

An original approach of risk management to improve quality and safety of care in assisted self-care dialysis centres in a French region

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Introduction

Assisted self-care dialysis centres (ADC) are outpatient settings with potentially high-risk for healthcare associated infections. To improve the quality and safety of care in ADC of Paris area, we used an approach of risk management focused on infectious diseases risk. The objective was to highlight critical points which would need a common corrective action.

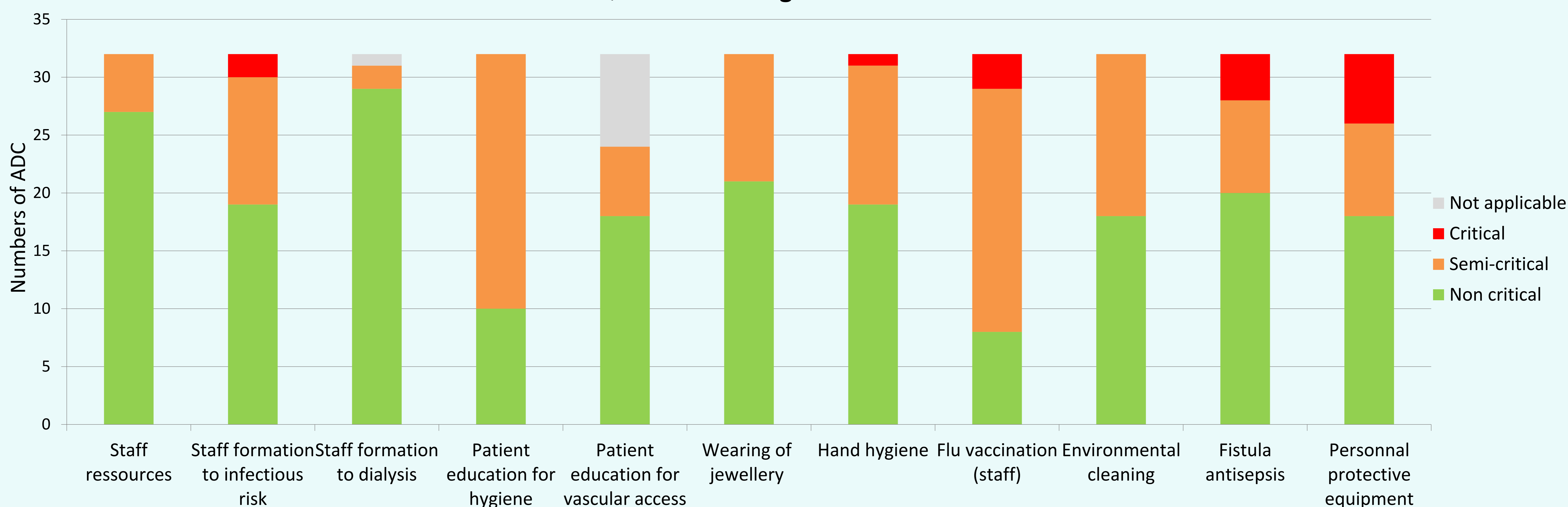
Methods

All ADC in Paris area were invited to perform an infectious safety walkround, using a standardized method developed by the regional infection control reference center. The visit included interviews with patients and all staff present, observations of arteriovenous fistula cannulation, facility visit and documentary census. All data were collected on a standardized form and a qualitative rating was assigned for each setting.

Results

Overall, 37 of the 62 ADC of Paris area performed the safety walkround (59.7%), of which 32 with data available for analysis. The standardized form contained 32 items of response, the most important are presented below :

Qualitative rating of infectious risk



- **Staff ressources** : nurse legal ratio was respected but there was an overwork due to patient with loss of autonomy and with many comorbidities.
- **Staff formation** : it was effective for the specificity of hemodialysis but the training for infectious risk is often neglected.
- **Patient education** : the communication of the information was difficult due to a lack of written support or because of language barrier.
- **Wearing of jewellery** : professionals still wear rings.
- **Hand hygiene** : in too many cases, plain soap was preferred to alcohol-based handrub and some hand hygiene opportunities are missed.
- **Flu vaccination** : in spite of information campaign, health care workers were still refractory to the vaccination.
- **Environnemental cleaning** : it was not always performed between two sessions due to organizational and financial constraints and some devices with high risk of cross transmission are often forgotten like the façade of dialysis machine or the weighing system.
- **Fistula antisepsis** : there was a lack of skin cleansing by the patient before applying antiseptic and nurses didn't check it.
- **Personnal protective equipment** : safety goggles and gown or disposable plastic apron weren't systematically used at cannulation time to prevent a blood exposure.

Conclusion

Cross-transmission risk remains not fully controlled in these high-risk settings. This original approach underlines critical common points that will be the focus of a regional work to improve the quality of care. Risk analysis methods which provide an action plan should be promoted to improve empowerment of patients and awareness of healthcare staff.