



Your Role In Keeping Patients Safe

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Take Aways

1. Describe common risks to the safety of dialysis patients

2. Recognize basic and advanced methods to prevent patient injury

3. Create a plan to implement or improve a patient safety program in your facility

Medical Errors

- Medical errors in the US result in an estimated 44,000 to 98,000 unnecessary deaths >1,000,000 instances of harm each year.
- A 13.5% level of harm was identified within the US Medicare population

Cost of Errors

- According to the Institute of Medicine, medical errors add \$17 to \$29 billion per year to the costs of healthcare in the US.

Most Common Patient Injuries

- Wrong site surgery
- Medication errors
- Healthcare acquired infections
- Falls
- Readmissions
- Diagnostic error

Most Common Patient Injuries: Potential in ESRD

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- Medication errors
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What Can You Do To Lessen The Risk?

Medication errors you can prevent:

- Heparin
- Saline
- Water/Dialysate
- Dialysis prescription

Your impact on HAI:

- Infection control
- Vaccination

What Can You Do To Lessen The Risk?

How you can prevent falls:

- Risk assessment
- Removal of environmental hazards

Cut down readmissions:

- Assist with medication reconciliation
- Call attention to changes (function, cognition, mobility)

Cut out diagnostic errors:

- Think fluid management...

How Do You Make Your Facility Safer?

- Staff orientation
- Staff training
- Competency testing
- Continuing education
- Audits of practice
- Others?
- Patient education
- Routine PE inspection

What Are Other Ways to Prevent Patient Injury?

Build in Safety:

- Product ordering/ receipt of supplies
- Systems design
- “Human factors” design: the study of all aspects of the way humans relate to the world around them, with the aim of improving performance and safety.
- Wikipedia

Human Factors Design

- Do you store heparin near lidocaine?
- Do you store different strengths of heparin near one another?
- Do you fill jugs with different acid concentrations—while all the jugs are on the same cart?
- How can you design your work space so that errors are less likely to occur?



**HOW TO BUILD A
CULTURE OF SAFETY
IN YOUR FACILITY**

Quality Improvement

Constant Process



Get Involved In QAPI

Technical staff members are key in:

- Identifying safety issues
- Formulating solutions
- Testing those solutions
- Implementing the best solution
- Measuring outcomes in order to improve patient safety

Root Cause Analysis

- Interdisciplinary team
- Includes the most expert frontline staff
- Includes those most familiar with the situation
- Impartial process
- Goal to identify changes that need to be made to systems

Focus On The Why & How, Not The Who

Root Cause



Why

Why

Why

Why

How

How

How

Prevention Not Punishment

The goal should be to find out:

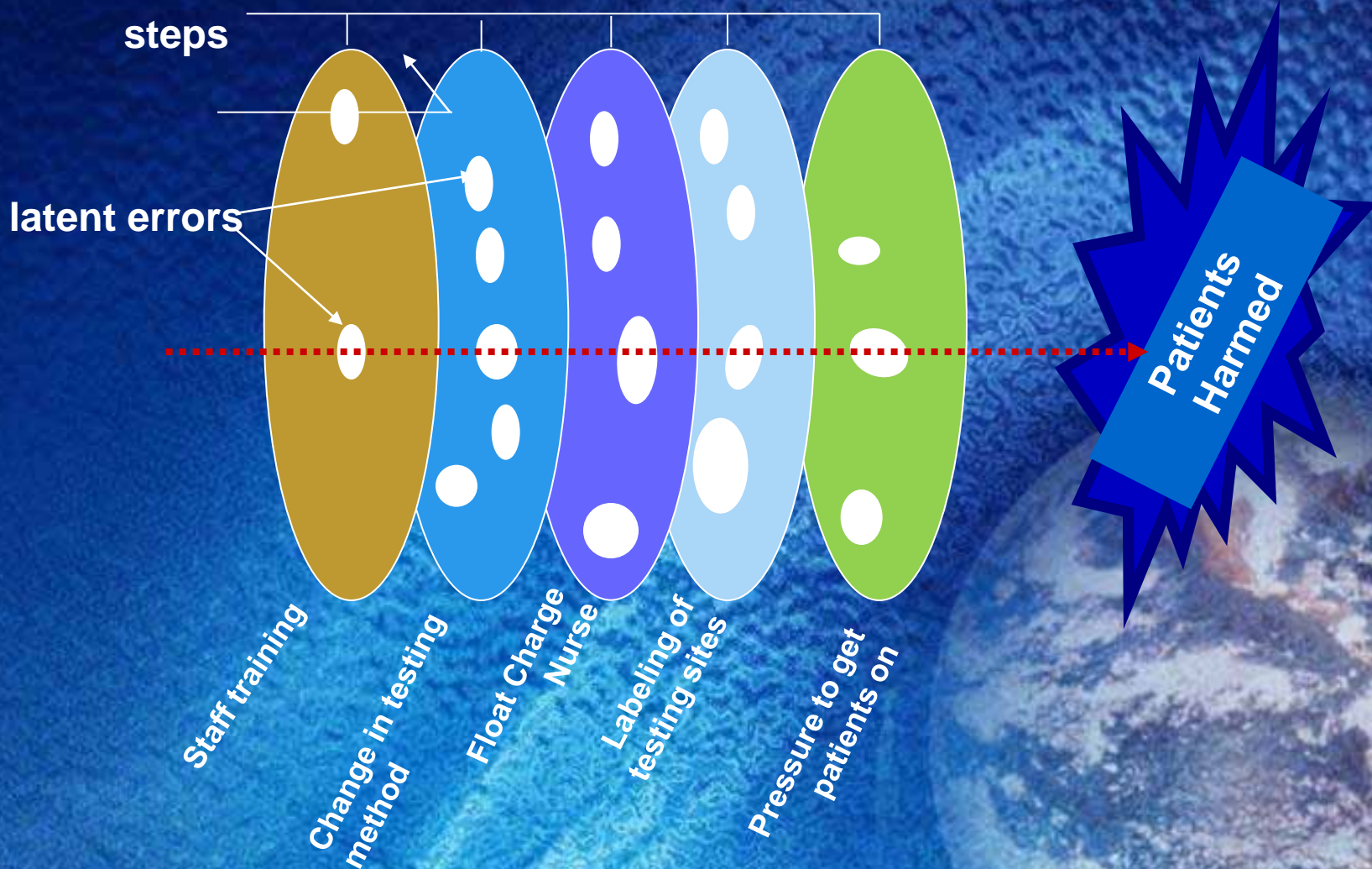
- What happened
- Why did it happen
- What to do to prevent it from happening again

Target Systems, Not People

- “Name and blame” culture allows underlying systems-based problems to be ignored and not addressed
- In “no blame” cultures, near misses are reported and learned from: leading to continuous quality improvement and safer environments for patients

Patient Exposure to Chlorine

Swiss Cheese Model



Can Never Eliminate All Errors

- Critical to design systems that are “fault tolerant”, so that when an individual error occurs, it does not result in harm to a patient

Patient Safety Program

Repeat

Assess

- Inspect facility for hazards
- Evaluate staff competency
- Determine med error rate
- Determine infection rate
- Evaluate patient engagement

Plan

- Develop facility PE monitoring tool
- Develop staff ed
- Develop med error reduction plan
- Develop IC guidance
- Develop patient education

Implement

- Routinely monitor PE
- Educate staff
- Implement med error reduction plan
- Implement IC plan
- Educate patients

But I'm Just One Person...

Most errors are the result of failures related to:

- Assumptions
- Presumptions
- Communication

On your own, you can improve each of these areas!

Assumptions and Presumptions

- “Assume” that every medication you are responsible for is potentially lethal: build in multiple check points to be sure the med is right for this patient
- Presumptions: routinely question presumptions—don’t presume someone has tested the water...

Communication: The Hardest Thing

- “Basic rule in human communication: if it can be misread, misunderstood, misinterpreted, misqualified, or just plain missed, it will be.”

Learn To CUS

- Concerned/ Uncomfortable/ Safety
- “I’m *concerned* about Ms. Jones’ dry weight. She just returned from the hospital and her records say she was coming off at 63 kg. there. I’m *uncomfortable* trying to take her much lower than 63 kg, and am not sure it is *safe* to try to take her weight down to 59 kg. now.

A globe of Earth is shown on the left side of the image, resting on a blue, textured surface that resembles water or a similar material. A shadow of the globe is cast to the right. The background is a gradient of blue and purple.

Thanks for the Work You Do!

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