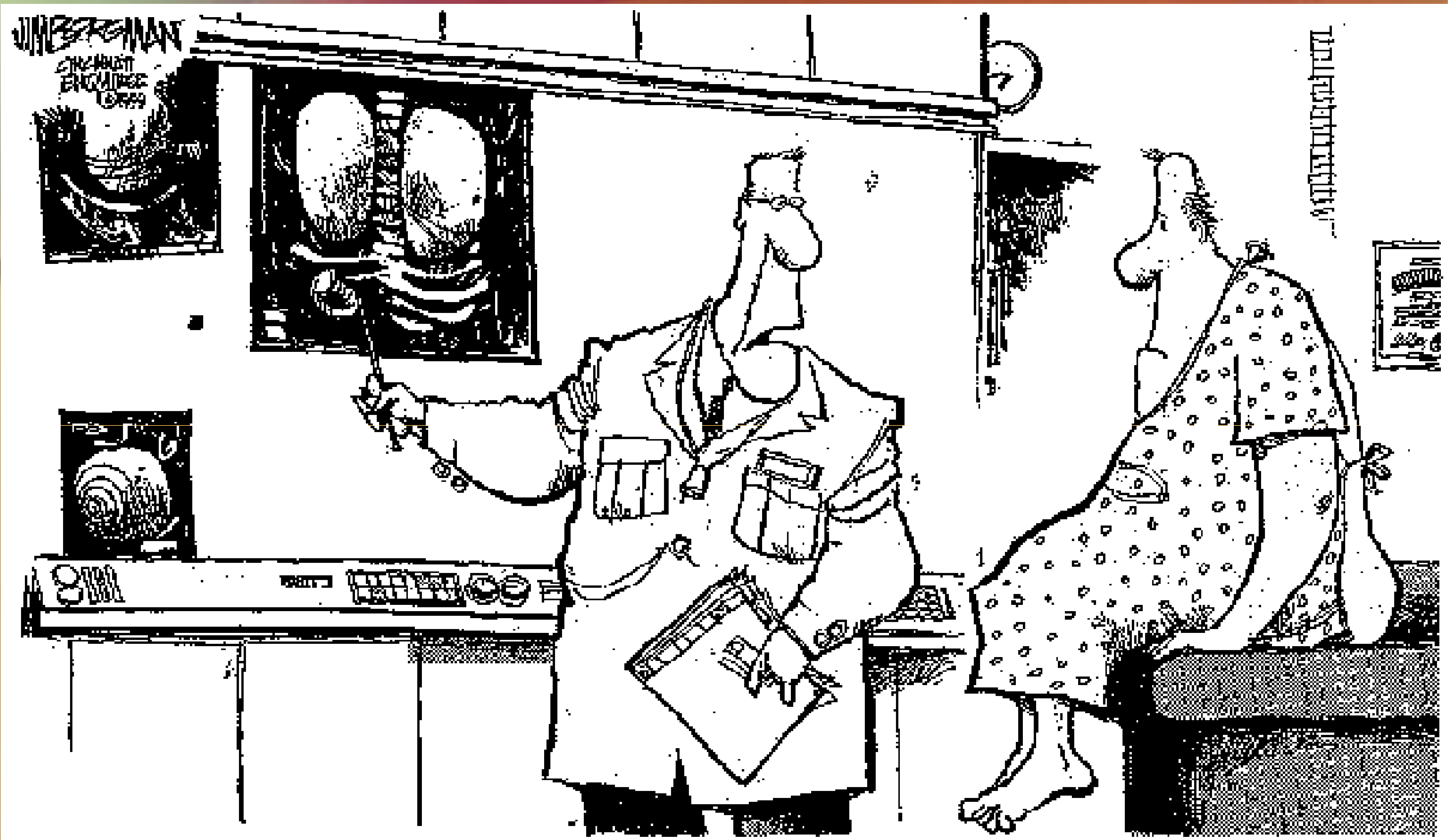
5 Diamond Patient Safety Program

What is Patient Safety?

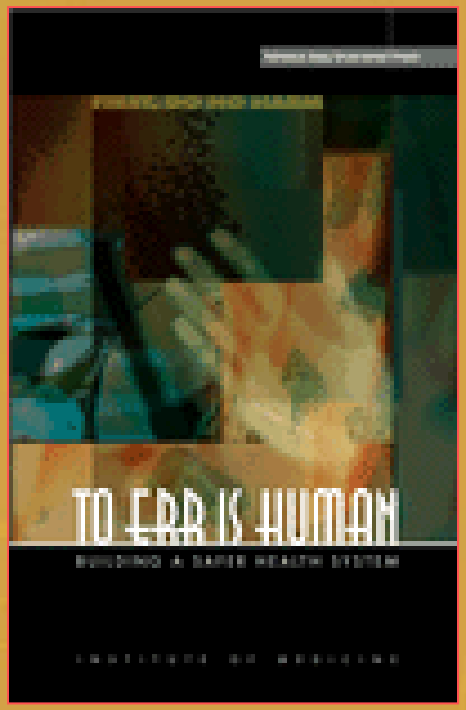
2008

***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.

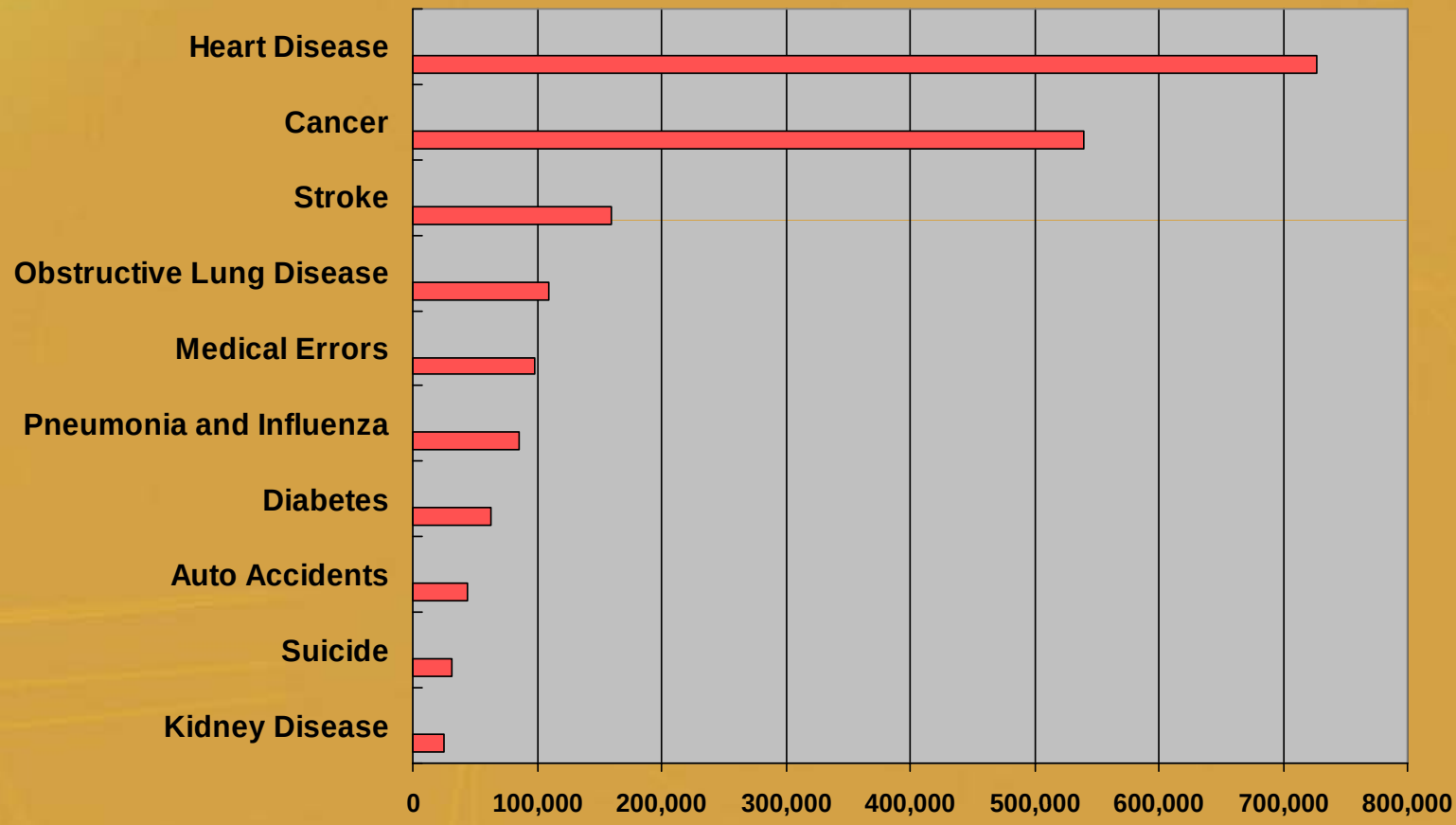
Why do Errors Occur?

- 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

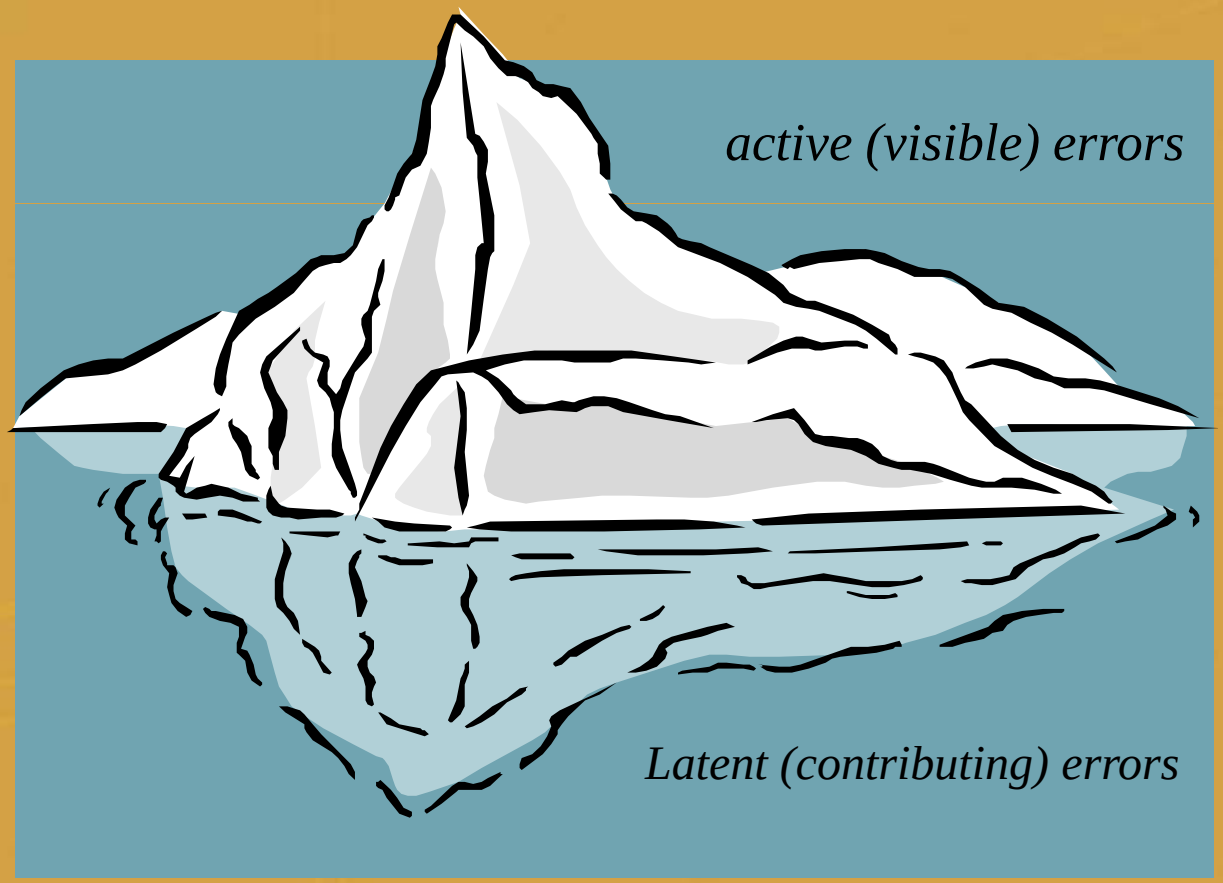
Framework for Dealing with Errors

- 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