



**Singapore Healthcare
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CISPER Cross Institution Sterile Processing Enterprise Risk Management (ERM) Review



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INTRODUCTION

Following the NDCS CSSD incident in June 2017, where incompletely sterilised instruments were dispatched to clinics, a **Cross Institution Sterile Processing ERM Review (CISPER)** was initiated across the SingHealth cluster.

Recognising the important role of sterile processing function in ensuring patient safety, all institutions with sterile processing facilities came together to learn from the incident and review processes and systems.

Sterile processing facilities **collaboratively identified risks and opportunities for improvement**, sharing a common goal to ensure that appropriate systems and processes are in place, and safety standards and best practices are applied to safeguard patient safety.



METHODOLOGY

Representatives from institutions with sterile processing facilities were nominated to participate in CISPER.

Sterile processing ERM reviews were held in 3 sessions, involving **SGH***, **KKH**, **CGH**, **NCCS**, **SNEC** and **NDCS** in the first session, followed by institutions employing table-top sterilisation – **SHP** and **BVH**, and finally, the newly established **SKH**.

(SGH* refers to Singapore General Hospital which also caters for National Heart Centre Singapore (NHCS) sterilised supplies needs; KKH refers to KK Women's and Children's Hospital; CGH refers to Changi General Hospital; NCCS refers to National Cancer Centre Singapore; SNEC refers to Singapore National Eye Centre; NDCS refers to National Dental Centre Singapore; SHP refers to SingHealth Polyclinics; BVH refers to Bright Vision Hospital; SKH refers to Sengkang General Hospital)

Each session comprised:

- Sharing of NDCS CSSD incident and lessons learnt
- ERM review of sterile processing facilities
- Sharing of risks identified, current mitigations and need for additional mitigations by each institution
- Identifying common key risks and best practices

RESULTS

Common key issues identified in institutions' ERM reviews were grouped under 4 broad categories.

Under 'People'

*The need for a structured **career pathway** to attract and retain the right people, to ensure **right fit** at recruitment, to **equip staff with skills** to meet increasing complexity of instruments and supplies, and to provide **adequate training** opportunities were raised.*

Under 'Process'

- ***Involvement of sterile processing functions in procurement of new equipment/ instruments is crucial to ensure alignment with sterile processing capabilities.***
- ***In the event of recall, method for traceability of sterile instruments dispatched varies with operating systems used.***
- ***There is a need to promote accountability in sterile processing responsibilities, including oversight of equipment maintenance/ servicing by vendor.***

Under 'Speak Up Culture'

*Management must build a trust-based relationship with staff and demonstrate that staff feedback is valued. This enables staff to **feel safe to speak up** and be **willing to speak up** when safety concerns arise.*

Under 'Communication'

*Proactive communication between **sterile processing units and end users** is essential in ensuring that important information (e.g. change in indicators used or recalls) is disseminated.*

8 best practices were also identified and encouraged for cluster-wide adoption, where applicable.

1. Biological indicator for every load
2. 2-person verification of critical functions
3. Competent and trained staff for critical functions
4. Clear segregation of clean and dirty areas
5. Restrict personnel access to sterile processing area
6. Provide avenues for speaking up
7. Establish process to facilitate timely recall
8. Oversight for equipment maintenance/servicing

CONCLUSION

In conclusion, **issues identified were found to be common** across institutions despite differences in operating systems and workloads.

Long-term issues i.e. **training, recruitment and career pathways** will be addressed at **cluster-level** by a separate taskforce, which will also look into establishing **common standards, harmonising workflows and systems**, and cross-institutional **audits**.