

**Reducir la infección del
sitio quirúrgico 50%**

¿Como llevarlo a cabo?

Capt. Hans Härting

Errores médicos- la tercera causa de muerte en Estados Unidos

ANALYSIS



Medical error—the third leading cause of death in the US

Medical error is not included on death certificates or in rankings of cause of death. **Martin Makary** and **Michael Daniel** assess its contribution to mortality and call for better reporting

Martin A Makary *professor*, Michael Daniel *research fellow*

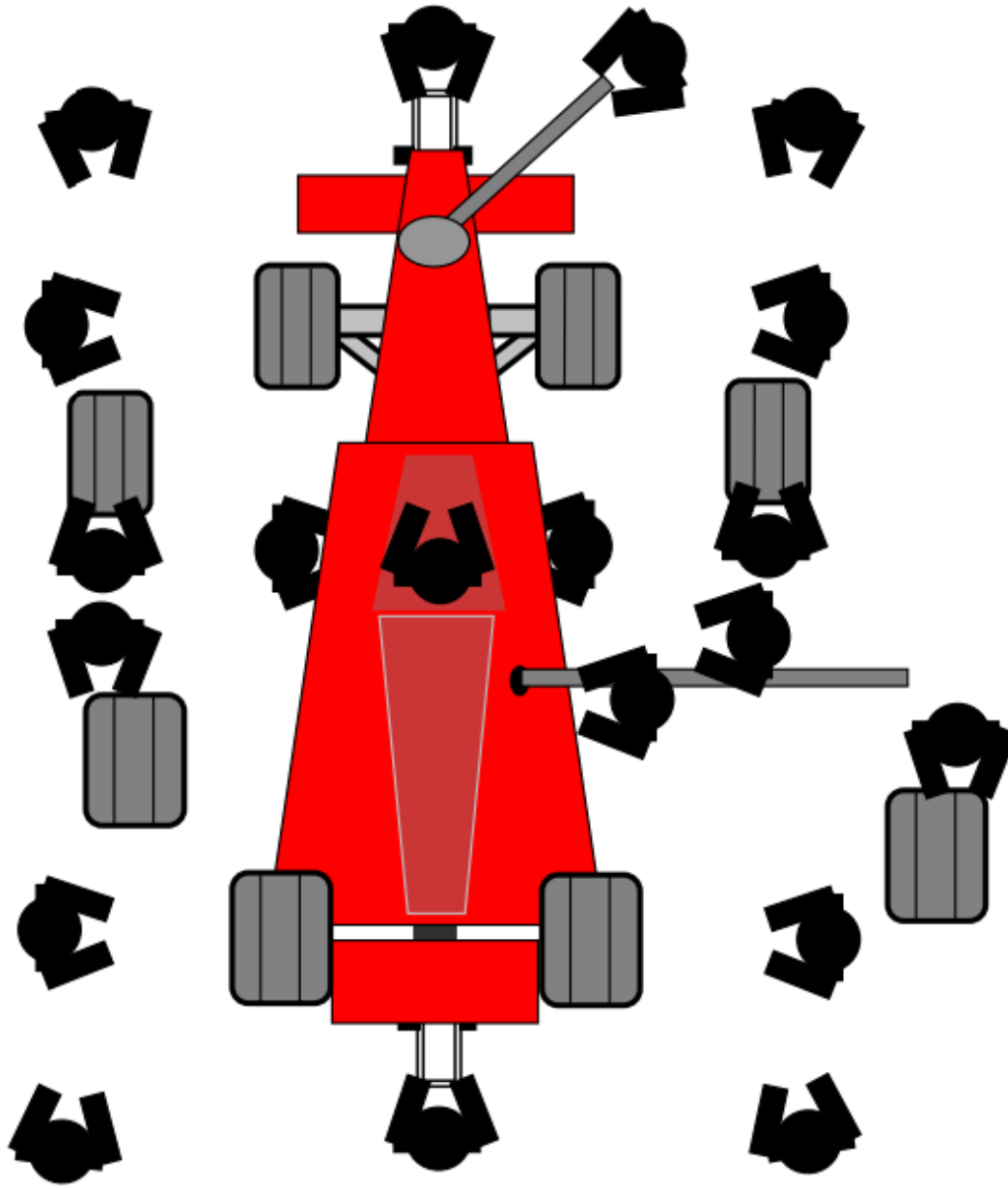
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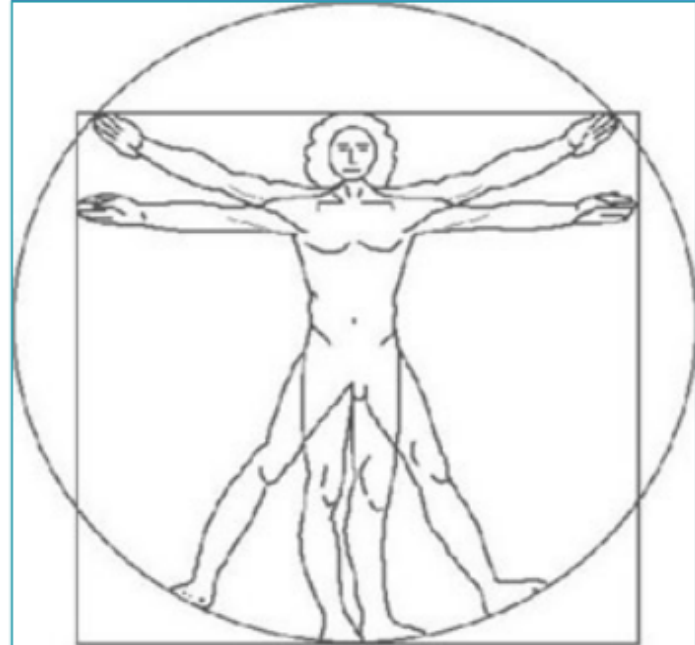






Entrenamiento del equipo

Factores humanos





- **Un equipo**
- **“Esto es acerca de nosotros”**
- **Un alto nivel de cooperación**
- **No de habilidades técnicas**



SISTEMA 80% NOTECHS

- **comunicación**
- **coordinación del equipo**
- **decisiones estructuradas**
- **conocimiento situacional adecuado**
- **liderazgo apropiado**

Como se regresa la inversión por la implementación de un programa de entrenamiento de la tripulación en un centro medico?

Article

— AMERICAN COLLEGE OF —
MedicalQuality

What Is the Return on Investment for Implementation of a Crew Resource Management Program at an Academic Medical Center?*

American Journal of Medical Quality
2019, Vol. 34(5) 502–508

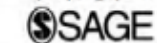
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Chris Ellison, MD, FACS¹, and Ann Scheck McAlearney, ScD, MS¹

Abstract

Crew Resource Management (CRM) training has been used successfully within hospital units to improve quality and safety. This article presents a description of a health system-wide implementation of CRM focusing on the return on investment (ROI). The costs included training, programmatic fixed costs, time away from work, and leadership time. Cost savings were calculated based on the reduction in avoidable adverse events and cost estimates from the literature. Between July 2010 and July 2013, roughly 3000 health system employees across 12 areas were trained, costing \$3.6 million. The total number of adverse events avoided was 735—a 25.7% reduction in observed relative to expected events. Savings ranged from a conservative estimate of \$12.6 million to as much as \$28.0 million. Therefore, the overall ROI for CRM training was in the range of \$9.1 to \$24.4 million. CRM presents a financially viable way to systematically organize for quality improvement.



En teoría no hay diferencia entre la teoría y la práctica. En la práctica sí hay.

Cumplimiento

Se asume

80 - 90 %

Realidad

15 - 20 %



Reducir 50% las ISQx



Major Article

Implementation of a comprehensive unit-based safety program to reduce surgical site infections in cesarean delivery



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Key Words:
Cesarean section
Patient safety
Surveillance
Nosocomial infection
Wound infection

Background: To evaluate whether using a comprehensive and multidisciplinary approach to implement an evidence-based bundle can reduce 30-day surgical site infection rates in women undergoing cesarean delivery.

Methods: This observational study with a preintervention and postintervention design included 2576 consecutive women undergoing cesarean delivery at our tertiary care hospital between January 1, 2013 and December 31, 2017. The primary outcome was 30-day surgical site infection rate after cesarean delivery defined according to the Centers for Disease Control and Prevention criteria. The preintervention period span from the January 1, 2013 to December 31, 2014. After initiation of a Comprehensive Unit-based Safety Program (ie, a continuous quality improvement program to improve patient safety using a comprehensive and multidisciplinary approach adapted on local demands), we introduced a bundle of evidence-based interventions (including preoperative shower, hair removal with clippers, correct antibiotic prophylaxis, maintaining normothermia, glycemic control, and strict compliance with hygiene standards as well as practice good hand hygiene) per January 1, 2015 into clinical routine. The postintervention period span from January 1, 2015 to December 31 2017.

Results: In the preintervention period the overall surgical site infection rate was 16 of 1,060 cesarean deliveries versus in the postintervention period the overall surgical site infection rate was 9 of 1,516 cesarean deliveries (1.50% vs 0.56%; $P = .033$). This corresponds to a relative risk reduction of over 60% after implementation of the evidence-based bundle (odds ratio 0.39, 95% confidence interval 0.17–0.89; $P = .020$).

Conclusions: In the present study, we have adapted the Comprehensive Unit-based Safety Program strategy to implement an evidence based-bundle into clinical routine. Using this comprehensive and multidisciplinary approach, we could markedly reduce 30-day surgical site infections.

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Cesarean delivery is the most common surgical procedure worldwide and women undergoing this procedure face a substantially increased risk of morbidity and mortality when compared with women who deliver vaginally.¹ Women who deliver by cesarean section suffer from markedly increased risk of surgical site infections.^{2,3} Surgical site

infections after cesarean delivery are persistent and preventable health care associated infections.⁴ To date, the global burden of preventable surgical site infections after cesarean delivery continues result in patient harm and increased health care cost on a broad scale.^{5,6} A recent guideline of the Center for Disease Control and Prevention provides new and updated evidence-based recommendations for prevention of surgical site infections which should be incorporated into comprehensive surgical quality improvement programs to improve patient safety.⁷

As part of our hospital nosocomial infection surveillance the hospital takes part in a national hospital infection surveillance

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Conflicts of interest None of the authors has any conflicts of interest regarding this article to disclose.

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A comprehensive unit-based safety program for the reduction of surgical site infections in plastic surgery and hand surgery

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Affiliations + expand

PMID: 31607274 DOI: 10.1017/ice.2019.279

Abstract

Objective: To reduce surgical site infection (SSI) incidence in plastic surgery and hand surgery.

Design: Uncontrolled before-and-after study.

Setting: Department of plastic surgery and hand surgery of a tertiary-care teaching hospital.

Patients: Patients undergoing surgery between January 2016 and April 2018.

Intervention: A comprehensive unit-based safety program (CUSP) consisting of a bundle of evidence-based SSI prevention strategies and a change in safety culture was fully implemented after a 14-month baseline surveillance and implementation period. SSI surveillance was performed over an intervention period of another 14 months, and differences in SSI rates between the 2 periods were calculated. Adherence with bundle components and risk factors for SSI were further evaluated in a case-cohort analysis.

Results: Of 3,321 patients, 63 (1.9%) developed an SSI, 38 of 1,722 (2.2%) in the baseline group and 25 of 1,599 (1.6%) in the intervention group ($P = .20$). The CUSP was associated with an adjusted relative SSI risk reduction of 41% (95% confidence interval [CI], 0.4%-65%; $P = .048$) in multivariable analysis, whereas the need for revision surgery increased SSI risk (odds ratio [OR], 2.63; 95% CI, 1.31-5.30; $P = .007$). During the intervention period, the proportion of checklists completed was 62.4%, and no difference in adherence with bundle components between patients with and without SSI was observed.

Conclusions: This CUSP helped reduce SSI in a surgical specialty with a low baseline SSI incidence, even though adherence with checklist completion was moderate and the main modifiable risk factors remained unchanged over time. Programs that include safety culture change may more effectively promote SSI reduction than prevention bundles alone.

Lista de chequeo

Patientenetikett		OP-Transfer - Checkliste - Plastische Chirurgie		
		OP-Datum:		
Geplanter Eingriff:		nicht zutreffend	ja	nein
Wer	Vor Eintritt/Abteilung	n.z.	ja	nein
PFL	Nikotinstopp eingehalten (Brief)		ja	nein
PFL	Körperhaarentfernung zuhause durchgeführt im OP - Gebiet (Brief)		ja	nein
Anmerkungen:		Name und Kürzel		

Auf Station vor Prämedikation (Pflege)		n.z.	ja	nein
PFL	Patientenidentifikation (Abgleich mit OP-Unterlagen, Etiketten, Armband und Bettmarkierung)		ja	
PFL	Eingriff und ggf. Zusatzeingriffe markiert oder veranlasst		ja	nein
PFL	n	n.z.	ja	nein
PFL	Letzte Gabe Thromboseprophylaxe bei Regionalanästhesie (Zeit):		ja	nein
PFL	OP-Aufklärung vorhanden		ja	
PFL	Isolationspflichtiger Patient (wenn ja: Vorinfo an Leitstelle)		ja	nein
PFL	Hygienische Körperwaschung vor OP, auch bei Pat., welche am OP Tag eintreten		ja	nein
PFL	Körpertemperatur gemessen, aktuelle Temperatur: °C		ja	nein
Anmerkungen:		Name und Kürzel		

OP - Schleuse bei Übergabe (AnästhesistIn resp. Pflege bei LÄ)		n.z.	ja	nein
AN/PFL	Patientenidentifikation (Abgleich Name und Geb. Datum mit Karte, Armband)		ja	
AN/PFL	Eingriff und ggf. Zusatzeingriffe markiert		ja	
AN/PFL	Saaluweisung gemäß eOP		ja	nein
Anmerkungen:		Name und Kürzel		

Lista de chequeo

Sign In Anästhesie		n.z.	ja	nein
AN	Patientenidentifikation durchgeführt (Abgleich Name, Geb. Datum mit ID Band und Unterlagen)		ja	
AN	Operative Aufklärung (vorhanden und unterschrieben)		ja	
AN	präoperative Antibiotikaprophylaxe verabreicht (15 bis 60 min vor Eingriff, bzw. vor Anlegen der Blutsperre)	n.z.	ja	nein
AN	Körpertemperatur gemessen, aktuelle Temperatur: °C		ja	nein
AN	Allergien vorhanden, wenn ja, welche:		ja	nein
AN	Anästhesiemethode/Operation besprochen		ja	nein
AN	Regionalanästhesien: Kontraindikationen vorhanden		ja	nein
AN	Zu erwartender schwieriger Atemweg / Aspirationsrisiko	n.z.	ja	nein
AN	Perioperative Medikationen (Antibiotika, Steroide, Immunsuppressiva)		ja	nein
AN	Basismonitoring vorhanden	n.z.	ja	nein
AN	Infusion vorbereitet	n.z.	ja	nein
AN	Alle Medikamente korrekt	n.z.	ja	
AN	Respiratorfunktion, Schläuche angeschlossen	n.z.	ja	nein
AN	Absaugvorrichtung	n.z.	ja	nein
Anmerkungen:				
		Name und Kürzel		

Sign In Check - Pflege und Chirurg		n.z.	ja	nein
CHI	chirurgische Händedesinfektion		ja	nein
PFL	chirurgische Händedesinfektion		ja	nein
PFL	Haarkürzung durch Clipping im OP Gebiet, falls notwendig (nicht bereits vorher! Wenn vorher bereits geschehen, bitte unter "Anmerkung" vermerken)	n.z.	ja	nein
CHI/PFL	Hautdesinfektion präoperativ durchgeführt		ja	nein
CHI/PFL	OP-Feld: Desinfektion und sterile Abdeckung korrekt durchgeführt		ja	
Anmerkungen:				
		Name und Kürzel		

Aufwachraum, IPS oder Abteilung postoperativ		n.z.	ja	nein
AN	postoperative Antibiotikatherapie festgelegt	n.z.	ja	nein
PFL	Körpertemperatur gemessen, aktuelle Temperatur: °C		ja	nein
Anmerkungen:				
		Name und Kürzel		

= für das Projekt zur Reduzierung von postoperativen Wundinfektionen relevante, zu überprüfende Punkte





Entrenamiento en simulador de vuelo para tripulación del personal de salud

Liderazgo en situaciones complejas

Entrenamiento para médicos y enfermeras

Primero



Primero hazlo todo bien

AssekuRisk



SAFETY MANAGEMENT

¡Gracias!

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