Safety in the Dialysis Unit

• Please place this call on MUTE—**not hold**.
  • Some facilities’ hold button have music playing and it will disrupt the conference.

• If you do not have a mute button, * 6 should allow you to mute your phone.

• To un-mute your phones during discussion or question sessions, * 6 will un-mute your line.

**FOR THE COURTESY OF EVERYONE ON THIS CALL, PLEASE MUTE YOUR PHONES UNTIL REQUESTED TO UN-MUTE THEM. - Thank you.**

*The WebEx will start in a few minutes. Thank you for your patience.*
Safety in the Dialysis Unit

Lisle Mukai, RN, Quality Improvement Coordinator
Lisa Hall, MSSW, LICSW, Patient Services Coordinator
Shean Strong, MBA, Quality Improvement Director
June 20, 2012 & June 21, 2012
Objectives:

- Review common patient safety complaints.
- Provide new knowledge to professional staff that could lead to process changes. (Creating a culture of safety.)
- Provide tools to create safer dialysis facilities.
Common Safety Complaints:

- Staff are not washing their hands
- Staff do not change gloves between patients
- Staff not wearing appropriate PPE
- Staff not performing safe procedure (catheter care)
- Staff unskilled in cannulation
- Staff not performing appropriate patient assessments
- Given the wrong dialyzer
- Giving the wrong medication
Safe Patient = Better Outcomes

- In HD patients, for every 3.1 medication exposures there is one medication-related problem:
  - Drug use without indication (30.9%)
  - Lack of lab testing to monitor medication therapy (27.6%)
  - Indication without drug use (17.5%)
  - Dosing errors (15.4%)

RPA Health & Safety Survey 2007
Safe Patient = Better Outcomes…

- The use of gloves does not eliminate the need for hand hygiene:
  - Gloves reduce hand contamination by 70-80%, prevent cross-contamination, protect patients and staff from infection
  - 11% of patients report seeing staff who fail to wash hands 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…

- Failure to adhere to procedures leads to medical errors, increased risk of hospitalization and mortality.
  - Examples: (include but not limited to)
    - Access being covered during treatment
    - Access not bandaged properly
    - Blood pressure not taken
    - Weight not taken

- Failure to report medical mistakes
  - Examples: (include but not limited to)
    - Multiple needle insertion attempts or needle dislodgement
    - Blood sample not taken though ordered
We are all human. 
Humans make mistakes.
Regulatory Requirements

ESRD facilities are required to:

Develop, implement, maintain, and evaluate an effective, data driven quality assessment and performance improvement program (QAPI) with participation by the interdisciplinary team.

**CfC 494.110 Condition:**
Quality Assessment and Performance Improvement
## Regulatory Requirements

### Performance Measures

Measures Assessment Tool (MAT)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>(V629) Adequacy</td>
<td>KT/V, URR</td>
</tr>
<tr>
<td>(V630) Nutritional Status</td>
<td>Albumin, body weight</td>
</tr>
<tr>
<td>(V631) Bone Disease</td>
<td>PTH, calcium, phosphorus</td>
</tr>
<tr>
<td>(V632) Anemia</td>
<td>Hemoglobin, ferritin</td>
</tr>
<tr>
<td>(V633) Vascular Access</td>
<td>fistulas, ↓ catheter rate</td>
</tr>
<tr>
<td>(V634) Medical Errors</td>
<td>frequency of specific errors</td>
</tr>
<tr>
<td>(V635) Reuse</td>
<td>adverse outcomes</td>
</tr>
<tr>
<td>(V636) Patient Satisfaction</td>
<td>survey scores</td>
</tr>
<tr>
<td>(V637) Infection Control</td>
<td>infections, ↑ vaccination status</td>
</tr>
</tbody>
</table>
Infection control:

- Analyze and document incidence of infection to identify trends and establish baseline information on infection incidence
- Develop recommendations and actions to minimize infection transmission; promote immunization
- Take actions to reduce future incidents
Regulatory Requirements...

The dialysis facility **must**:

- Continuously monitor its performance
- Take actions that result in performance improvements
- Track performance to ensure that improvements are sustained over time
Our Goal

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

Teach your staff why this is important:

- What is the danger?
- How does this danger occur?
- To whom is it dangerous?
- What could happen?
Make a Commitment
to a Patient Safety Program

Renal Physicians Association (RPA) &
The Forum of ESRD Networks

Keeping Kidney Patients Safe Website
https://www.kidneypatientsafety.org
Make a Commitment to a Patient Safety Program

- **Personnel**
  - All team approach

- **Time**
  - Training staff
  - Educating patients
  - Evaluating ongoing patient safety

- **Technology**
  - Modifying systems as needed
Make a Commitment…
to a Patient Safety Program

- Engaging staff
  - Patient safety committee.
  - Lead safety officer.
  - Foster an environment that is constructive and supportive.

- Engaging Patients
  - Part of the team.
  - The more they know and understand the safer they will be.
  - Communication with the healthcare team.
Make a Commitment…
to a Patient Safety Program

- 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 an environment that encourages people to speak up about safety concerns, makes it safe to talk about mistakes and errors, and encourages learning from these events.

Institute for Healthcare Improvement (IHI)
A Culture of Safety

- Patient-centered care
  - Meetings
  - Trainings
  - Postings

- Open communication
  - Forum for requesting and sharing information
  - Clear communication to all
  - Consistency
A Culture of Safety

- Blame-free environment
  - All staff accountability for safety vs. “name, blame, shame”
  - Reporting without fear of recrimination
  - Focus on systems improvement rather than individual staff
  - Error awareness
  - Support staff when an error is made
  - Reward staff for safe actions

- Shared responsibility
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

- System for reporting errors/adverse events
  - Specific written directions
  - Discussions for clarity
  - Reporting form

- Data tracking system
  - Transfer of all information to a database
  - Staff training to ensure complete documenting
Patient Safety Plan: Core Elements

- Root cause analysis
  - Identification of problem + determining contributing factors

- Ongoing evaluation to modify systems
  - Evaluate program implementation
  - Evaluate data
Patient Safety Plan: Core Elements

- Staff training/education
  - Approaches should be varied and reinforced
  - Should be brief, evidence-based, ongoing, and supplemented with regularly held safety awareness activities

- Communicate plan and all aspects of implementation to all staff
  - Open and ongoing
  - Distribute and post written plan
  - Reinforce plan 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 a Role Model…

- Encourage patients to take an active role in safety and to question staff when they believe procedures are not being followed consistently or safely.
“It takes a team effort of patients and staff, working together, to reduce error occurrences.”

Roberta Mikles, RN, BA
“Dialysis Patient Safety”
Resources

- Renal Physicians Association & Forum of ESRD Networks’ *Keeping Kidney Patients Safe*
  [http://kidneypatientsafety.org](http://kidneypatientsafety.org)

- The Joint Commission International Center for Patient Safety [http://www.jcipatientsafety.org](http://www.jcipatientsafety.org)

- National Patient Safety Foundation [http://www.npsf.org](http://www.npsf.org)

Resources ..... (continued)

• Journal of Patient Safety
  http://www.journalpatientsafety.com

• CMS Conditions for Coverage for ESRD Facilities
  http://www.cms.hhs.gov

• National 5-Diamond Patient Safety Program
  http://www.5diamondpatientsafety.org/
References

• Renal Physicians Association & Forum of ESRD Networks’ *Keeping Kidney Patients Safe* website; http://kidneypatientsafety.org

• Slides from:
  • ESRD Network 14
  • ESRD Network 16


• Merriam-Webster Dictionary
References

• Citation Frequency Report 2011; S&C PDQ


References

• American Society for Quality. *Failure Mode Effects Analysis (FMEA)*
  http://asq.org/learn-about-quality/process-analysis-tools/overview/fmea.html

Recording

• A recording of this presentation will be posted on both Network 16 and Network 18’s websites.
  o Presentation slides will also be available.

Northwest Renal Network (Network 16)
www.nwrenalnetwork.org

Southern California Renal Disease Council, Inc.
(Network 18)
www.esrdnetwork18.org
Continuing Education Unit – Nurses and PCTs

Nurses and PCTs

- To receive 1 contact hour each person must be registered for the WebEx and submit an Evaluation Form:
  - Network 18 Evaluation Form [nurses/PCTs]
  - NKF Evaluation Form [SW]

- Fax Evaluation Form to:
  Network 18 at (323) 962-2891

Evaluation Forms were emailed to each individual who registered for this WebEx.

**DUE DATE:** Friday, July 6, 2012 to Network 18 office.
Contact Information

Lisle Mukai, RN
Quality Improvement Coordinator – Network 18
lmukai@nw18.esrd.net

Lisa Hall, MSSW, LICSW
Patient Services Coordinator – Network 16
lhall@nw16.esrd.net

Shean Strong, MBA
Quality Improvement Director – Network 18
sstrong@nw18.esrd.net