




**Root Cause Analysis used in the field of infection control**  
**Prof. Pierre Parneix, C.C.L.I.N. Sud-Ouest - CHU Pellegrin**  
**A Webber Training Teleclass**



**Root Cause Analysis used in the field of infection control**

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**Hosted by Dr. Hugo Sax**  
University Hospital Zurich



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Accueil Notifications Messages infection control and root cause a Q

**infection control and root cause analysis**

Top Direct Comptes Photos Vidéos Autres options

**Suggestions** - Actualiser · Tout afficher

-  **sabrinaTCA92** @sabrinaTC...  
Suivi par Directeur des Soins...  
[Suivre](#)
-  **Upbm-asso** @UpbmAsso  
Suivi par Michèle Drechsler...  
[Suivre](#)
-  **HUEP\_75** @HUEP\_75  
[Suivre](#)

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**Tendances** · Modifier

- #otobomb
- Sponsorisé par Fanta France
- #hubforum
- #mondaymotivation
- #EnfinLundi
- Lakers
- Palmyre

**C DIFF FOUNDATION** et 1 autre suivent

**Aereus Technologies** @AereusTech · 30 sept. 2014  
#CHES2014 #9 Confluence of **infection control** and hospital engineering. Work with others to conduct **root cause analysis**.

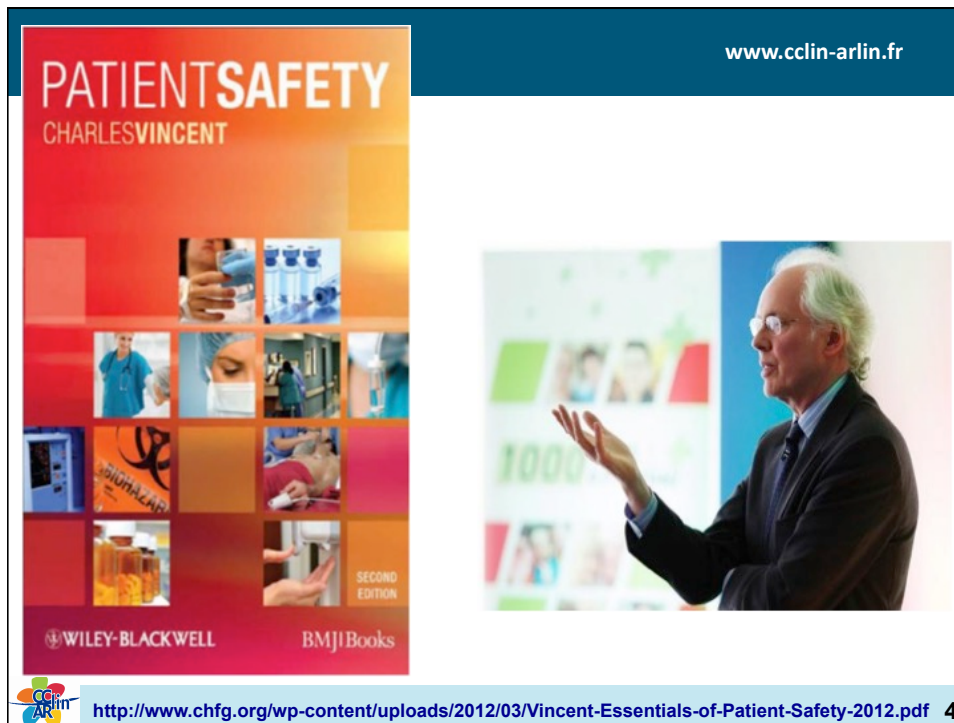
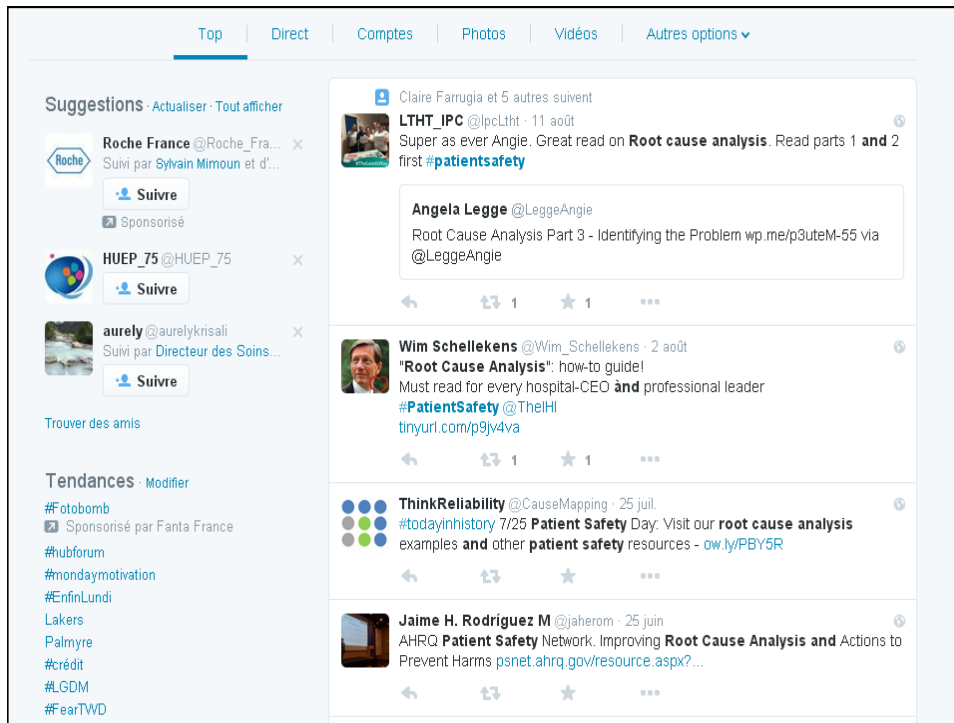
**parneix pierre** @peyo3319 · 30 janv. 2014  
**Infection control** in healthcare is more and more based on reporting and performing **root cause analysis**. We must switch in this direction.

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# Root Cause Analysis used in the field of infection control

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**RCA and infection control**

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**KEY POINTS**

An error is something realised only after the event

Slips and lapses are errors of action and memory

Mistakes are errors of knowledge and planning

Errors can only be properly understood in context

Patient, task, individual, team, environment, organisational and institutional context factors may all influence incidents and accidents

Incidents may act as a 'window' on the healthcare system



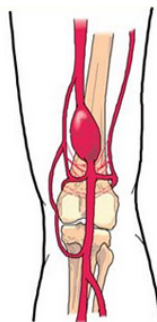
<http://www.chfg.org/wp-content/uploads/2012/03/Vincent-Essentials-of-Patient-Safety-2012.pdf> 5

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**Why we need to broaden our vision**

**Bypass of popliteal aneurysm – Wrong side surgery**



- contralateral pain in the foreground,
- no cross checking prior induction (no check list),
- absence of marking on the side to operate by the surgeon during the preoperative visit,

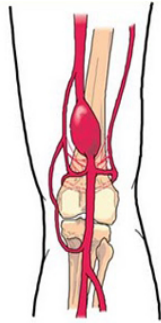


<http://www.ccecqa.asso.fr/page/prage>

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## Why we need to broaden our vision

### Bypass of popliteal aneurysm – Wrong side surgery



- contralateral pain in the foreground,
- no cross checking prior induction (no check list),
- absence of marking on the side to operate by the surgeon during the preoperative visit,
- extension of hair removal to both legs for « esthetic concern ».



## Plan

**Don't miss the power  
of root cause analysis!**



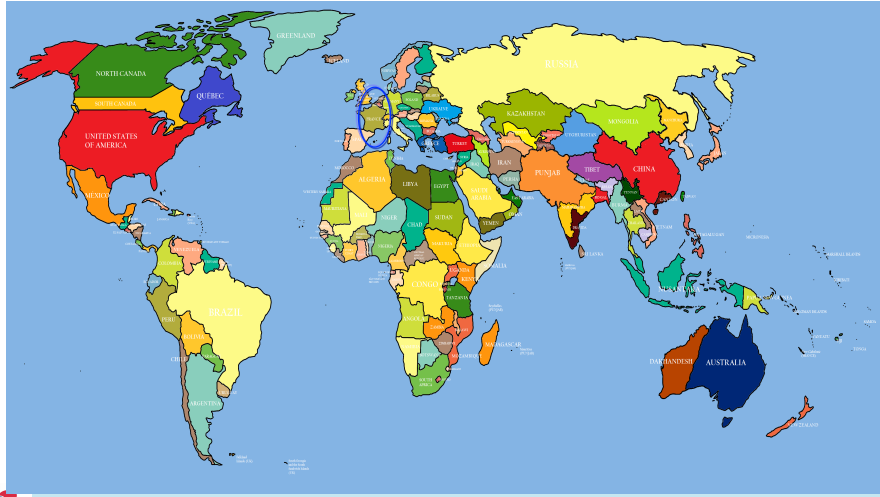


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**Just enjoy a little trip to France!**



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## Root cause analysis

### A delight to return



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## Root cause analysis

### A delight to return



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## WHO RCA definition

- ☞ Systematic analysis of all the factors which (...) have the potential to prevent an error
- ☞ Explains how the incident occurred
- ☞ Designs mechanisms to prevent the incident from happening again
- ☞ Can be applied to incidents or to 'near misses'.



## RCA

### Work on near misses



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**RCA**

**Work on near misses**

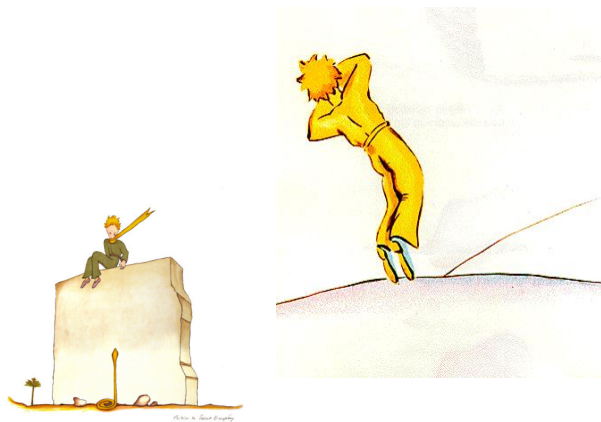


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**Understand the complexity of life**



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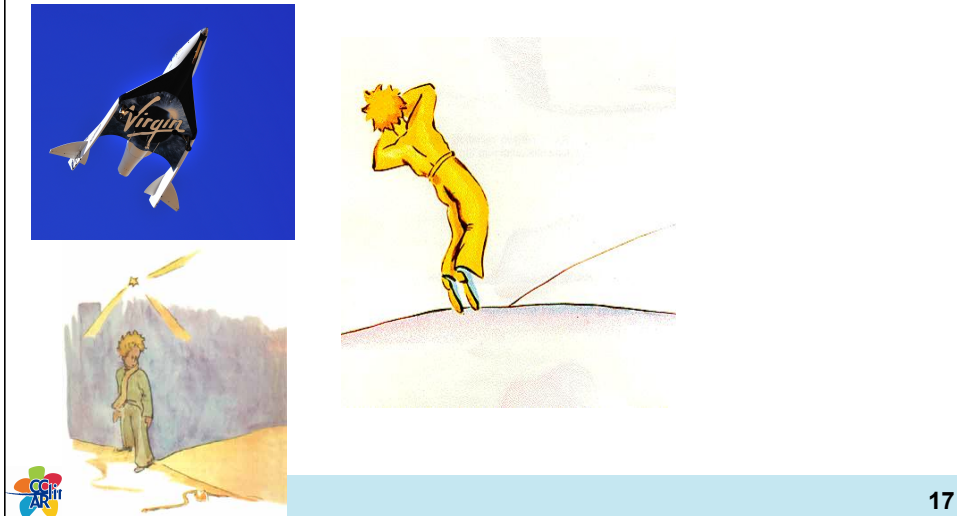
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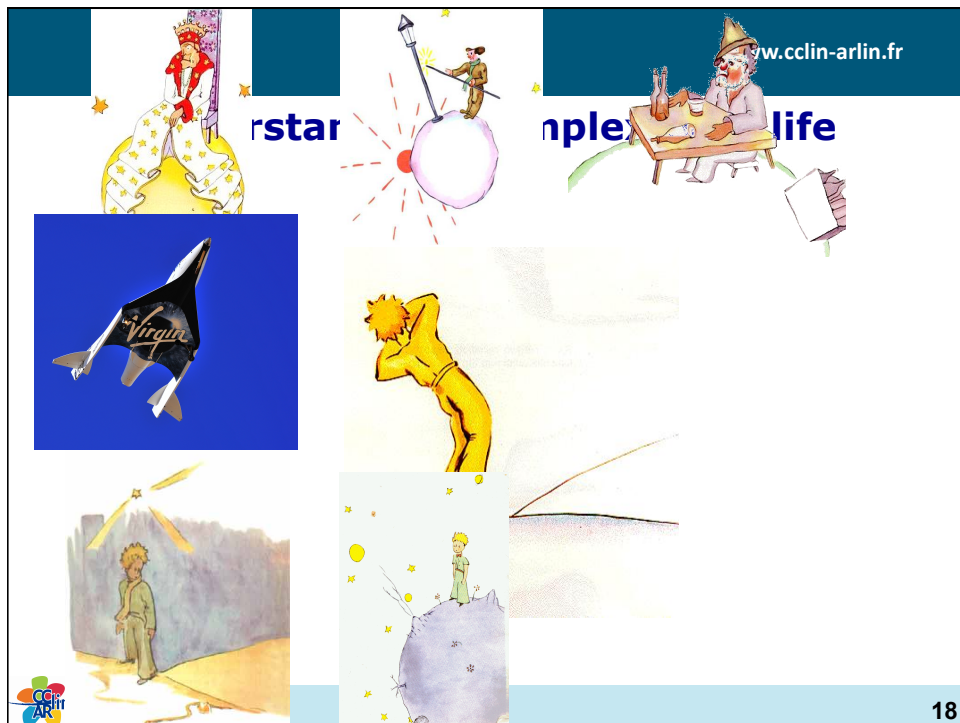
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## Understand the complexity of life



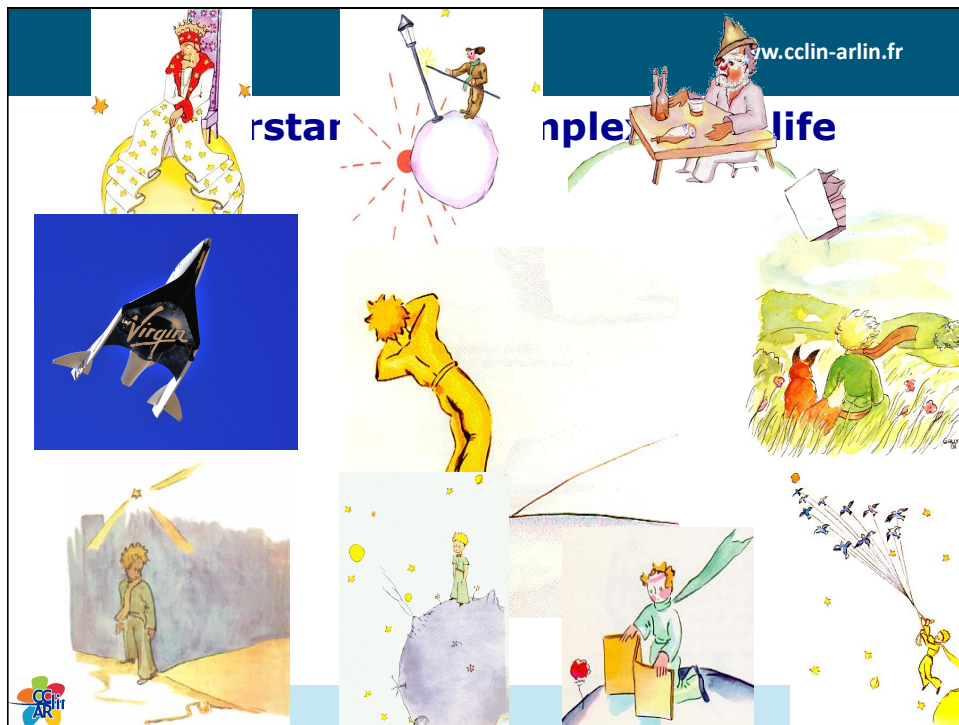
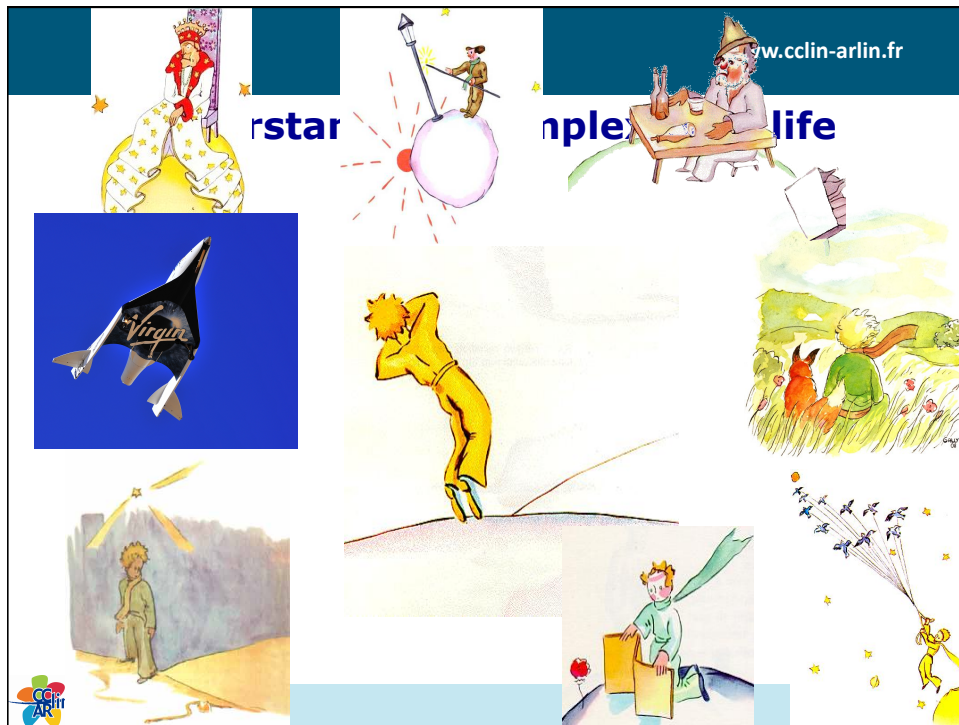
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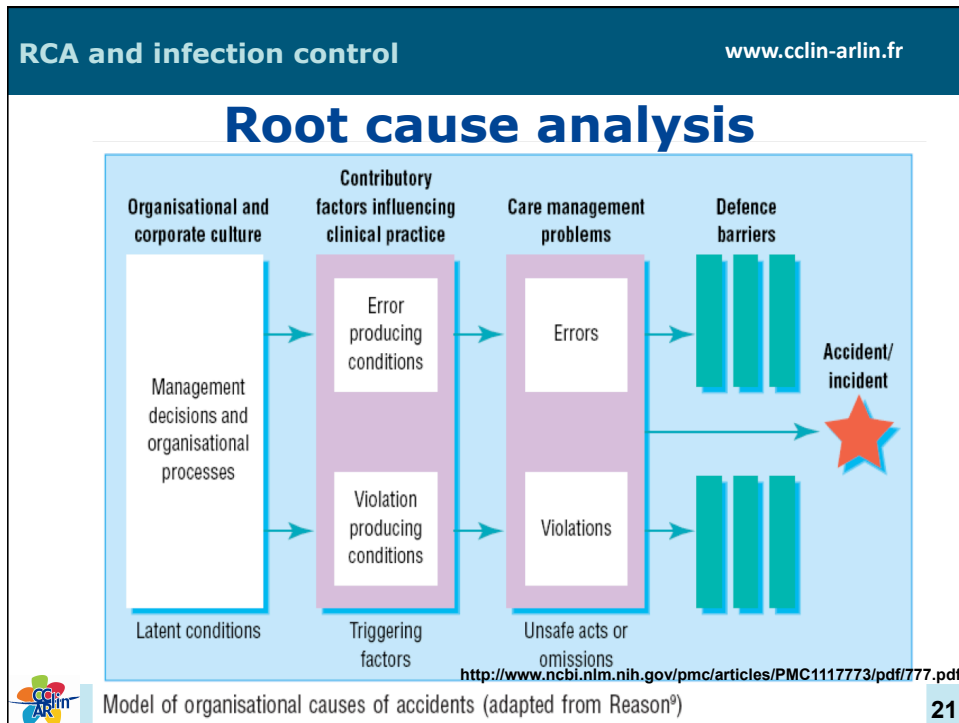
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### Philosophy

📄 **A single and simple answer to a complex situation is most often not appropriate**

A hand is shown holding a bundle of tangled wooden sticks, illustrating the complexity of a situation where a simple answer is not appropriate.

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## Root Cause Analysis

<p><b>Patient factors:</b> Clinical condition Physical factors Social factors Psychological/ mental factors Interpersonal relationships</p>	<p><b>Task factors:</b> Guidelines/ procedures/ protocols Decision aids Task design</p>	<p><b>Working condition factors:</b> Administrative Design of physical environment Environment Staffing Workload and hours Time</p>
<p><b>Team factors:</b> Role congruence Leadership Support + cultural factors</p>	<p><b>Organisational + strategic factors:</b> Organisational structure Priorities Externally imported risks Safety culture</p>	

<http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

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## Plan

### The French vision of the topic

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## RCA process

- 📄 Define the incident or near-miss to investigate
- 📄 Select a multidisciplinary team
- 📄 Gather information (interviews, documents, observations)
- 📄 Establish the timeline of the event
- 📄 Identify problems
- 📄 Identify contributory factors and root causes
- 📄 Identify solutions
- 📄 Prioritize and implement solutions
- 📄 Write a report



## Field experience in South West France


### Surgical site infections following bariatric surgery

- In a two-month period, 4 surgical site infections following bariatric surgery (mostly by-pass surgery) occurred. The IC team investigations showed universal precautions needed to be optimized.
- The IC team gave recommendations regarding hand hygiene and skin preparation.
- During the next 4 months, 7 new surgical site infections occurred. Surgical site infection rate was 8.7% in this six-month period whereas usual surgical infection rate in this ward was only 3.1%. Various micro-organisms were involved (cutaneous and digestive flora).
- The IC team decided to perform RCA.




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<b>Surgical site infections following bariatric surgery</b>			
	Problems	Causes	Solutions
<b>Patients</b>	Patients usually with poor cutaneous state.	Patients with comorbidities.	
	Difficulties to shower alone before surgery.	Mechanical difficulties due to obesity.	Help patients to shower.
	Patients did not ask for help to shower before surgery.	Psychological difficulties accepting someone looking at them.	Patients education to make them aware that showering before surgery is necessary.


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<b>Surgical site infections following bariatric surgery</b>			
	Problems	Causes	Solutions
<b>Health care workers</b>	Did not check the cutaneous state of patients neither that they correctly shower before surgery.	No protocol for such checking.	To integrate in the check-list the cutaneous state and the realization of the shower.
	Did not offer to help patients to shower.	Psychological difficulties to ask patients about showering and to offer help.	Awareness to make them be confident that showering before surgery is a care which needs to be checked.
		No training or protocol to help patients shower.	HCWs training + protocol.
	Wearing rings and wrist watches in the ward.	Underestimation of the risk.	Forbid rings and wrist watches.



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**Surgical site infections following bariatric surgery**


	Problems	Causes	Solutions
<b>Tasks</b>	Boxes of surgery devices were opened a long time before surgery.	Increase in the activity. Small time between interventions.	Stop early box opening by respecting time between interventions and adapting the program activity.
	Complex postoperative dressings.	Ward habits.	Discussion on medical prescriptions.
	Increased nursing workload because of many patients with a Picc-line.	Picc-line were used instead of peripheral venous access in obese patients because physicians thought it was easier to use.	Only use Picc-line when justified.

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**Surgical site infections following bariatric surgery**

	Problems	Causes	Solutions
<b>Context and organization</b>	Increased nursing workload because of reduction in paramedical workers.	Institutional strategy.	
	Nurses were regularly interrupted when performing cares and dressings.	Nurses had to frequently answer the telephone.	To be more organized to stop answering the phone when performing a care.

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## Surgical site infections following bariatric surgery

### Prioritized solutions

- Help the patient to shower before surgery
  - Protocol
  - Patients and healthcare workers education
  - CCLIN Sud-Ouest Video <https://www.youtube.com/playlist?list=PLyBYWsX9QAMHlatjHkD2kdEa3GgoSxJWV>
- To be more organized to limit cares' interruption
- To restrict the indication of PICC lines

**Return to SSI baseline rate.**



## Plan

**The French MRSA tool**



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**Outil d'aide à l'analyse des causes des bactériémies nosocomiales acquises à SARM**

L'analyse approfondie des causes (AAC) des bactériémies nosocomiales (BN) acquises à SARM permet de répondre en partie au nouvel indicateur BN-SARM du tableau de bord 2013 (INSTRUCTION N° D005/PF2/2014/06 du 04 mars 2014 relative au bilan des activités de lutte contre les infections nosocomiales dans les établissements de santé pour l'année 2013).

Cet indicateur reflète l'exigence que possède un établissement de santé à réaliser une AAC, suivant une méthodologie reconnue, afin de mettre en place des actions d'amélioration et d'éviter la survenue ultérieure d'événements similaires.

Cet outil a été créé dans l'objectif d'aider les établissements de santé dans la conduite d'analyse approfondie des causes (AAC) des BN acquises à SARM.

- ☛ Cet outil permet de lister les épisodes de bactériémies à SARM survenues dans l'année, d'identifier les bactériémies nosocomiales acquises, puis de tracer l'analyse des causes de celles-ci et enfin de suivre la mise en œuvre des actions d'amélioration.
- ☛ Afin d'aider les professionnels, des listing des principaux écarts ou causes immédiates et des causes profondes susceptibles d'être identifiés, sont proposés lors
- ☛ Cet outil vous permet également de calculer les indicateurs demandés par BN-SARM : Proportion d'épisodes de BN acquises à SARM ayant fait l'objet d'une AAC et proportion d'épisodes de BN acquises à SARM sur l'ensemble des épisodes de bactériémie à SARM identifiés dans l'année.

**Les macros doivent obligatoirement être activées. Si ce n'est pas le cas, se reporter à l'aide** ? Help  
*Dans chaque onglet, vous ne pourrez saisir des données que dans les cases jaunes.*

Guide d'utilisation    Liste des épisodes de BN à SARM    Accès aux référentiels

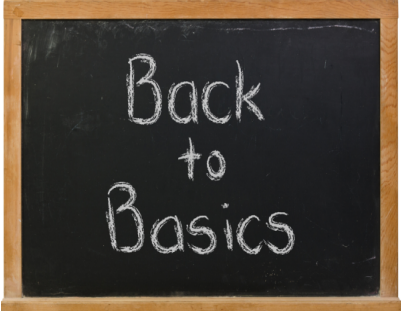
*Cet outil est une première version qui sera amenée à évoluer et à s'enrichir chaque année en intégrant les retours des utilisateurs afin d'en faire un véritable outil participatif. A cette fin, vous pouvez contacter Caroline Bervas et Muriel Pétau au CCLin Sud-Ouest dont les coordonnées figurent ci-dessous pour donner vos avis et commentaires.*

[http://www.cclin-arlin.fr/GDR/Analyse\\_causes/Outil\\_BacteriemieSARM\\_Reseau\\_Cclin\\_Arlin\\_2015.xls](http://www.cclin-arlin.fr/GDR/Analyse_causes/Outil_BacteriemieSARM_Reseau_Cclin_Arlin_2015.xls)

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## RCA basics



**What has arrived?** Time line / Chronology

**How it has arrived?** Gaps / Immediate causes

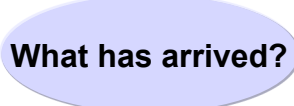


**Why it has arrived ?** Root - latent causes

[http://www.cclin-arlin.fr/GDR/Analyse\\_causes/Outil\\_BacteriemieSARM\\_Reseau\\_Cclin\\_Arlin\\_2015.xls](http://www.cclin-arlin.fr/GDR/Analyse_causes/Outil_BacteriemieSARM_Reseau_Cclin_Arlin_2015.xls)


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### RCA basics


<b>Prevention phase (before the event)</b>		<b>Time line / Chronology</b>
<b>Attenuation phase (after the event)</b>		<b>Gaps / Immediate causes</b>
		<b>Root - latent causes</b>

[http://www.cclin-arlin.fr/GDR/Analyse\\_causes/Outil\\_BacteriemieSARM\\_Reseau\\_Cclin\\_Arlin\\_2015.xls](http://www.cclin-arlin.fr/GDR/Analyse_causes/Outil_BacteriemieSARM_Reseau_Cclin_Arlin_2015.xls)

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### MRSA Bacteraemia RCA




**Facts**

Death from MRSA bacteraemia associated to a peripheral venous catheter (PVC) on a patient admitted in emergency seven days before in the cardiology department of a hospital for left heart failure

**People met, two group interviews**

- 1 with the emergency team:
  - ❖ Doctors, head nurse, nurse, nurses aid.
- 1 with the cardiological team : Doctors, head nurse.

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Prevention phase

Tuesday

- **20h00** : Patient of 89 years covered by the SMUR for left heart failure with chest tightness; PVC posed by SMUR simple skin disinfection (Multiple patient risk factors)
- **20h30** : Admitted to the emergency. Support information transcribed by the physician on the emergency SMUR software.
- **00h00** : Patient transferred in cardiology; no change of the PVC

**Friday 15h30** : Redness at the puncture site of the PVC observed and reported internally; PVC removed and rested in the other arm, prescription of an alcoholic dressing

**Saturday 8h13** : Presence of pus at the puncture site, sampling prescribed by resident for the next day; low-grade fever in the afternoon.



Prevention phase

**Wednesday 00h00** : Patient transferred in cardiology; no change of the PVC

**Gap/IC**: no change of the PVC neither at the emergency unit nor in the cardiological ward

**LC**:

**Emergency unit**: Not the habit of the service to change PVC posed by SMUR, leave it to the downstream service to do but communication error on this point between units.

**Cardiology**: traceability of PVC emergency poses non clear in the software. Lack of knowledge of indications of PVC max duration.

**Saturday 8h13** : Presence of pus at the puncture site, sampling prescribed by resident for the next day; low-grade fever in the afternoon

**Gap/IC** : pas de PEC / pas de prélèvement

**LC**: Weekend, resident alone / Communication default between nurse / resident and resident / Senior / Under estimation of the risk / Lack of protocol for vascular access infections in the first-line antibiotics guide / No national recommendations for local PVC infection treatment



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Attenuation phase

Sunday 

- Morning: At the dressing refection, evacuation of pus, sampling, fever
- 23h20: 1st series of blood cultures, fever

Monday 

- 5h20: 2nd series of blood cultures, fever
- 7h30: Sepsis, fever treatment
- Morning: Information from the lab about positive blood cultures (cocci gram +)
- 23h00: 3rd and 4th series of blood cultures, fever, patient deterioration (Acute pulmonary edema, call the intensivist, treatment with Linezolid and Beta lactam antibiotics.

Tuesday 

- 7h30 : Stable ; painless ; Glasgow 14/15
- 8h30 : Patient found dead



Gap / Immediate causes :

- Sampling delay (30h) / delay in antibiotic treatment (60 h)
- Antibiotic treatment adequacy? Patient surveillance?

Latent causes:

- Poor alert transmission of the of blood culture positiveness between lab and unit.







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### MRSA Bacteraemia RCA Actions proposed and Priorities

	Proposed action	Responsible	
<b>1</b>	New configuration of computer software to be able to notify a PVC emergency insertion by checking a box	IT services	
<b>2</b>	Review PVC practices through an observational audit	IC team	
<b>3</b>	Probabilistic antibiotic treatment protocol to complete with a part on PVC infection	Infectiologists	
<b>4</b>	Positioning of positive blood cultures results as a management priority. Inform your doctor as soon as the alert by the laboratory for immediate care.	All wards of the hospital	

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## Plan

**Root cause analysis of  
 blood and body fluid exposures**

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## Exploring BBFE

- ▶ Blood and Body Fluid Exposures (BBFEs) involve a complex sequence of events combining technical, human and organizational factors.
- ▶ Performing root cause analysis (RCA) of these events is promoted to improve safety.
- ▶ RCA of a BBFE was conducted in a radiology unit using a recently developed French method called Orion®.
- ▶ The objective was to identify how the BBFE had happened and to implement actions to prevent its reoccurrence.



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## Exploring BBFE

**The starting point of the RCA was the report of a BBFE by a radiologist to occupational medicine. BBFE occurred during a non scheduled breast biopsy.**

- ▶ Analysis was conducted in collaboration with occupational medicine and the South-Western Centre for Healthcare Infection Associated Control.
- ▶ All Health care workers involved in the event have participated at the RCA : radiologist, radiology technician, nurse manager.
- ▶ Management risk team, Infection control team and pharmacist were present at the brainstorming on corrective measures to implement.



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## Exploring BBFE

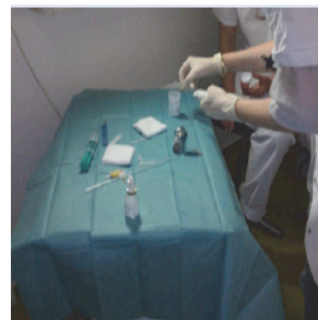
ORION comprises six steps:

- collecting data;
- rebuilding the chronology;
- identifying gaps;
- identifying contributing and influential factors;
- proposing actions to implement;
- writing the analysis report.




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## Exploring BBFE



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<h2 style="color: #0056b3;">Exploring BBFE</h2>		
<u>Chronology</u>		
Friday 9:00 AM	Beginning of MRI session for radiologist.	
11:00 AM	The radiologist adds on the schedule a breast microbiopsy for a patient with a suspicious MRI image. The radiology technician sets the patient in the biopsy room.	
12:20 AM	The radiologist comes in the biopsy room.	
	She puts a sterile drape upside down on the table to place sterile medical devices.	
	First of all, the radiologist performs a subcutaneous anesthesia then manually removes the subcutaneous needle and puts it down on the sterile drape. Next, she performs intramuscular anesthesia.	
	Afterwards, she inserts the bisopsy gun, pulls the trigger and removes it.	
	The radiologist takes the subcutaneous needle placed on the sterile drape to drag the carrot into the bottle of formol. Then, she replaces the needle on the sterile drape.	
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<h2 style="color: #0056b3;">Exploring BBFE</h2>		
12:30 AM	The radiologist, who wears open shoes, feels a needlestick on the back of her foot. She sees the subcutaneous needle on the floor and notes the <b>BBFE</b> . The radiologist reports the BBFE to the radiology technician and asks for an antiseptic. The technician returns with a bandage. The radiologist continues her act and performs two other samples with the same process.	
12:45 AM	End of the biopsy. The radiologist disinfects the wound with sterile gauze soaked with Dakin® for at least 5 minutes.	
1:30 PM	She meets the nurse manager who reminds her the protocol to follow in case of BBFE.	
1:35 PM	The radiologist goes to emergency. The source patient returns at hospital for serology at 2:30 PM.	
6:30 PM	The laboratory calls the radiologist to inform her about the negative results of serology.	
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## Exploring BBE

<u>Main gaps</u>	<u>Contributing factors</u>	<u>Influential factors</u>
Non immediate disposal of the needle	Lack of safety container close to the work area	Lack of adequate safety container
Reuse of subcutaneous needle	Difficulties to drag the carrot into the bottle of formol because of its adhesion in the biopsy gun needle	Lack of adequate material device to drag the carrot into the bottle of formol
Non scheduled breast microbiopsy	Biopsy session scheduled 6 days after the RMI session. Recent increase of biopsy activities	Sub-optimal organization for the breast microbiopsy procedure: no protocol, inadequate time-slot, lack of dedicated time

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## Exploring BBE

<u>Main gaps</u>	<u>Corrective measures implemented</u>
Non immediate disposal of the needle	<p>1 Providing adequate safety containers closer to care procedure</p> 
Reuse of subcutaneous needle	<p>2 Providing adequate medical device to drag the carrot</p> <p>It is a cassette with foam inside that allows the adhesion of the carrot. Once the carrot is deposited, the cassette is closed and is placed into the formol</p> 
Non scheduled breast microbiopsy	<p>3 Reorganizing the care with an additional microbiopsy session close to RMI session.</p>

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## Exploring BBFE

### Lessons learnt:

- This first use of the ORION method to analyse a BBFE proved successful.
- This method seems quasi-intuitive and easier to conduct than previously described methods because it relies on a detailed chronology.
- It allows the implementation of BBFEs preventive measures and promotes collaborative teamwork..



## RCA to support IC teams daily work

### An IC team correctly using a RCA process for a HAI

- implements more adequate prevention measures
- improves clinical practices
- improves collaborative working and teamwork
- reduces the risk of HAI... and more!

IC teams could use RCA for their own errors and near-misses....



## Conclusion

**RCA should be integrated in IC teams daily work and state of mind:**

- It is a useful tool for HAI investigation and prevention
- It is a useful tool to improve IC teams practices

**RCA brings value to IC teams work**

**One healthcare-associated infection should lead to one safety improvement action!**



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## The grown-ups are very strange



[http://download.bioon.com.cn/upload/201111/21084046\\_8501.pdf](http://download.bioon.com.cn/upload/201111/21084046_8501.pdf)



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**Root Cause Analysis used in the field of infection control**  
**Prof. Pierre Parneix, C.C.L.I.N. Sud-Ouest - CHU Pellegrin**  
**A Webber Training Teleclass**

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