

5 Diamond Patient Safety Program

Patient Safety in the Dialysis Unit

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).

Safety Culture

- Culture is “the way we do things around here.”
- Safety culture – the product of individual and group values, attitudes, perceptions, competencies, and *patterns of behavior*
that determine the commitment to and proficiency of an organization’s health and safety management.

Results of Staff Survey

- Surveys items showing high level of agreement:

- Survey items showing lowest level of agreement:

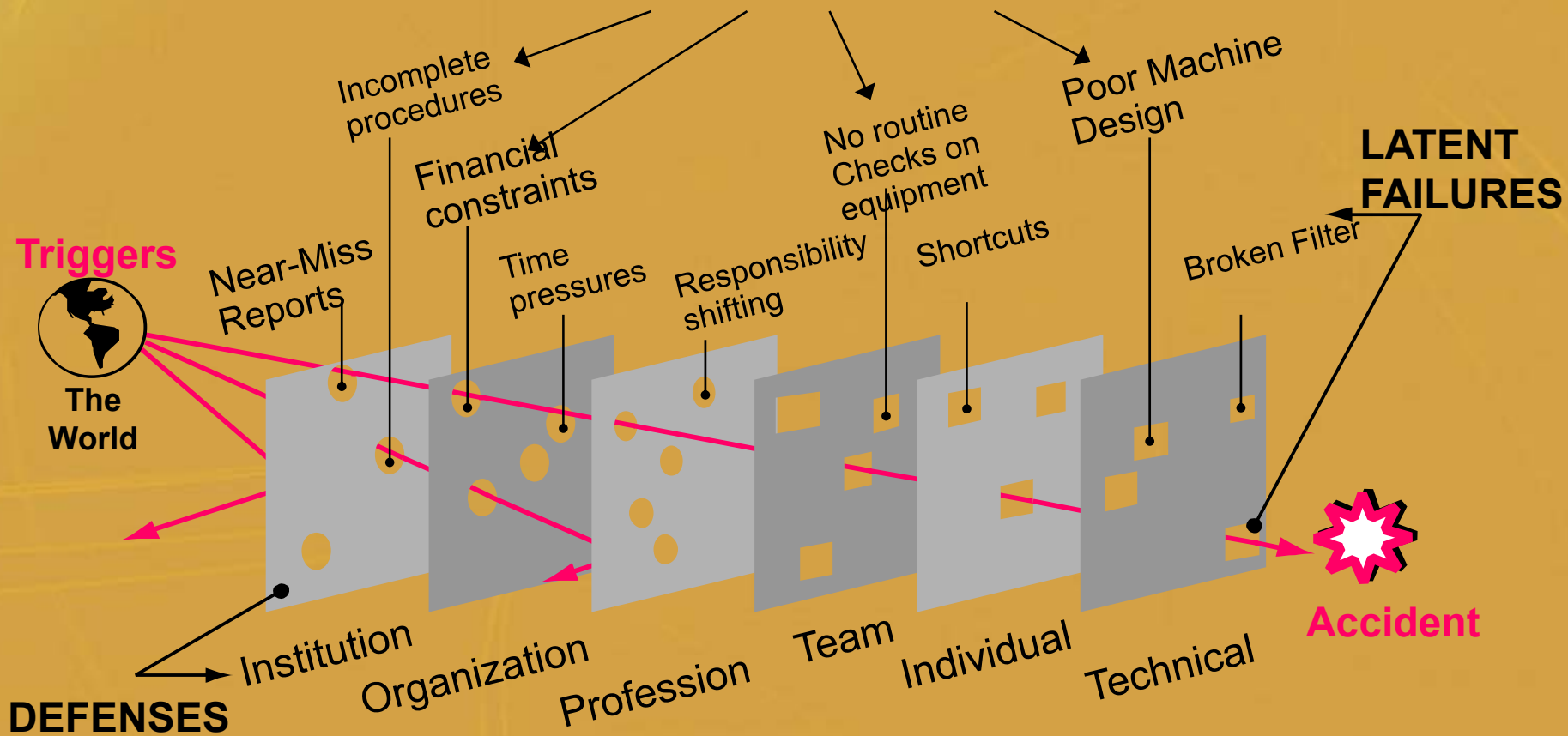
Understanding Errors Post-Hoc

- Minimize emotional component – “...get past it and move forward.”
- Describe and understand what happened – “the facts please...”
- Gather as many perspectives as possible as to why it happened.
- Uncover “latent errors” – those contributing factors under the surface.



Multiple Defenses Help to Prevent or Minimize Errors

Complex System Latent Failure Model



Comprehensive Approach to Patient Safety

Analyze

Structure in the organization

Environment in which care is provided

Equipment/Technology used to provide care

Systems/Processes of how work is done

People who provide the care

Leadership creating the philosophy and culture

Structure

Basic organizational components such as:

- Physical facilities - Designed to promote safety
- Supplies – are they appropriate and available?
- Policies and procedures – do they address safety in operations?



Environment

Complimentary to structure such as:

- Lighting – e.g. inadequate leading to falls
- Temperature – e.g. too high discouraging use of protective wear
- Noise – e.g. leading to inability to hear alarms
- Ergonomics – e.g. leading to staff injury with difficult patient transfers

Equipment/Technology

Characteristics that promote patient safety:

- “Default” safe modes
- Pre-dialysis alarm testing
- Standardized alarm settings
- Computerized care plans

Systems and Processes

How work is designed and accomplished:

- Is the process too complex – too many steps?
- Is there too much variation and risk for error?
- Are procedures “evidence-based”?
- Is the information needed for the next step available?
- Are procedures realistic in terms of resources and time available?

People

Impact of human resources:

- Attitude and motivation – affects performance and attention
- Physical and mental health – affects memory, mental processing, and energy levels.
- Training and education – determines ability to respond to unexpected problem

Leadership Systems/Culture

Commitment to values underlying safety culture:

- Effective two-way communication
- Blame avoidance
- Human resource policies to support safe practice
- Interdisciplinary teamwork toward common goal
- Avoiding hierarchical attitudes impeding effective communication

Teamwork Disconnect

- RN: Good teamwork means I am asked for my input
- MD: Good teamwork means the nurse does what I say



Zeroing in on cause
brings us one error closer
to *zero* error.