

# *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

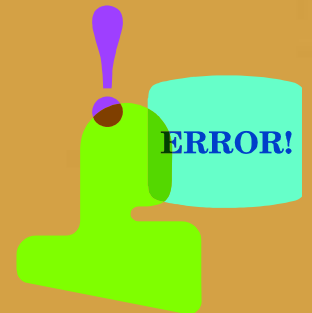
- Culture is “the way we do things around here.”
- Safety culture – the product of individual and group values, attitudes, perceptions, competencies, and *patterns of behavior* ....  
that determine the commitment to and proficiency of an organization’s health and safety management.

# Results of Staff Survey

- Surveys items showing high level of agreement:
  
- Survey items showing lowest level of agreement:

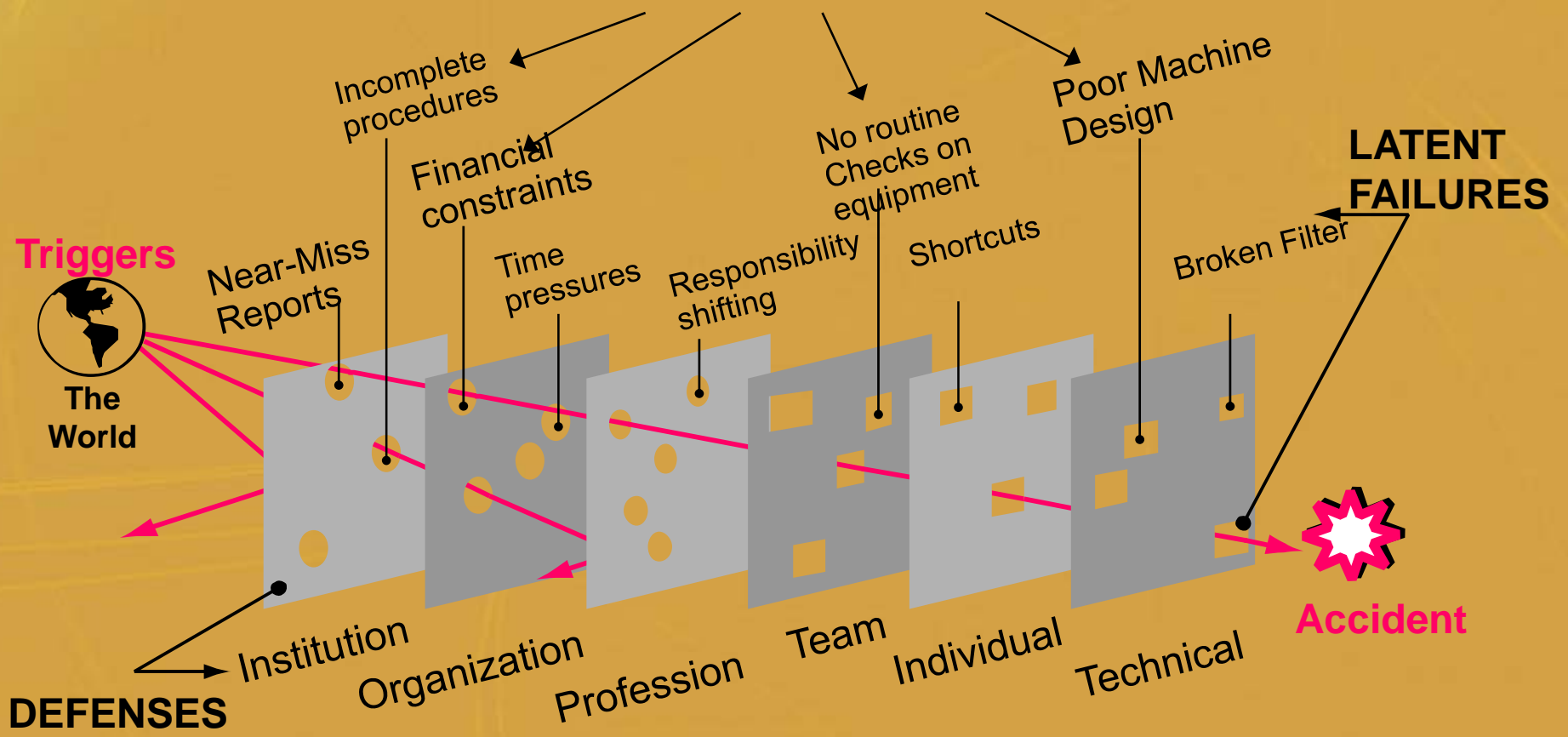
## Understanding Errors Post-Hoc

- 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

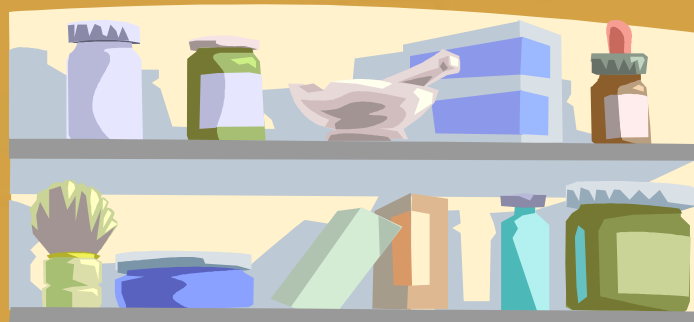
**People** who provide the care

**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.