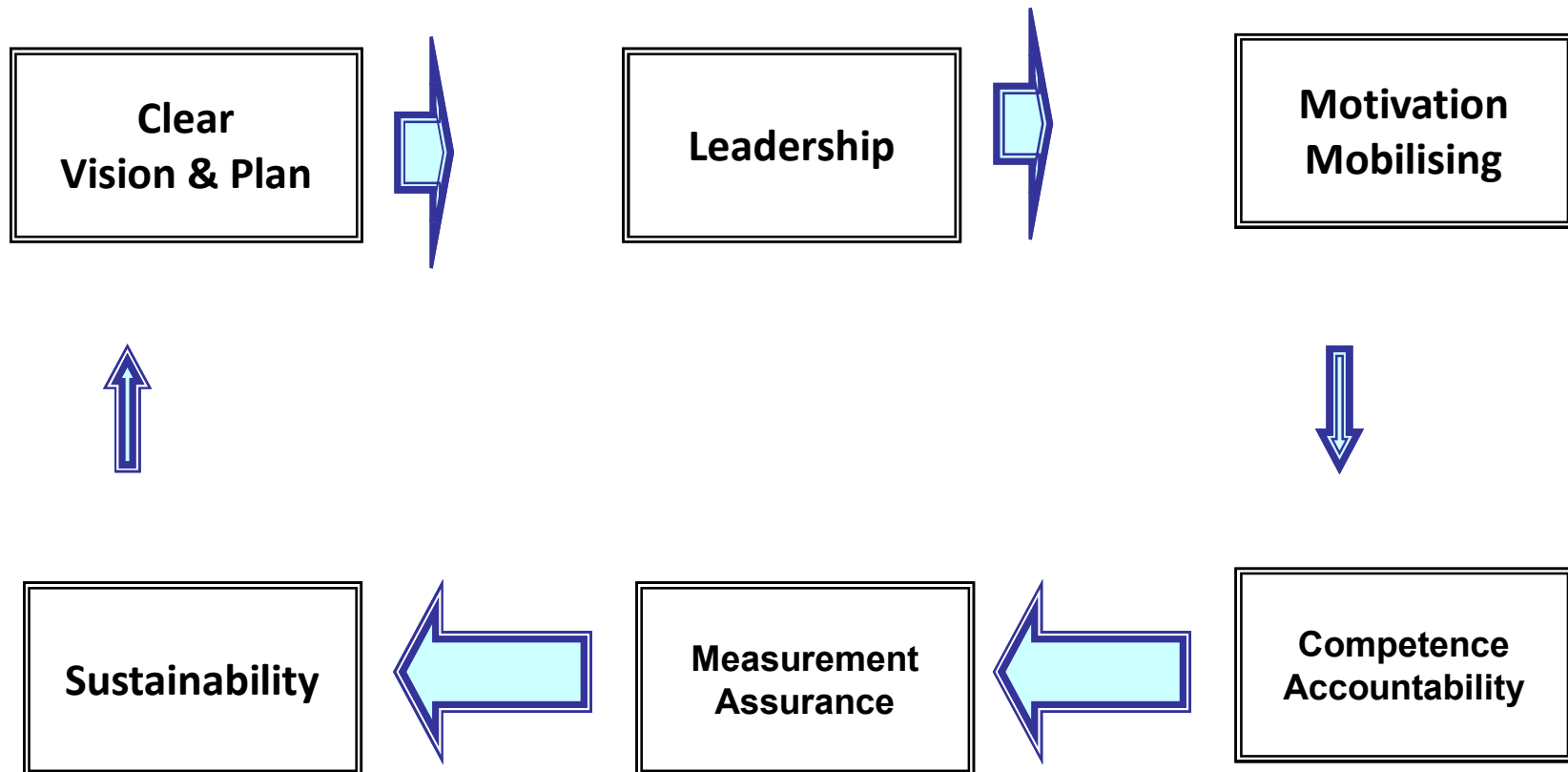
"Staff believe it is important
"They have a role to play
"They realise there are things they can do
"They know what to do & where to focus
"One infection is too many ..
"Can show data/compliance

The shift achieved



The journey to delivering improvements in infection prevention and control

HCAI - reducing the risks in future



At the heart of large scale change...

Belief

Behaviour

Be Sure

The importance of leadership.....

- “ Strong leadership form ward sister
 - . Role model
 - . Knows patients
 - . Challenges practice
 - . Coaches/supports
- “ Staff know what is expected of them
- “ Good working relationships with doctors
- “ Cleaners feels part of team
- “ Clean, uncluttered
- “ Other standards of care high
- “ Few formal complaints
- “ Clinical practice . good

- “ **There is passion, pride & professionalism**



The Importance of Leadership.....

*“enabling others to achieve
purpose in the face of
uncertainty”*

Marshall Ganz's definition of leadership

Leaders need to be able to motivate & mobilise..õ

- “ To change, each person has to make a personal connection to the message we give
- “ It has to be powerful enough to inspire us to take decisive action
- “ The key to motivation is to understand the values
- “ Values inspire action through emotion
- “ A way to do that is through narrativeõ õ õ õ

Knowledge, skills & competence

- “ Variation in compliance to Protocols
- “ Unconscious incompetence
- “ Lots of training, but assumed competence
 - . aseptic technique
 - . bloods, lines, wounds, catheters
 - . Antibiotic prescribing
- “ Staff too embarrassed to ask questions about basic care
- “ Staff uncomfortable with challenging colleagues

Methods of training.....

- “ Range of ways to support different learning styles
- “ Dip-in, dip-out ò ò ò . Pace
- “ On the job+ - but need to think about skills of person, facilitator, trainer
- “ Need theory, test skills, assess knowledge & competence

Audit and assurance.....

The audits you do, should drive improvement are about improving consistency & reliability of practice

They

- “ should generate dialogue and action
- “ should inform training
- “ should be one of the mechanisms to assure the Board that the policies, procedures are being applied consistently
- “ Examples

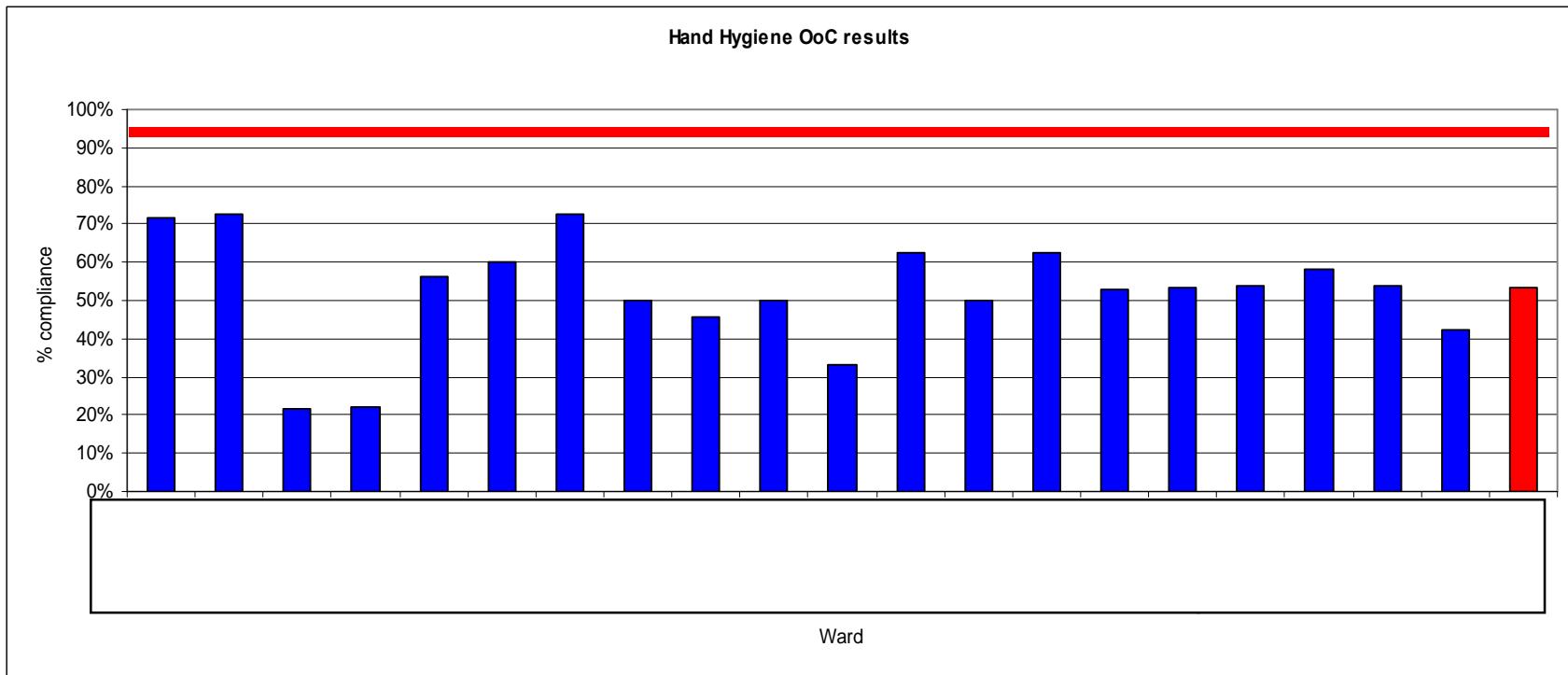
HII

- “ HIAs . falls, pressure ulcers
- “ Hand hygiene

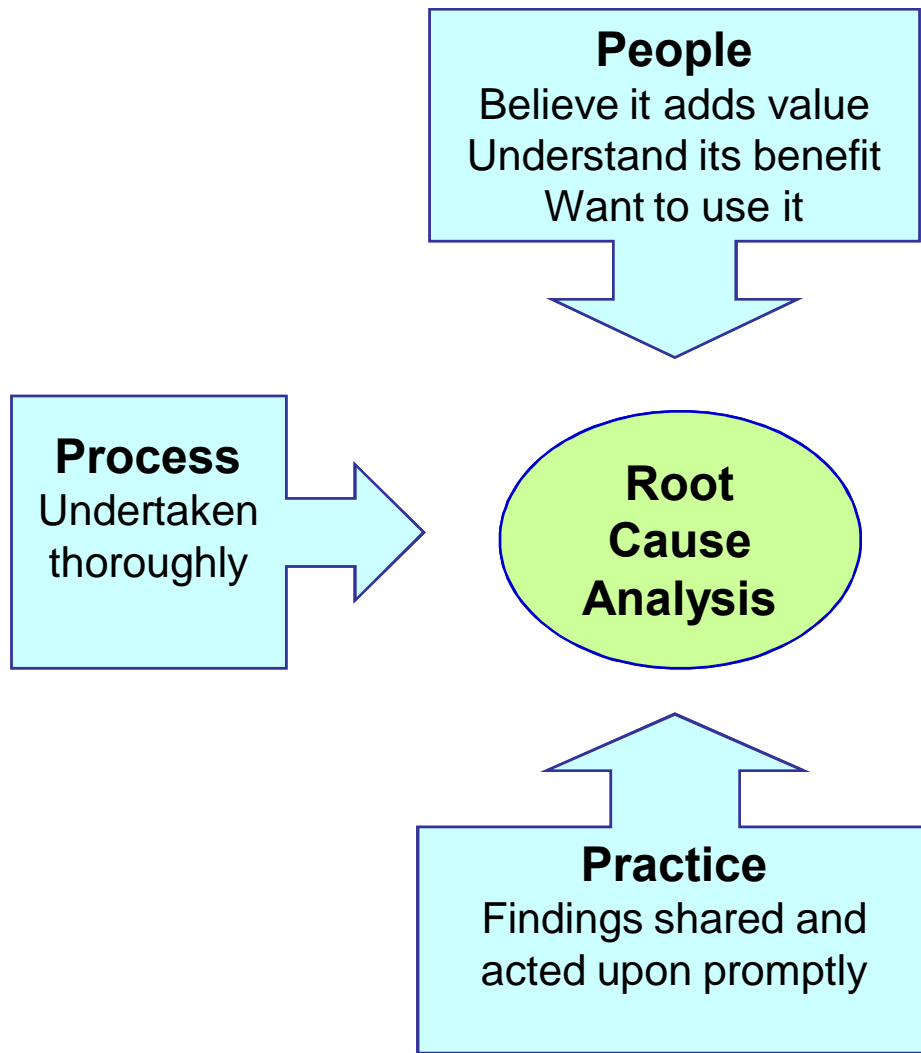
But

- “ The method matters ã õ ã

Audit processes and methods



HCAI - Root Cause Analysis



NHS
National Patient Safety Agency

Learning through action to reduce infection

What is this for?
This is a quick, simple action tool to use when a patient has a confirmed infection such as an MRSA infection.

It is based on the Root Cause Analysis (RCA) approach and is primarily a learning exercise.

Why use it?
To find out what factors or events led to the infection, and how you can reduce the risks of it happening again.

The results will help your organisation to gain a better overall understanding of the causes and contributory factors associated with severe infections and take action to reduce the risks of them occurring elsewhere in the future.

Who will use it?

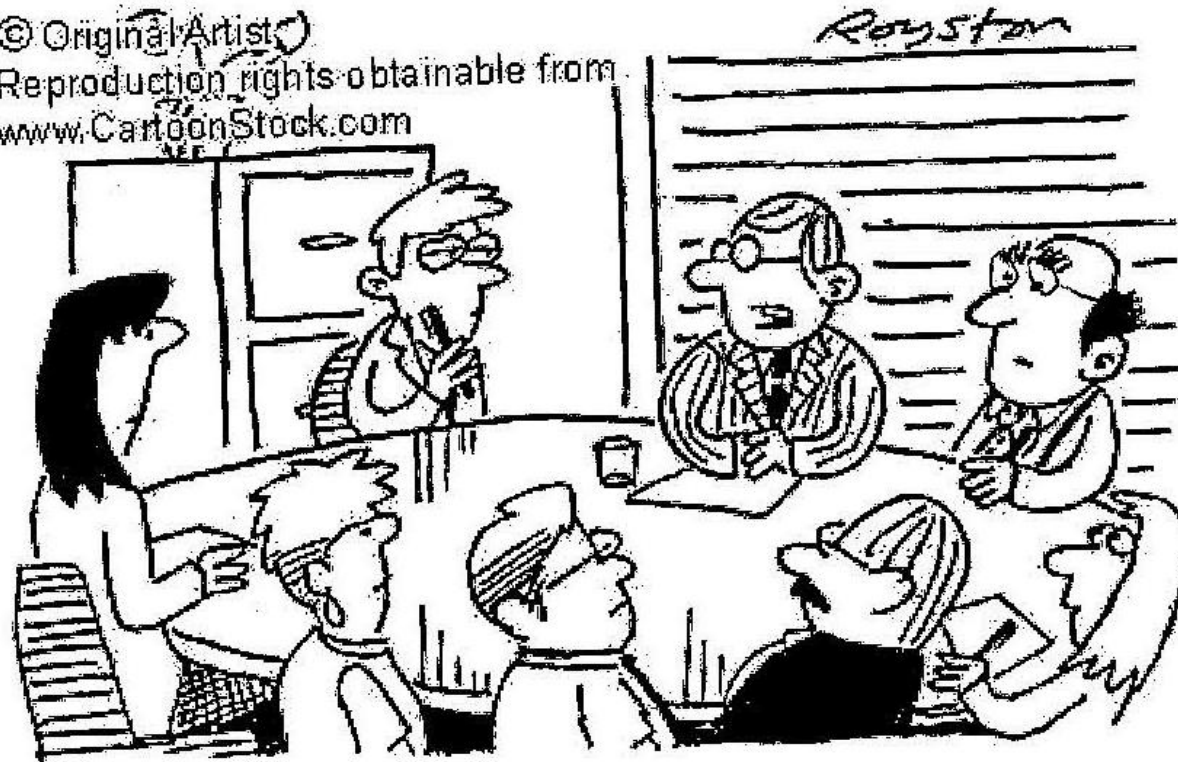
- ward managers and nurses with the support of infection control teams
- anyone who is involved in learning from infections such as MRSA bacteraemia to reduce future occurrences.

How long will it take?
Once you are familiar with it, the process should take around 15 minutes to complete.

How does it work?
The process is organised as an action checklist in three stages:

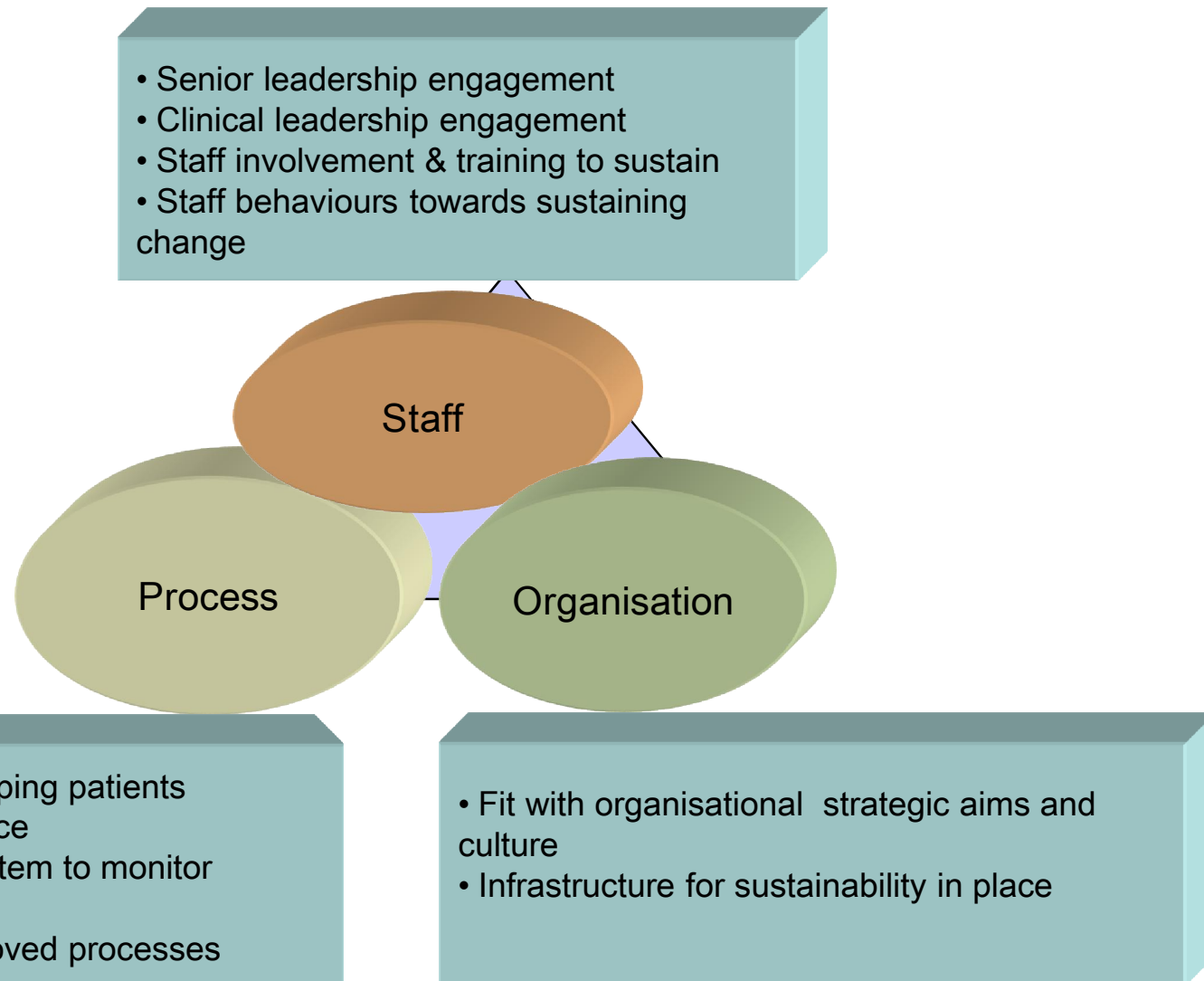
- 1 React
- 2 Record
- 3 Respond

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"To address this mistake we must use root-cause analysis. I'll begin by saying it's not my fault."

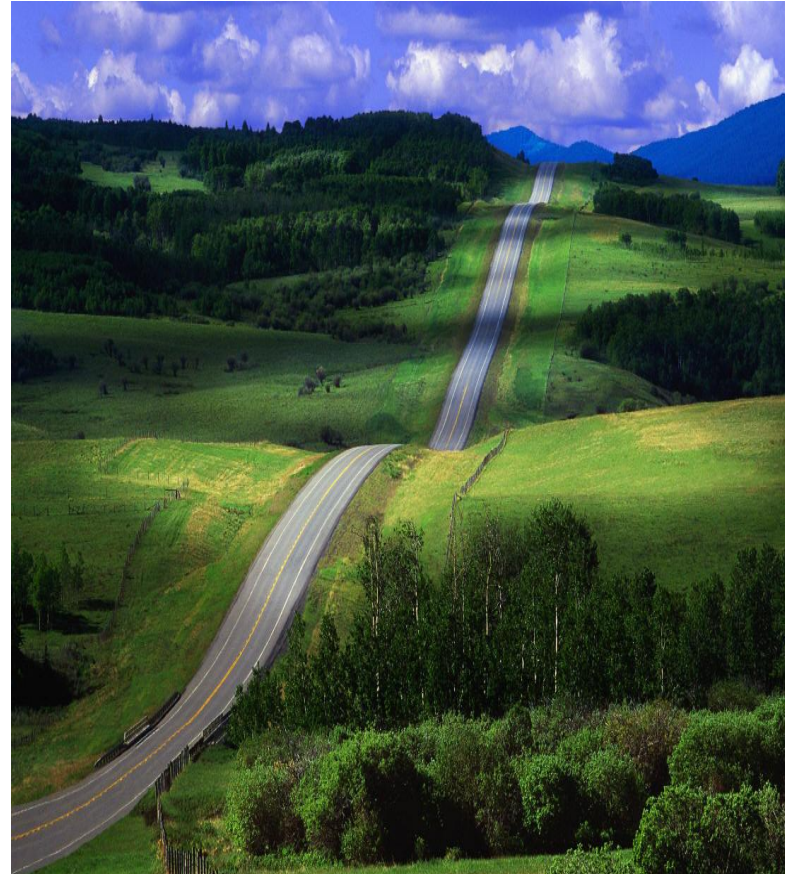
Important to understand features for sustainability



Looking to the future.....

- “ HCAI remains important
- “ Other infections
 - . MSSA
 - . CDI
- “ Transparency of data
- “ Align to QulPP

- “ Maintain focus
- “ Part of how we deliver careõ .



Thoughts to take away.....

- “ How is your clinical area viewed . by peers/patients
- “ What is your leadership style?
- “ How skilled /knowledgeable are you and your team
- “ What works well?
- “ What hinders progress

- “ What is your vision - what is your plan?
- “ What is your narrative+õ õ õ ..how are you going to %motivate and mobilise+

- “ Do you accept %we can't do anything about that++or are you ready to challenge and change