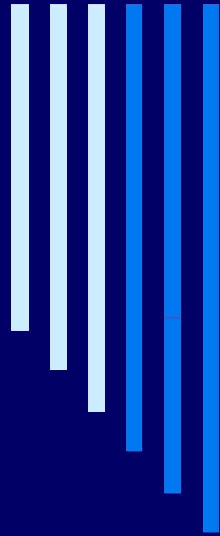
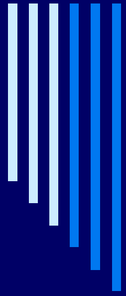


Errors in the Dialysis Unit: Enhancing Patient Safety

Carol Roe, JD, MSN, RN

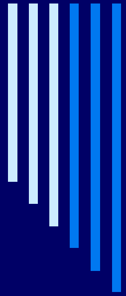
Director of Regulatory Compliance & Risk Management

Centers for Dialysis Care



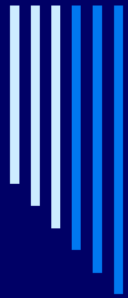
Disclaimer

- Although this presentation was prepared by professional with expertise in the topic, it should not be considered as the rendering of legal advice.



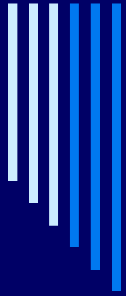
Registered Nurse

- Professional Considerations
  - Definition of professional nursing
  - Standards of clinical practice
  - Standards of Professional performance
  - Code of Ethics



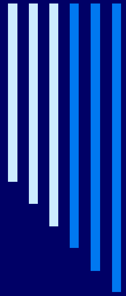
Registered Nurse and Technician

- Legal scope of practice
- Conditions of Coverage



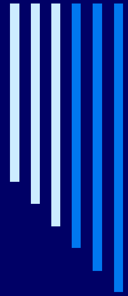
Accountability and Liability

- Accountability is inherent
- Liability- apportionment of financial responsibility after an untoward event in which damages have occurred



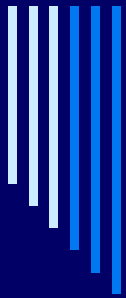
Elements of Negligence

- Standard of care
- Duty
- Breach
- Damages



IOM (Institute of Medicine)

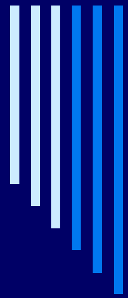
- What is It?
- Why is important?
- www.nationalacademies.org



Health and Safety Survey to Improve Pt. Safety in ESRD

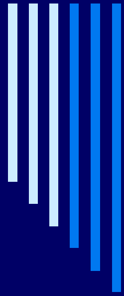
- www.kidneypatientsafety.org

- 5 adverse events
  - Incorrect dialyzer or solution
  - Patient falls
  - Medication errors or omissions
  - Non-adherance to procedures
  - Hand hygiene



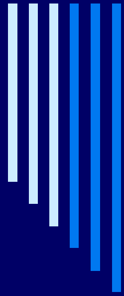
Another view of challenges in dialysis

- Falls
- “Disruptive patients”
- Disconnects
- Shortened treatments
- Communication issues



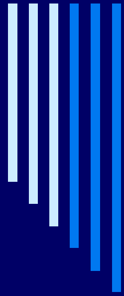
"Top Safety Issues in HD"

- Falls
- Medication Administration
- Needle dislodgement
- Water/Dialysate
- Reuse



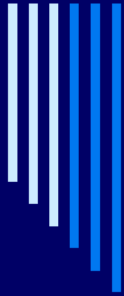
Risk Reduction

- Relationship of safety, quality, compliance and risk management
- Components of Safety System
  - Policies and procedures
  - Adequately trained staff
  - Adequate tools
  - Appropriate supervision



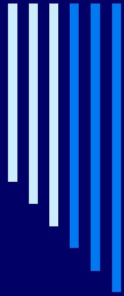
Developing Safety Culture

- Fostering error and near miss reporting
- Promotion of blame-free culture
- Priority from top
- Clear delineation of accountability
- Effective system to review history, trends, and link safety, quality, risk management and compliance



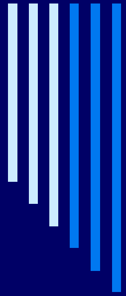
Effective Safety Teams

- Study trends in health care and safety stats
- Set priorities
- Receive and evaluate safety complaints
- Perform work place walk throughs, document and provide feedback
- Review incidents to identify and prevent risks



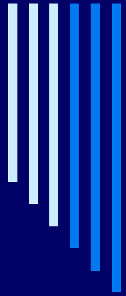
Effective Safety Teams

- Educate staff
- Publicize effective solutions and problems
- Form groups to address
- Assist in inspections
- Solicit input from line workers
- Raise safety culture consciousness



Barriers to Actualizing

- Institutional or Self Imposed
- “Paperwork” Perception
- Vigilance
- Leadership



So, Where do we go from here?

- "Merely looking at the sick is not observing."