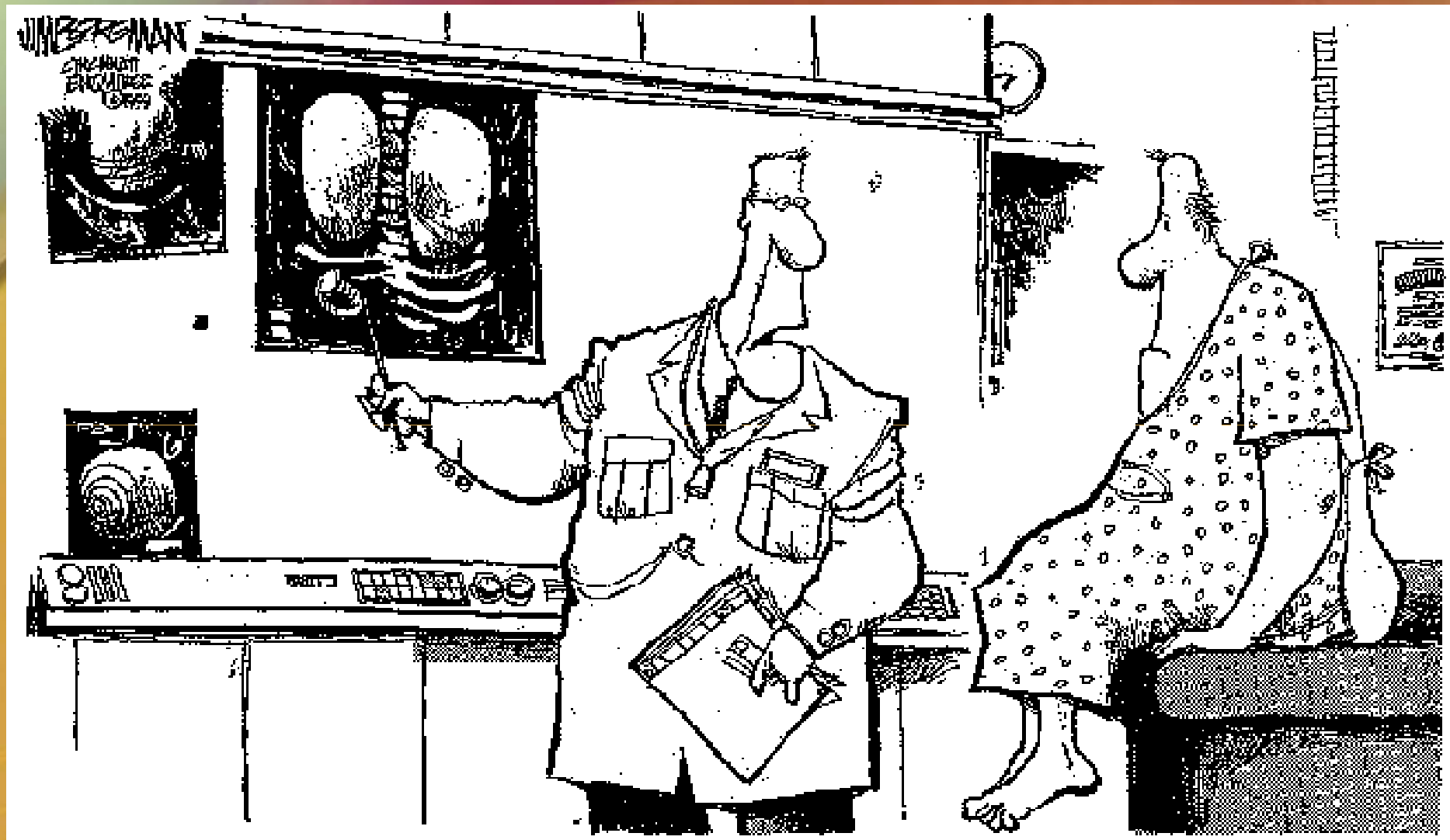
# *5 Diamond Patient Safety Program*

# What is Patient Safety?

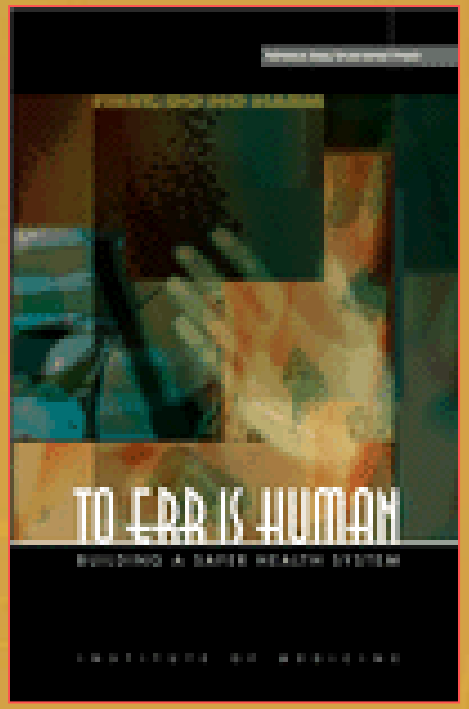
***2008***

**** This presentation was collaboratively developed by the Mid-Atlantic Renal Coalition (MARC) and the ESRD Network of New England for the* 5-Diamond Patient Safety Program.**

***The* 5-Diamond Patient Safety Program *is endorsed by the Renal Physicians Association (RPA) and American Nephrology Nurses' Association (ANNA).***


"CONTRARY TO ALL THESE REPORTS ON DOCTOR ERRORS, MR. JOHNSON, YOUR SURGERY WAS PERFORMED COMPETENTLY AND PUNCTUALLY, AS MY WATCH CLEARLY INDICATES."

# Institute of Medicine Report (1999)




44,000 – 98,000 people die each year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer and AIDS--combined--making medical errors the fifth leading cause of death in this country.

# Background

A survey conducted by the Commonwealth Fund identified the following:

- 25% of US patients have experienced a medical or drug error and 50% of these said it caused serious problems.

- 42% of adults stated they had been personally involved when a medical mistake was made.

# Background

Several surveys of hospital workers identified the following statistics:

- 84% of physicians and 62% of nurses reported they have seen co-workers take shortcuts that could harm a patient
- 1/5 of the physicians said they have seen patients injured as a result of a negligent colleague
- Fewer than 10% stated they would confront a colleague or discuss these issues with a supervisor

# Overuse v. Under use v. Misuse

- Overuse
  - Service is provided when the potential for harm exceeds the possible benefit.
- Under use
  - Failure to provide a service when it would have produced a favorable outcome
- Misuse = Error
  - An appropriate service has been selected but a preventable complication occurs

# Errors

- Errors occur because those responsible for maintaining systems safety are human and are therefore fallible.
- Errors are made by highly competent, careful and conscientious people for the simple reason that everyone makes mistakes every day. -Leape, 1997

# Errors vs. Adverse Events

- Errors can be ***prevented*** before they result in injury and become ***adverse events.***

- Reporting "near-misses" to diagnose system problems can reduce unwanted patient injury.

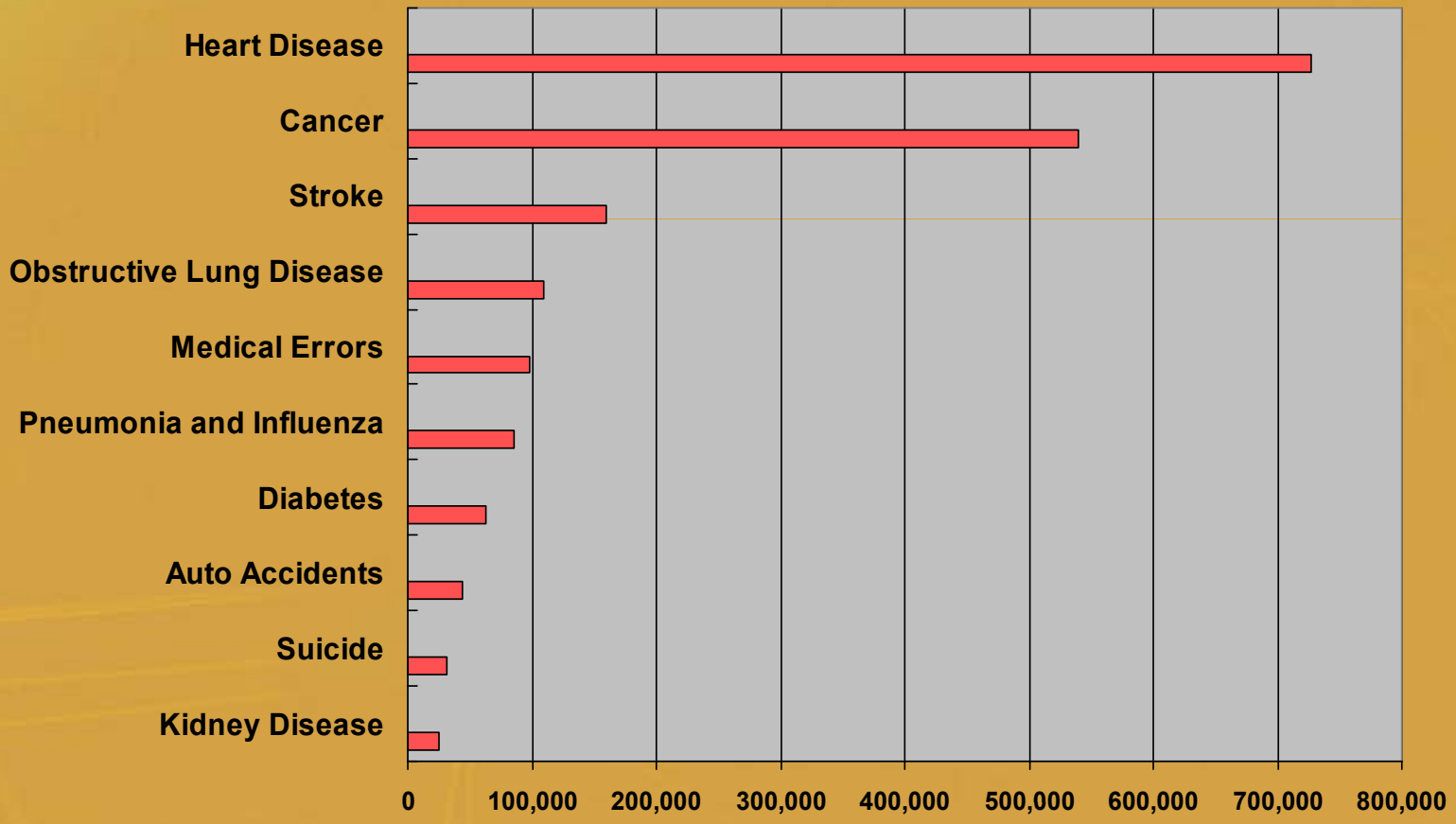
# Why do Errors Occur?

- Medical care occurs in complex systems
- Errors are usually the result of system failures
- Root Cause Analysis is needed to discover the cause of errors

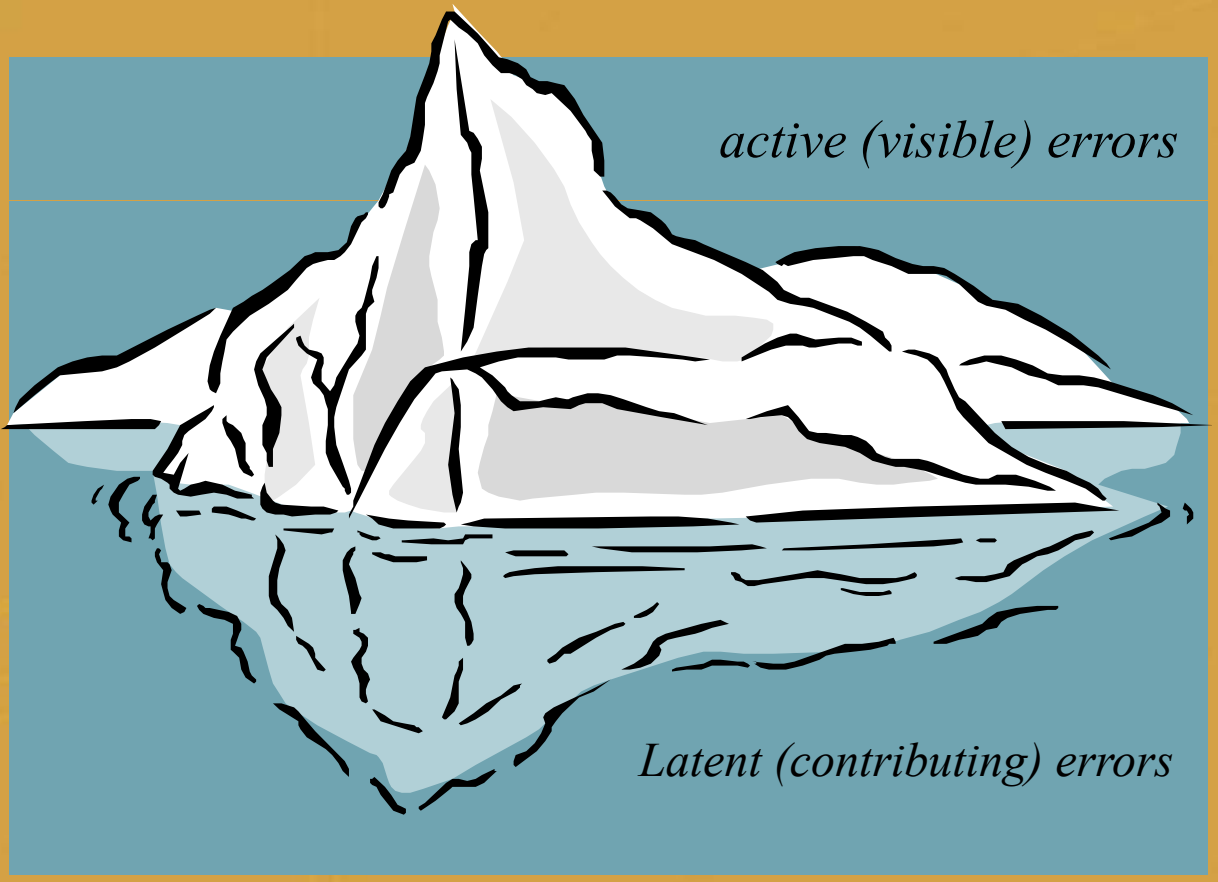
# Framework for Dealing with Errors

- Errors are commonplace
  - Most are inconsequential
- Error free should not be our goal
  - Errors awareness should be the goal – anticipant the likelihood of error and focus on recovery

# Deadly Results



# Anatomy of an Error



# Investigating Errors and "Near-Misses"

- **Old approach** – investigate single error at patient/caregiver interface after it has occurred.
- **New approach** – study systems and processes that have the potential for causing error. These are identified by those who use them and can assess their impact on work practices.

# Safety Culture

To have a safety culture, the following elements should be present

- Pervasive Commitment to Patient Safety
- Open Communication
- Blame-free Environment
- Safety Design
- Employee & Physician Involvement & Accountability

# Pervasive Commitment to Patient Safety

- Articulates patient safety as a goal
- Establishes patient safety programs to include senior level management

# Open Communication

- Openly discusses patient safety at all levels
- Includes patients and promotes patient/family questioning whenever something doesn't feel "right"
- Disclosures information
- Keeps governing body informed of errors, safety program and efforts to improve

# Blame-free Environment

- Embraces the concept that individuals do not purposely seek to create errors, that errors occur as a result of ineffective, improperly designed or flawed systems
- Develops way to reward reporting of errors or patient safety concerns
- Celebrates successes
- Works to alter its mindset
- Implements methods of feedback to learn from errors

# Safety Design

- Recognizes system issues and addresses such items as work hours, work loads, rotation schedules, sources of distraction, staff turnover, use of temporary staff
- Seeks to reduce variation through use of protocols, checklists and standardized work processes
- Evaluates internal processes (number of steps, hand offs, number of people involved)
- Benchmarks and examines what works elsewhere

# Employee & Physician Involvement & Accountability

- Accountability is incorporated into position descriptions
- Patient safety is a component of employee orientation and performance evaluation
- Training is organized to assure that participants understand responsibilities

# Culture of Safety

- Report errors and near-misses in a no-blame atmosphere
- Learn from failures, generalize
- Instead of making local repairs, look for system reforms
- Expect to make errors and train to recognize and recover from them

# Create the Environment for Safety

- Seek the root causes of the error
- Avoid Name/Blame/Shame
- Encourage reporting of errors or “near-misses”
- Organization’s leaders should ask questions aimed at systems improvement

# 8 Step Program

1. Educate leadership
2. Develop leadership consensus
3. Perform assessment of current management strategy to reduce errors
4. Design a better program to reduce errors

# 8 Step Program

5. Define Barriers to the program
6. Ask senior management to re-commit resources
7. Implement program
8. Monitor results