HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND

Collaborative to Prevent Central Line Associated Bacteraemia

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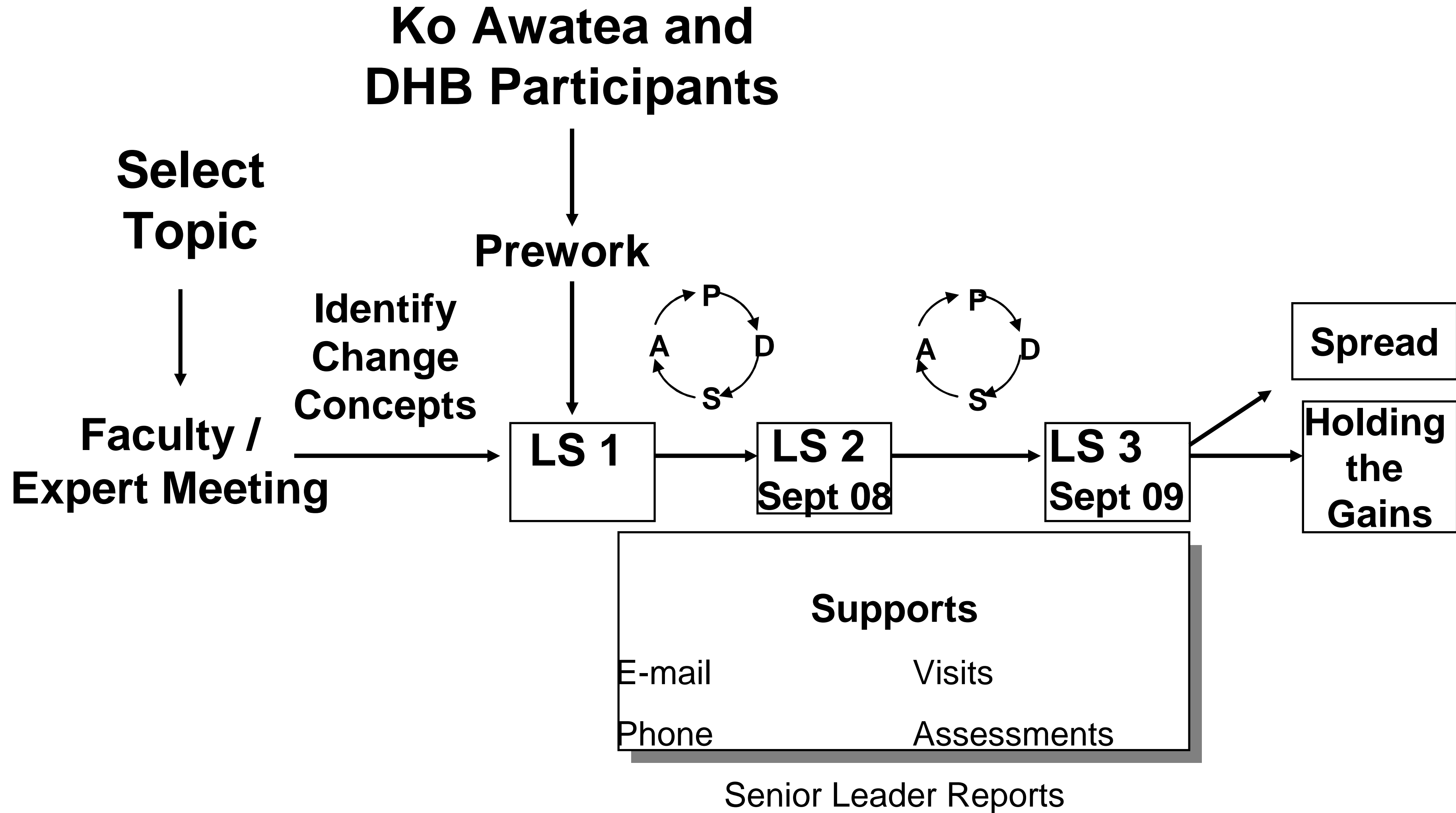
Learning Session Zero

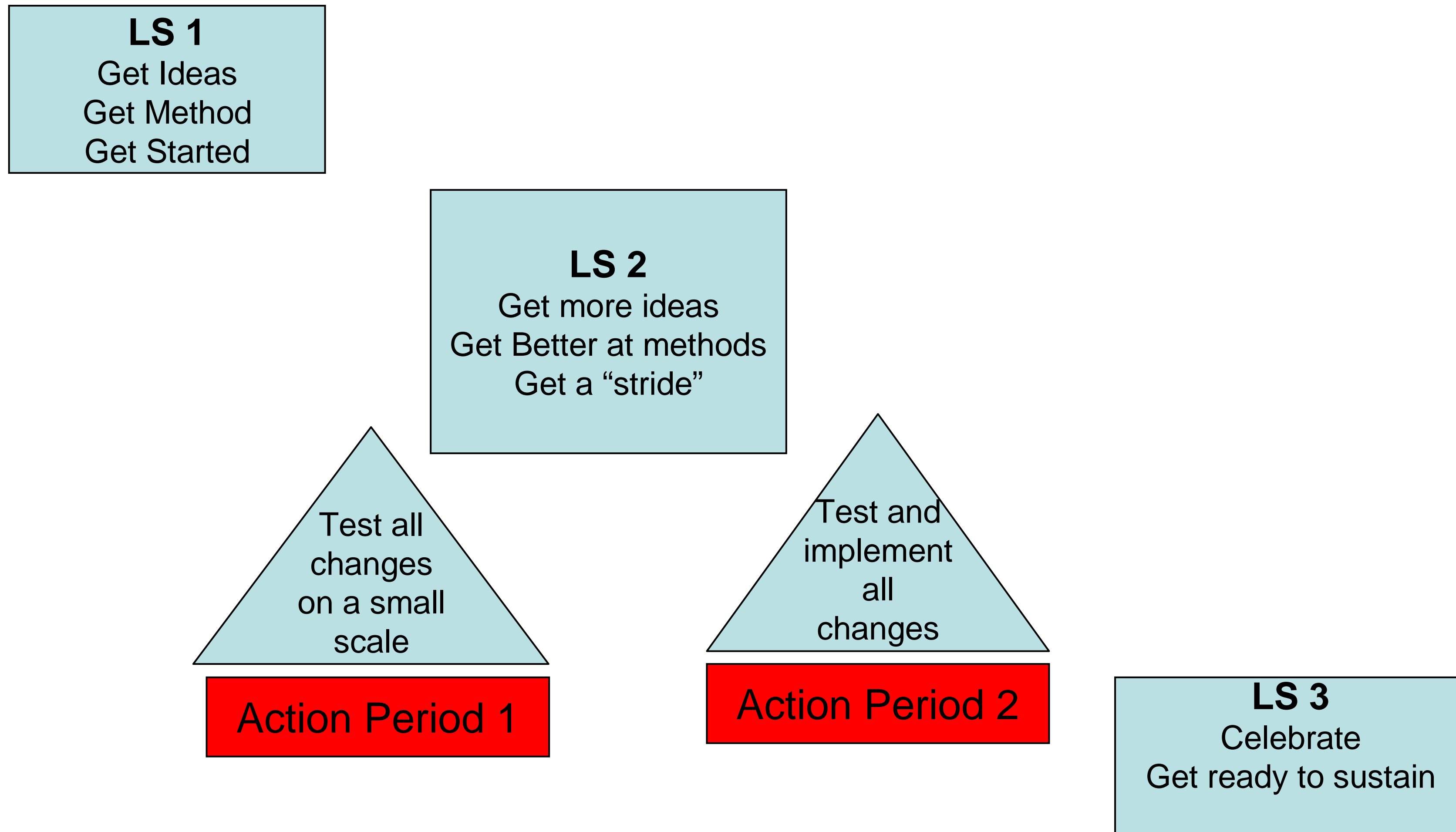
8th November 2011

12.00hrs to 14.00hrs

Collaborative Structure



Learning Session Structure



Campaign Overview

Event	Dates	City	Main Focus
CLS 1	**November 2011** 28th and 29th November	Auckland Ko Awatea	Methodology, tools and understanding data. Get ideas for Improvement. Refine aim and measures
Action Period 1	Test changes and get feedback from results. Establish monthly reporting. Get support from the Campaign Team.		
CLS 2	**July 2012** 30th & Tues 31st July	TBC	More ideas for change. Deeper understanding of testing and implementation. Overcoming barriers. More collaboration.
Action Period 2	Test changes in all areas of change package. Collaborate with colleagues. Begin discussing plans for spread.		
CLS 3	**March 2013** 18th &Tues 19th March	TBC	Celebrate results. Plan for holding gains and spread. Get more ideas for change. Develop detailed plans for team's role in spread. ***Plenary Speaker Dr Peter.J. Provonost***

Issues to Anticipate

- Effective teams
- Time and resources
- Physician involvement
- Resistance to change

Support for Teams

- Faculty for Healthcare Improvement
- Content Specialists
- Regional Coordinators
- Monthly reporting
- Development of data base
- Site Visits
- Regional Visits

Why would you be involved?

Ultimately we are all called to action to do the right thing and be part of an initiative that helps you to deliver high quality, safe care, through a proven methodology.

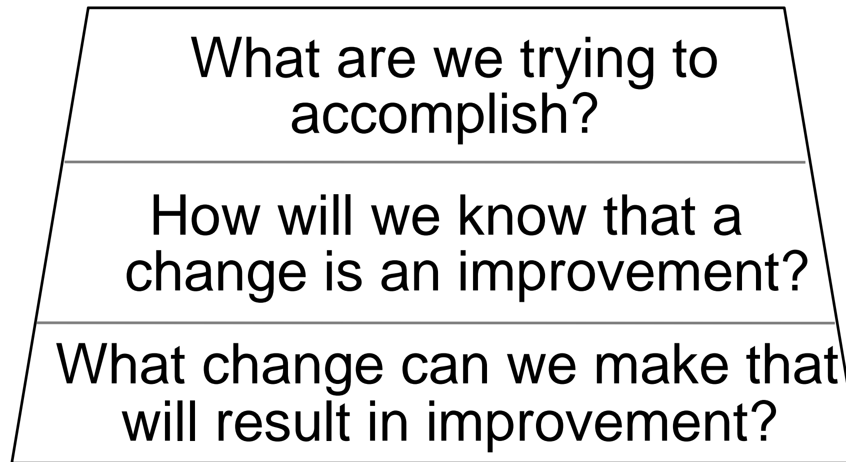
Evidence states:

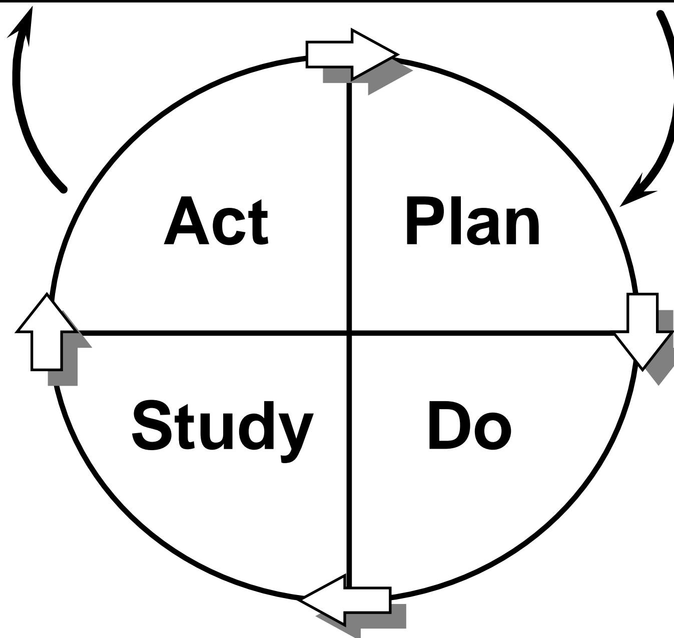
- CLAB is preventable and zero CLAB rates are achievable
- Cost per CLAB estimated to be between $NZ 20,000 and $54,000
- Each year 19,000 patients get admitted to ICU in New Zealand, approximately 50% have CVL
- The mortality rate from CLAB has been estimated to be between 10 and 50%

Campaign Goals

- To reduce the rate of CLAB in New Zealand ICUs towards zero (<1 per 1000 line days by 31 March 2013).
- To support local implementation of best practices regarding the reduction of CLAB across New Zealand Intensive Care Units.
- To establish a robust measurement approach to CLAB
- To establish a national web-based data base for collection, analysis and sharing of information.
- To develop capacity and capability in the application of the Model for Improvement

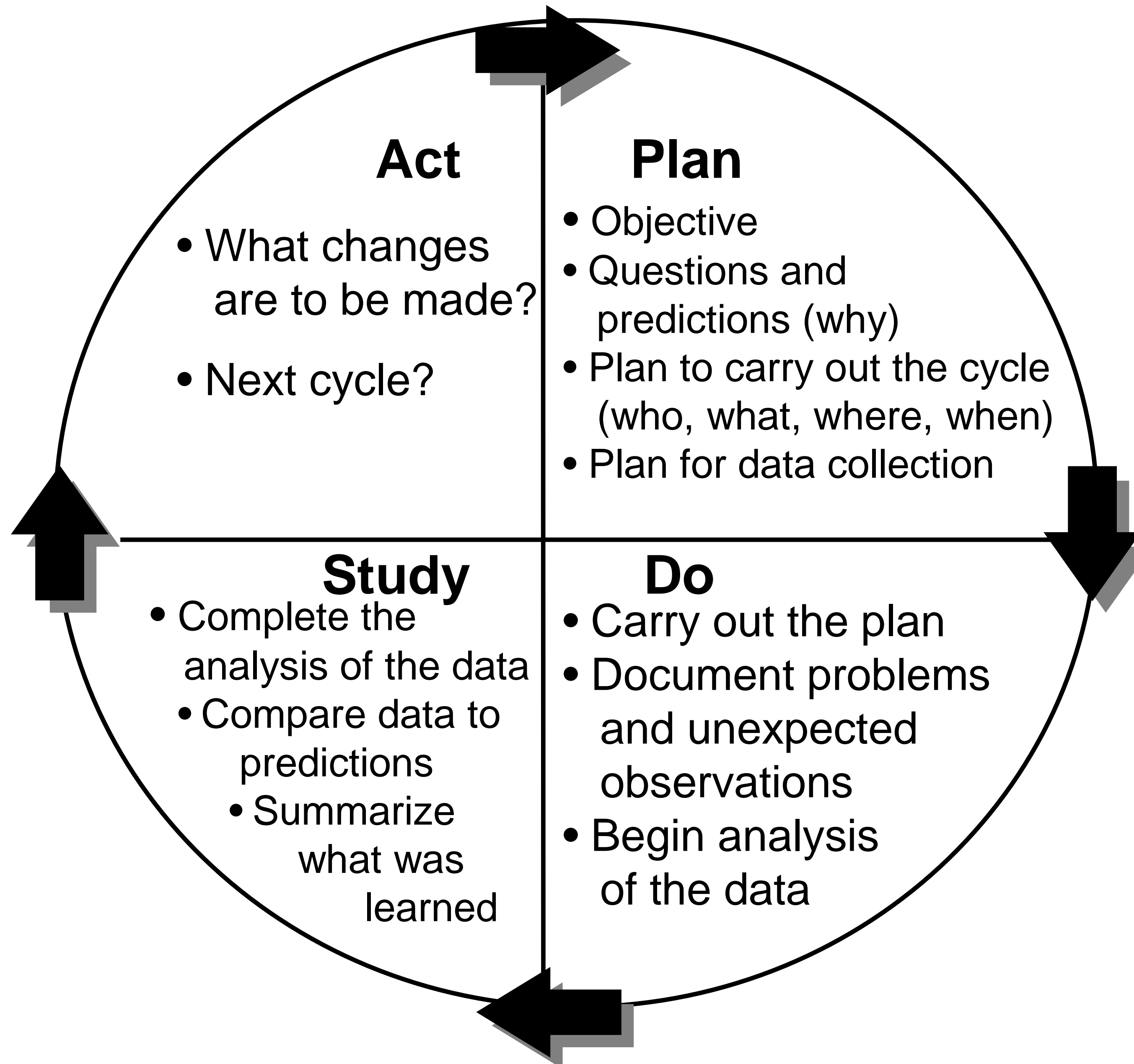
Model for Improvement



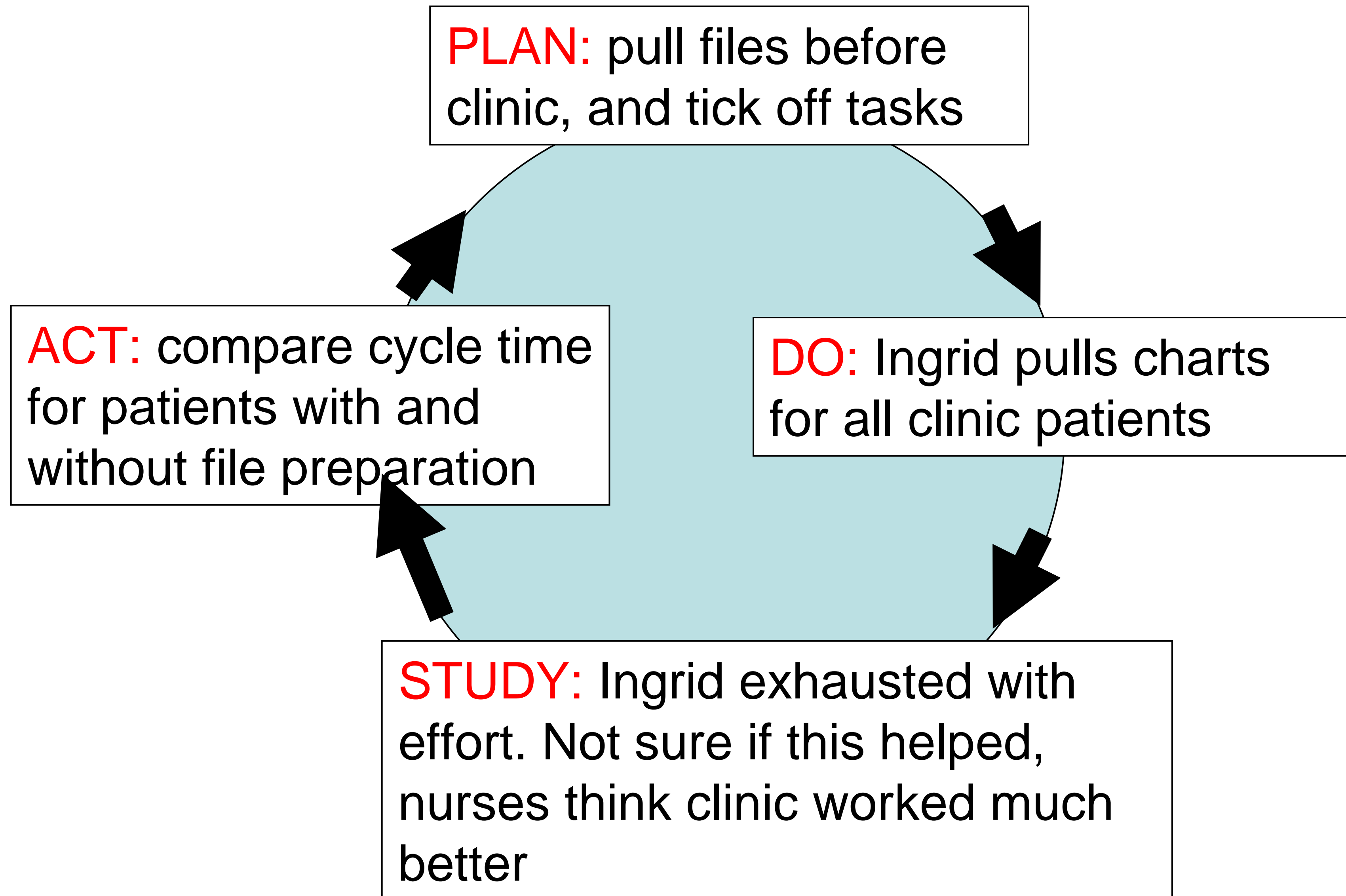


The PDSA Cycle for Learning and Improvement

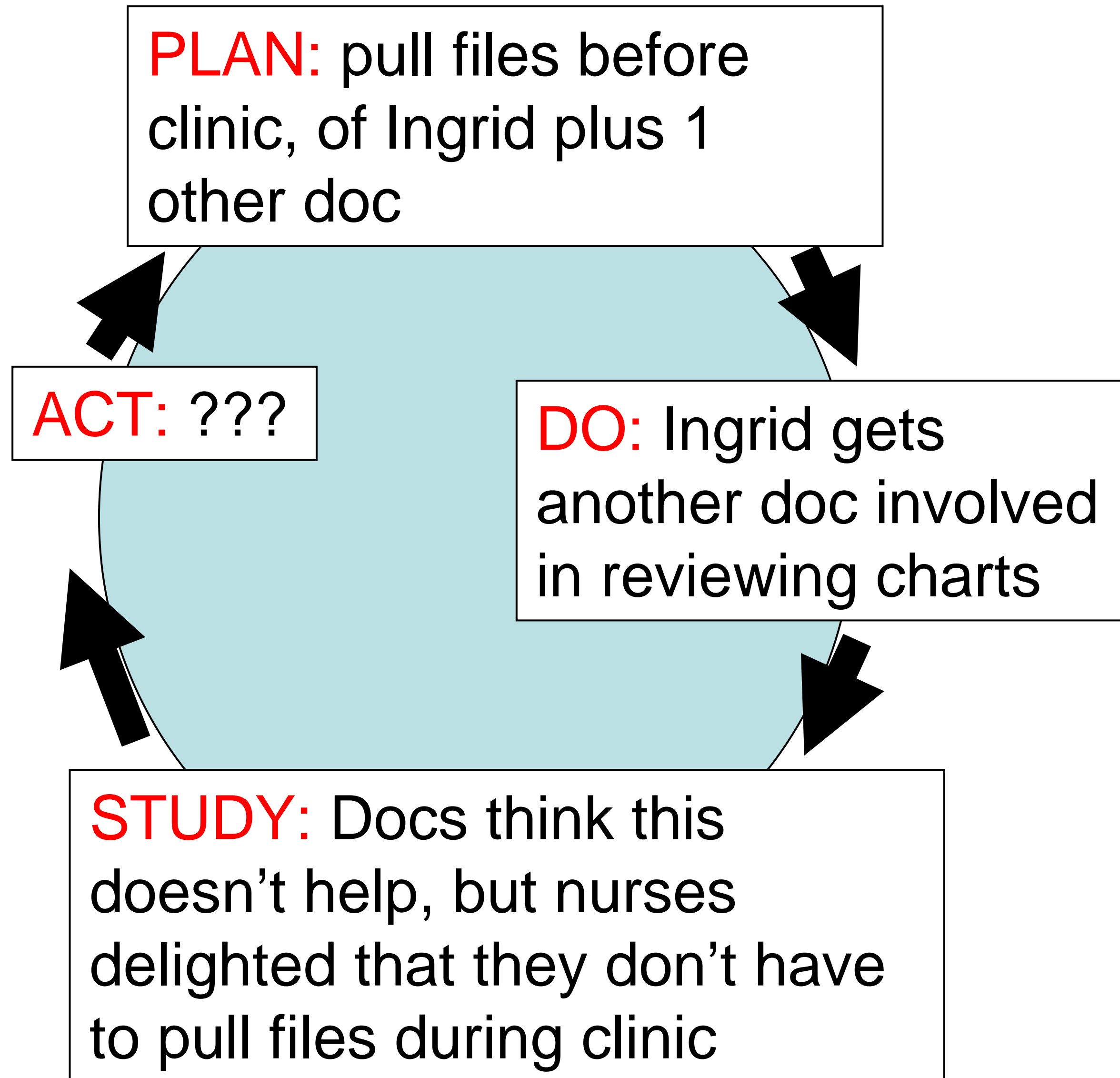
What change can we make that will result in an improvement ?



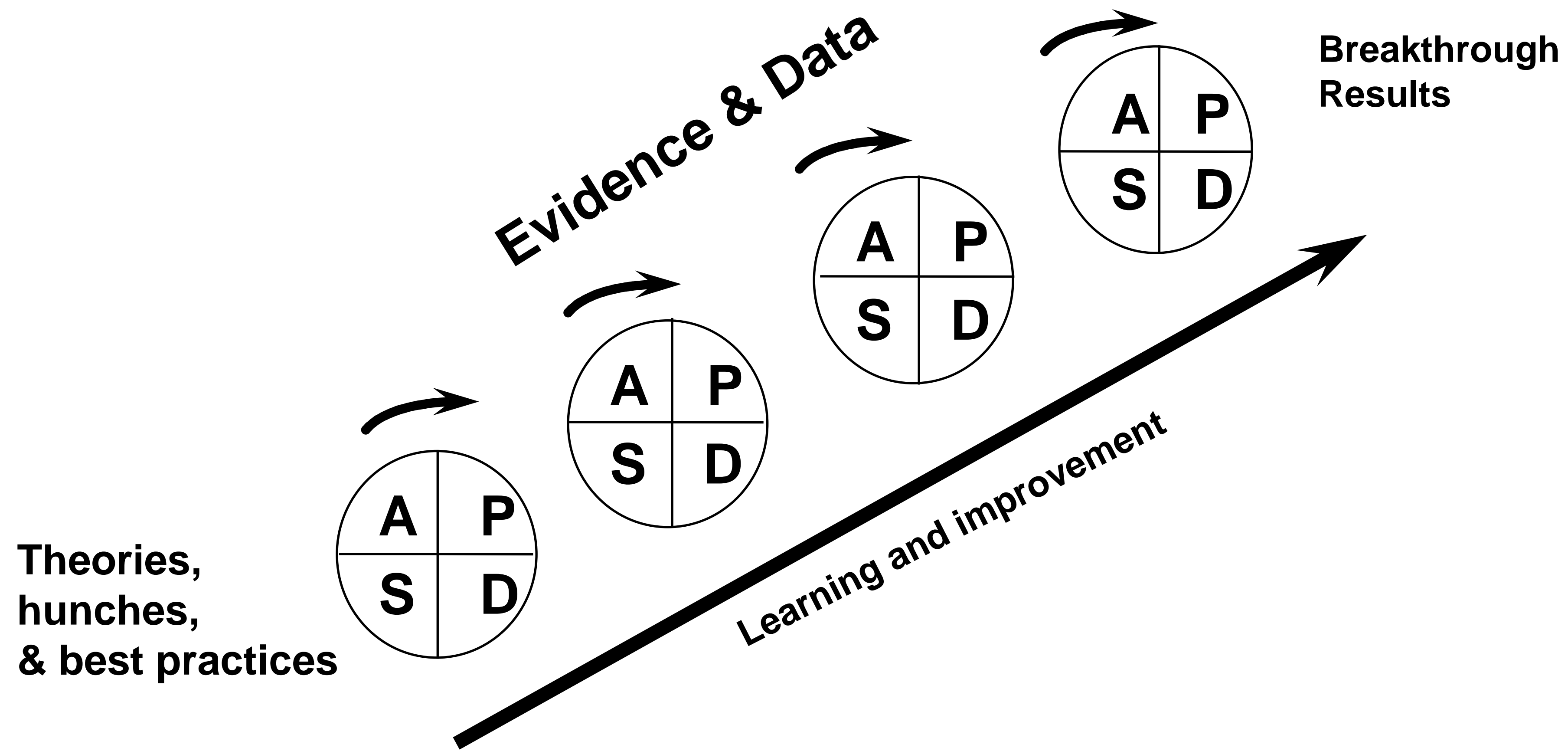
Tests of change: Doctors (cycle 1)



Tests of change: Doctors (cycle 2)



Sequential Building of Knowledge: Include a Wide Range of Conditions in the Sequence of Tests



Developing “best practice”