

Safety In the Dialysis Unit

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Safe Patient = Better Outcomes

- Each year over 98,000 deaths occur due to medical errors in hospitals.
- In hemodialysis patients, for every 3.1 medication exposures there is one medication-related problem. Most common problems were:
 - Drug use without indication (30.9%)
 - Lack of laboratory testing to monitor medication therapy (27.6%)
 - Indication without drug use (17.5%)
 - Dosing errors (15.4%)
- The use of gloves does not eliminate the need for hand hygiene.
 - Gloves reduce hand contamination by 70-80%, prevent cross-contamination and protect patients and health care personnel from infection.
 - 11% of patients report seeing nurses or technicians who fail to wash hands or change gloves before touching a patient's access or change gloves before touching their access site.
 - 27% of professionals reported observing staff fail to wash hands or change gloves before touching a patient's access.

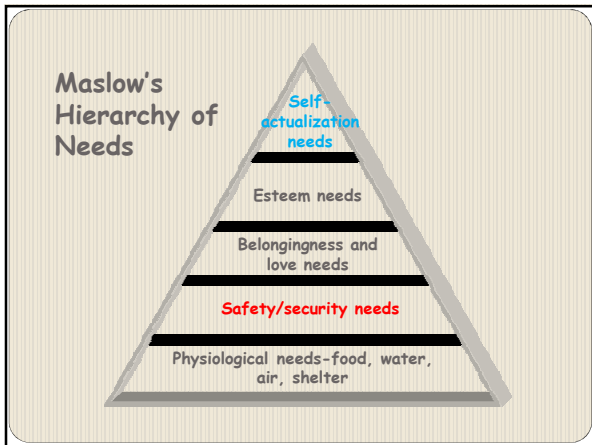
RPA Health & Safety Survey 2007

Safe Patient = Better Outcomes (cont.)

- Failure to adhere to procedures leads to medical errors, increased risk of hospitalization and mortality.
- Non-adherence may also include failure to follow procedures regarding trouble with needle insertion and failure to complete event reports when medical errors occur. Most common problems:
 - Problems from multiple needle insertion attempts
 - Patient's blood pressure not taken
 - Patient's weight not taken
 - Patient's blood sample not taken when ordered
 - Patient's accesses covered
 - Patient's access not bandaged properly
 - Machine stopped before treatment completed
 - Needle dislodged
 - Failure to report medical mistake
- **We are all human. Humans make mistakes.**

RPA Health & Safety Survey 2007





- ### Common Patient Safety Complaints
- Staff are not washing their hands
 - Staff do not change gloves between patients
 - Staff not wearing appropriate PPE
 - Given the wrong medication
 - Given the wrong dialyzer
 - Staff not performing safe procedure (catheter care)
 - Staff unskilled in cannulation
 - Staff not performing appropriate patient assessments

Patient Safety

- The perception the patient has of their own personal safety is paramount!
- Critical!
- **Scared patient's act out.**

Our Goal

- For you to be able to walk away today with tools you can use to create a safer dialysis facility.



Keeping Kidney Patients Safe

www.kidneypatientsafety.org

Safety Improvement Basics

- As part of the Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage for ESRD facilities are required to develop, implement, maintain, and evaluate an effective, data driven quality assessment and performance improvement program with participation by the interdisciplinary team.
- § 494.110 Condition: Quality assessment and performance improvement

The program must include the following:

- Adequacy of dialysis
 - Nutritional status
 - Mineral metabolism and renal bone disease
 - Anemia Management
 - Vascular Access
 - Medical injuries and medical errors identification
 - Hemodialyzer reuse program, if the facility practices reuse
 - Patient satisfaction and grievances
 - Infection control; with respect to this component *facility* must:
 - (A) Analyze and document the incidence of infection to identify trends and establish baseline information on infection incidence
 - (B) Develop recommendations and actions to minimize infection transmission, promote immunization; and
 - (C) Take actions to reduce future incidents
- (b) *Standard: Monitoring performance improvement. The facility must continuously monitor its performance; take actions that result in performance improvements, and track performance to ensure that improvements are sustained over time.*

5 specific areas to address

- Incorrect dialyzer / dialyzing solution;
- Patient falls;
- Medication omission and errors;
- Non-adherence to procedures; and
- Failure to maintain hand hygiene

“Why ?”

- Teach your staff why this is important
 - What is the danger?
 - How does this danger occur?
 - To whom is it dangerous?
 - What could happen?

Making A Commitment to a Patient Safety Program

- Personnel: All team approach
 - Patient safety committee
- Time:
 - Training staff
 - Educating patients
 - Evaluating ongoing patient safety
- Technology:
 - Modifying systems as needed

Making A Commitment to a Patient Safety Program

- Patients: Part of the TEAM
 - The more they know and understand, the safer they will be
 - Involvement in treatment and care planning
 - Communicating with healthcare team
 - Key events to prevent errors:
 - Clean hands
 - Correct dialyzer /solution
 - Correct medications
 - Following procedural routines
 - Fall prevention

Making A Commitment to a Patient Safety Program

- Engaging Staff
 - Patient safety committee
 - Lead safety officer
 - Foster an environment that is constructive and supportive
- Creating a Culture of Safety
 - Necessary to provide optimal care
 - What a facility does in its practice, procedures, and processes

A Culture of Safety Is Characterized by...

- Patient-centered care
 - Meetings
 - Trainings
 - Postings
- Open communication
 - Forum for requesting and sharing information
 - Clear communication to ALL
 - Consistency

and by...

- Blame-free environment
 - All staff accountability for safety v “name/blame/shame”
 - Reporting without fear of recrimination
 - Focus on systems improvement rather than blame
 - Error awareness
 - Support staff when an error is made
 - Reward staff for safe actions
- Shared Responsibility
 - Patient safety is a team effort; all are responsible

Patient Safety Plan: Core Elements

- Standardized systems to reduce possibility of errors
 - Human limitations
 - Decreases variation
- Defined core issues/defined adverse events
 - Foundation for patient safety plan
 - Communication of these to patients and staff

Patient Safety Plan: Core Elements

(cont.)

- System for reporting errors/adverse events
 - Specific written directions
 - Discussions for clarity
 - Reporting form
- Data tracking system
 - Transfer of all information to a data base
 - Staff training to ensure complete documenting
- Root cause analysis
 - Identification of problem => determine contributing factors

Patient Safety Plan: Core Elements

(cont.)

- Staff training/ education
 - Approaches should be varied and reinforced
 - Should be brief, evidence-based, ongoing, and supplemented with regularly held safety awareness activities
- Ongoing evaluation to modify systems
 - Evaluate program implementation
 - Evaluate data
- Communicate plan and all aspects of implementation to all staff
 - Open and ongoing
 - Distribute and post written plan
 - Reinforce with every opportunity

Be a Role Model

- Research shows the action of Clinicians influences the behavior of others, especially co-workers and patients
 - Practice hand Hygiene and show you are serious about your health, the health of your co-workers and the health of your patients
 - Model a cooperative spirit and ask patients to watch you wash your hands so that they are assured it has been done
 - Be an advocate for self-management, including encouragement of self-cannulation
 - Encourage patients to take an active role in safety and to question staff when they believe procedures are not being followed consistently or safely

Resources

- Renal Physicians Association & Forum of ESRD Networks' Keeping Kidney Patients Safe
<http://kidneypatientsafety.org>
- The Joint Commission International Center for Patient Safety
<http://www.jcipatientsafety.org>
- National Patient Safety Foundation
<http://www.npsf.org>
- Agency for Healthcare Research & Quality Patient Safety Network
<http://psnet.ahrq.gov>
- Journal of Patient Safety
<http://www.journalpatientsafety.com>
- CMS Conditions for Coverage for ESRD facilities
<http://www.cms.hhs.gov/CFCsAndCoPs/downloads/ESRDfinalrule0415.pdf>
- ESRD Networks 5-Diamond Program
<http://www.esrdnet5.org/5Diamond.asp>

Thank You!

- A recording of this program will be made available on Network* website for future viewing and staff training
- Certificates of attendance will be provided to those completing an evaluation and providing contact information
- Details will be provided on the Network* website
- Facilities* will be notified when the recordings are posted

*Participating Networks:
 ESRD Network of New England (Network 1)
 Mid-Atlantic Renal Coalition (Network 5)
 Southeastern Kidney Council (Network 6)
 The Renal Network (Network 9/10)
 Renal Network of the Upper Midwest (Network 11)
 ESRD Network of Texas (Network 14)
