

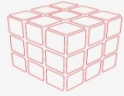
# ‘Come and give us a taste of your quality’

## Regulation and Quality Management in HPC Transplant Programmes

Tuula Rintala, RN, MSc

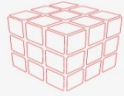
Service Manager, KCH

Jacie Inspector, Collection Facility



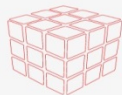
‘Come give us a taste of your  
quality. Come, a passionate  
speech’

Shakespeare: Hamlet, Act 2, Scene 2



# 8 most common problems in health care

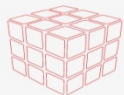
1. Unknowing variation in clinical practice and service delivery
2. Errors of commission and omission
3. Waste
4. Failure to implement new knowledge and technology systematically and appropriately
5. Over-use and under-use – inappropriate care
6. Unsatisfactory patient experience
7. Poor quality clinical practice
8. Failure to manage uncertainty



# Cancer Plan 2000

- Development of a comprehensive package of guidance of services which are likely to improve the outcomes of different kinds of cancer
- Translation of this guidance into measurable national standards
- Institution of a programme of peer review assessment of services against the national standards to ensure quality of cancer services

NHS Cancer Plan: three year progress report;  
Maintaining the momentum, DH 2003

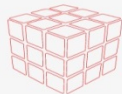


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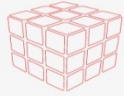
EU TCD 2004





# Inspections

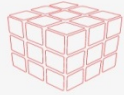
- Self –assessment
- Peer review (DH&JACIE) vs. Inspectorate (MHRA & HTA)
- Voluntary (JACIE) vs. Mandatory (HTA & MHRA)



# Common Themes

- Roles & Responsibilities
- Consent
- Quality Management
- Risk Management
  - Audit
  - Adverse event management

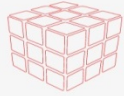




# What is Quality?

- Moullin (2002)
  - Quality leads to a service better meeting the patient's requirements, and increases patients confidence in the service; staff is more empowered and higher job satisfaction; better quality can reduce costs
- MacKenzie (2005)
  - Multidimensional & changeable concept
  - 'an acceptable compromise'
- Donabedian (2005)
  - reflection of values and goals current in healthcare and in the larger society



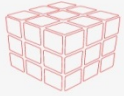


# What is Quality?

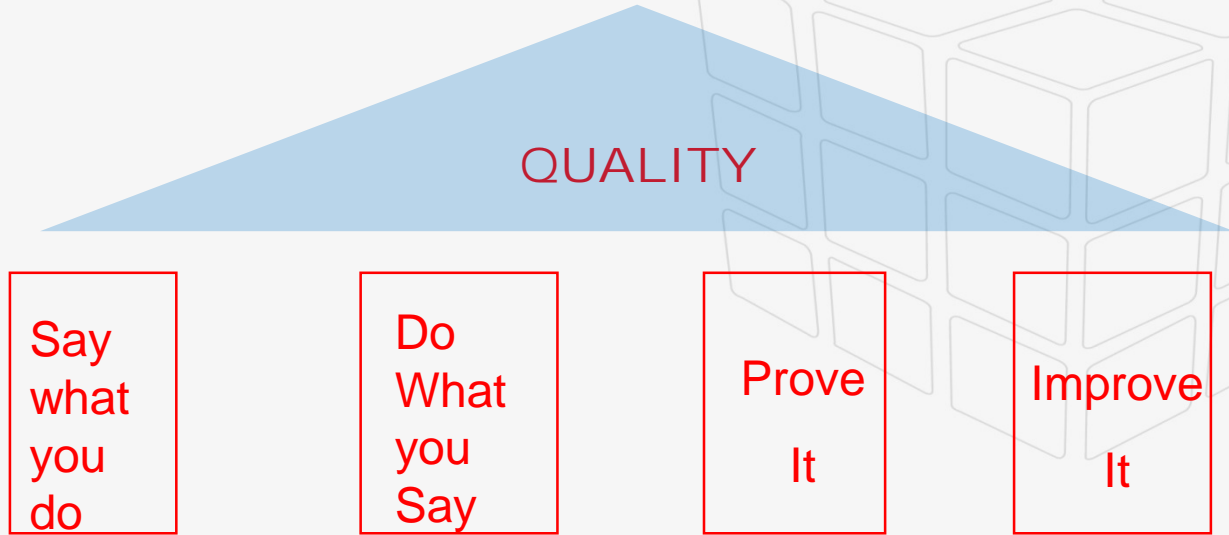
US Institute of Medicine: Six dimensions of healthcare quality:

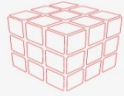
- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable



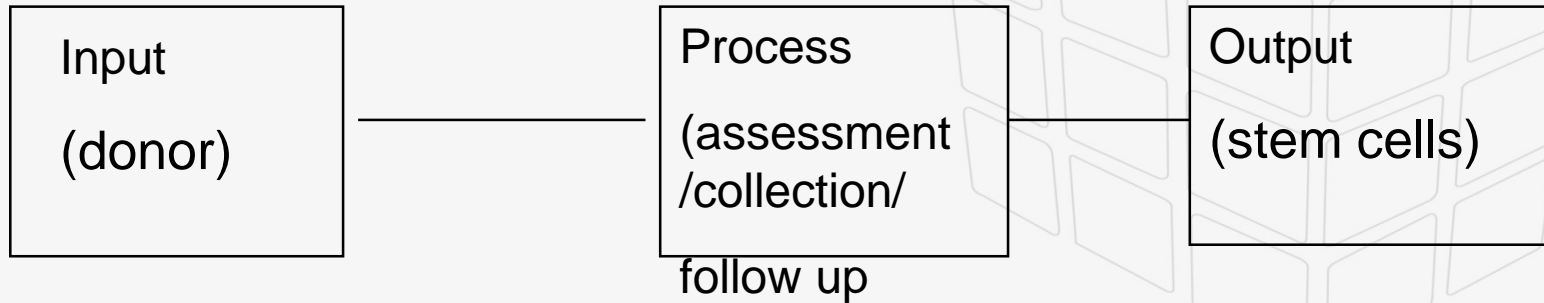


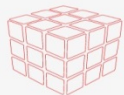
# 4 Pillars of Quality





# Everything we do is a process





What

Reference (Standard)

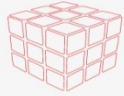
+

How

Agreements (within the  
dpt)

Examine

In reality



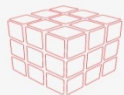
# Ferlie & Shortell: Model for quality improvement

- Levels of Change

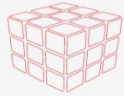
- Individual
- Group /Team
- Organisation
- Larger system / environment

- Core properties

- Leadership
- Organisational culture
- Team /microsystems development
- Information Technology

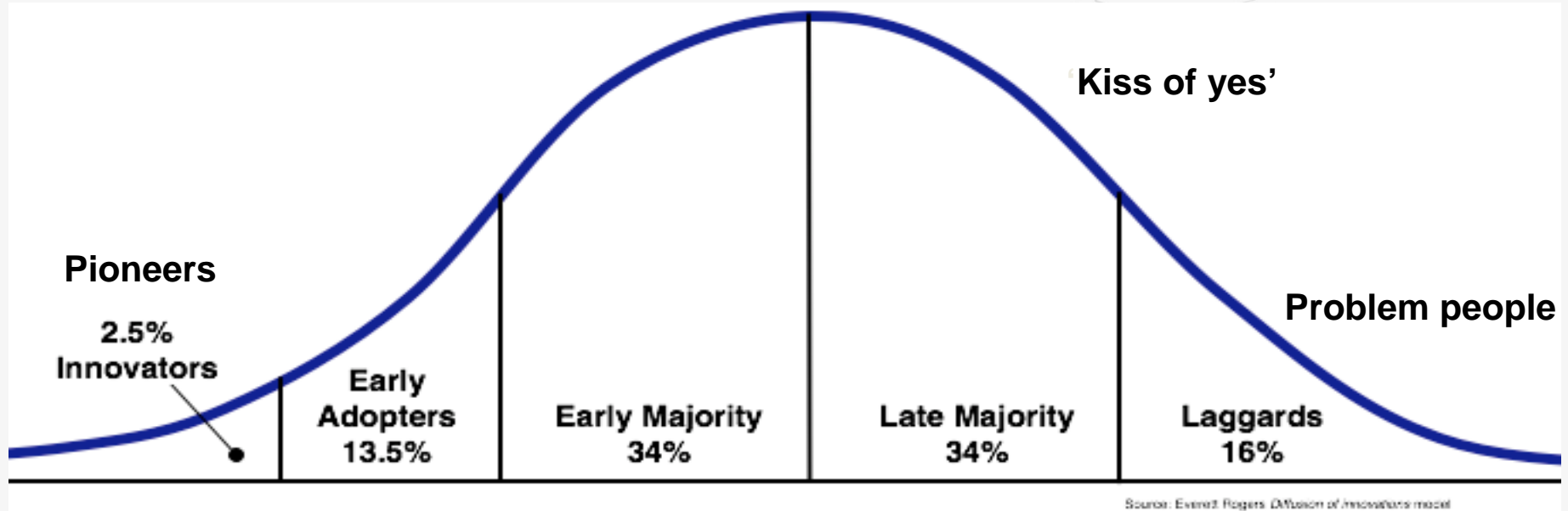


Key Properties	Leadership	Organisational Culture	Team Development	Information Technology
Levels of Change				
Larger Systems / Environment	JACIE	-	JACIE	-
Organisation	BMT Commissioners	Hospital Infrastructure (incident reporting / audit)	National Quality Forum	Hospital IT infrastructure
Team Level	Programme Director	Multidisciplinary Teams	Collaborative working	Task redesign (Data Management / SOPs)
Individual	Quality Manager	Training / Documentation	Training / SOP implementation	SOP implementation / documentation

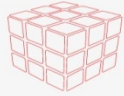


Not self-supporting system

Self-supporting system

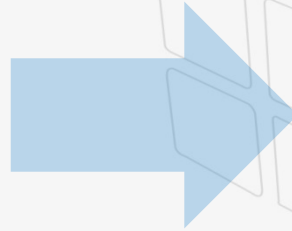


20% 'tipping point'



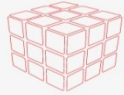
# How to maintain QMS?

- Make it relevant
- Focus on improvement
- Make it patient centred
- Share it



- Safe
- Effective
- Patient-centred
- Timely
- Efficient
- Equitable





# How do we know how we are doing?

- Collect Data
  - Scorecards
  - Surveys
  - Audits
- Make collecting data easy
  - Use & review data hospital collects & evaluates
  - Share data
- Engage all staff
  - Make sure everyone knows what the purpose of collecting data is





4  
3  
2  
1  
0

**satisfaction  
with turnaround  
time for donor  
searches**

**satisfaction  
with  
communication  
about typing**

21st - 23rd September



# Are skin-tunnelled catheters essential for myeloma autograft transplant?

Liz Bishop, Nurse Consultant ; Marinella Colosio, Staff Nurse  
Guy's and St Thomas' NHS Foundation Trust, London

Guy's and St Thomas' **NHS**  
NHS Foundation Trust



## Objectives

The British Committee for Standards in Haematology (BCSH) recommend skin-tunnelled ("Hickman-type") central venous catheters for patients when central venous access is required for more than 30 days (BCSH 2006). Skin-tunnelled catheters carry significant risk and may cause additional morbidity to patients, as well as increased cost. The risks and benefits of the use of central venous catheters in this population required further examination.

### The aims of the audit were to:

- Establish the number of catheter *in situ* days and Length of Stay (LOS)
- Determine the infection rates and use of antimicrobials
- Establish if patients had a preference for peripheral or central venous access

## Methods

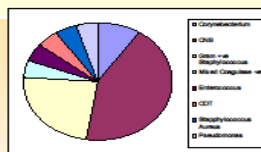
The casenotes and computerised microbiology records of 23 patients treated with high dose melphalan and PBSC autograft between November 2003 and November 2006 were reviewed.

All 23 patients were sent a questionnaire with specific questions about their experiences and preferences.

## Results

- 23 patients had a melphalan autograft for myeloma (200mg/m<sup>2</sup>)
- New skin tunnelled catheters were inserted < 1 week prior to the transplant
- Mean number of catheter *in situ* days was 30.5 days (range 11-60 days)
- Mean LOS was 20.2 days (range = 15-35 days)
- There were 2.61 catheter related blood stream infections per 1000 catheter days
- Fever developed day +7 (mean). Only one patient had no fever and no IV antibiotics
- Positive cultures were obtained in 47.8% of patients (n=11) requiring IV antibiotics.
- Intravenous antibiotics were administered for a mean of 8.2 days (range = 4-21 days)
- 30% of patients were needlephobic or had poor peripheral venous access

### Positive Blood Culture results



### Questionnaire analysis:

17/23 questionnaires were returned

	Yes	No
Did you understand why the Hickman catheter was inserted?	100%	0%
Did you find the insertion painful?	80%	20%
Did you believe catheter removal would save you more discomfort?	80%	20%
Did you have any problems with your Hickman catheter?	80%	20%
Would you prefer to not have the Hickman catheter during the transplant?	80%	20%

### Patient comments:

"I think I could have coped with drips. Having the Hickman line for a long time causes a worry..."

"As my veins were not good as a result of several courses of chemotherapy, I think finding a vein for a cannula may have proved difficult"

"I had a deep vein thrombosis therefore the idea of a Hickman line was not very good"

"Yes I preferred it, but it (Hickman catheter) was very difficult to remove and it was very painful"

"It was always a concern it would become infected during the transplant, which psychologically for patients is not good"

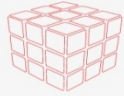
## Conclusions

In patients who have adequate peripheral veins it may be preferable to avoid central venous catheterisation. Many patients are anxious about the insertion of these catheters and they carry significant risk. Peripheral access may also be a more economical option, by excluding the risk of catheter-related bloodstream infection and thereby reducing the use of intravenous antibiotics and minimising length of stay in hospital. There are further reduced costs of insertion and of the device itself. In addition, as there is an increasing trend towards out-patient transplantation management of the patient using the peripheral venous access strategy may be safer.

## Key points

- Skin tunnelled central venous catheterisation may not be necessary for melphalan autograft procedures
- Vein assessment is essential prior to transplant
- Patient choice should be considered
- Costs and Length of Stay may be reduced by avoiding the use of skin tunnelled central catheters

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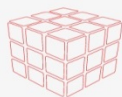
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# Learn from Mistakes

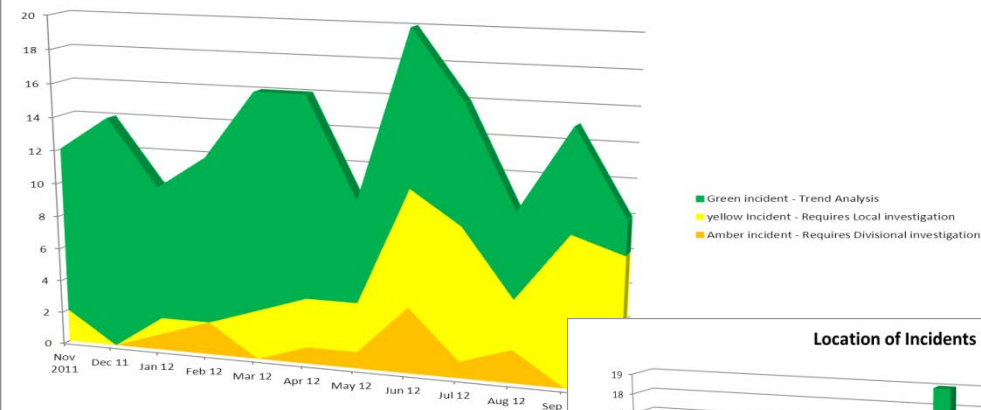
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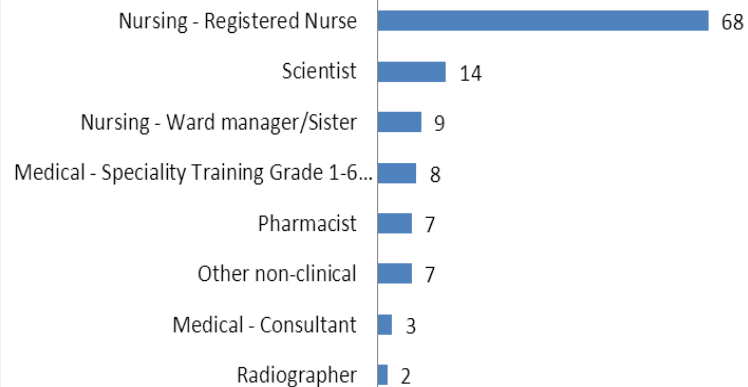
*“Yellow? Don’t call us until it’s at least an orange alert.”*



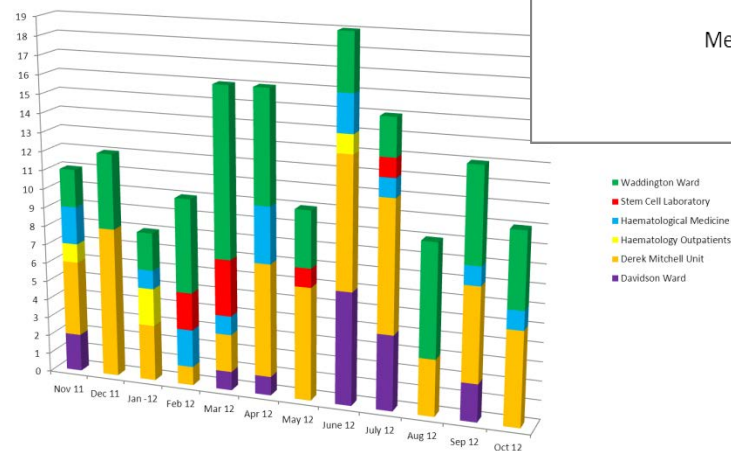
**BMT Incident Grades between Nov'11-Oct'12**

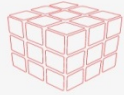


## Incident Reporters Nov 11 - Oct 12



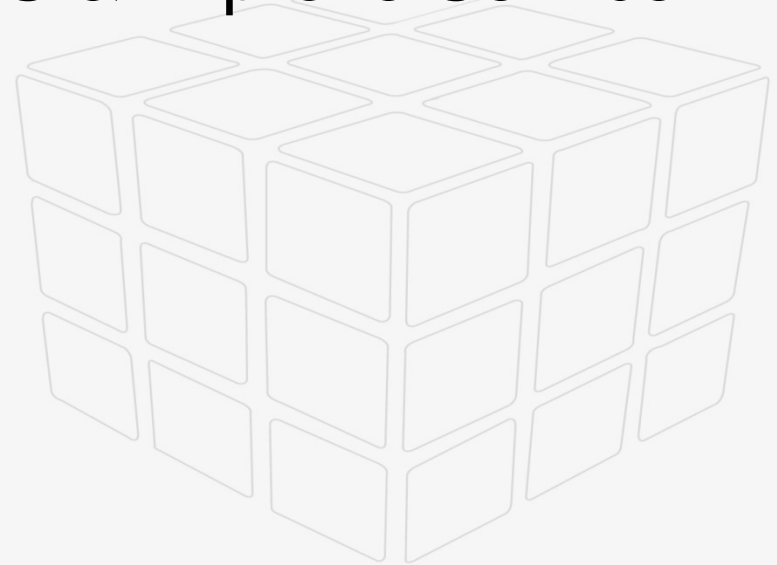
**Location of Incidents No 11 - Oct 12**



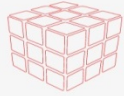


# How can we maintain QMS & improve Service?

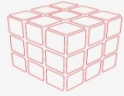
1. Measure what you are doing
  - Learning through the process
  - Measure over time
2. Understand the process
  - Explains WHY the problem exists
  - Tool for engaging staff
3. Improve reliability
  - Helps to reduce waste in the process (time, resource & reduces harm)
  - Consistent care







4. Demand, capacity and flow
  - Understand the variation in the capacity available
5. Engage all staff
  - How the change is introduced, predicts the success
  - Engaging frontline staff is crucial
6. Involve patients
  - Ask - 'How do we know what constitutes good care?'
  - Patients may define quality differently from clinicians & managers



# Acknowledgments

- Mr Eoin McGrath & JACIE Office, Barcelona
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- Dr Juan Baeza, KCL
- National Quality Forum (UK)