A Culture of Safety

The Critical Role of the Dialysis Technician

DTX20

A Culture of Safety Defined by AHRQ

"The safety culture of an organization is the product of individual and group

values,

attitudes,

perceptions,

competencies, and

patterns of behavior

that determine the commitment to, and the style and proficiency of, an organization's health and safety management.

Organizations with a positive safety culture are characterized

- by communications founded on mutual trust,
- by shared perceptions of the importance of safety,
- and by confidence in the efficacy of preventive measures.”

You Are Key!

Not just words

Each of you matters

Make time for safety

Lets Back Into This Discussion…

- EMS called 30 times in April 2008
- Called only twice in prior 15 months
- Patients concerned about a specific nurse
- Nurse had been fired by several healthcare services
- Convicted of capital murder of up to 5, deliberately injuring 5 others

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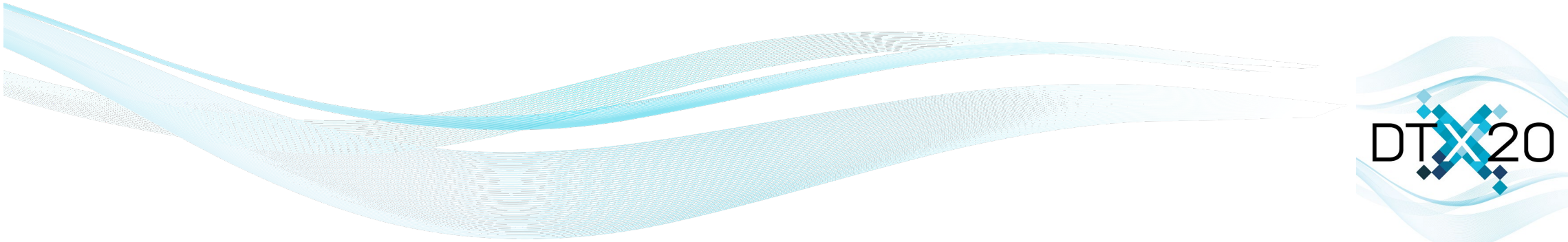
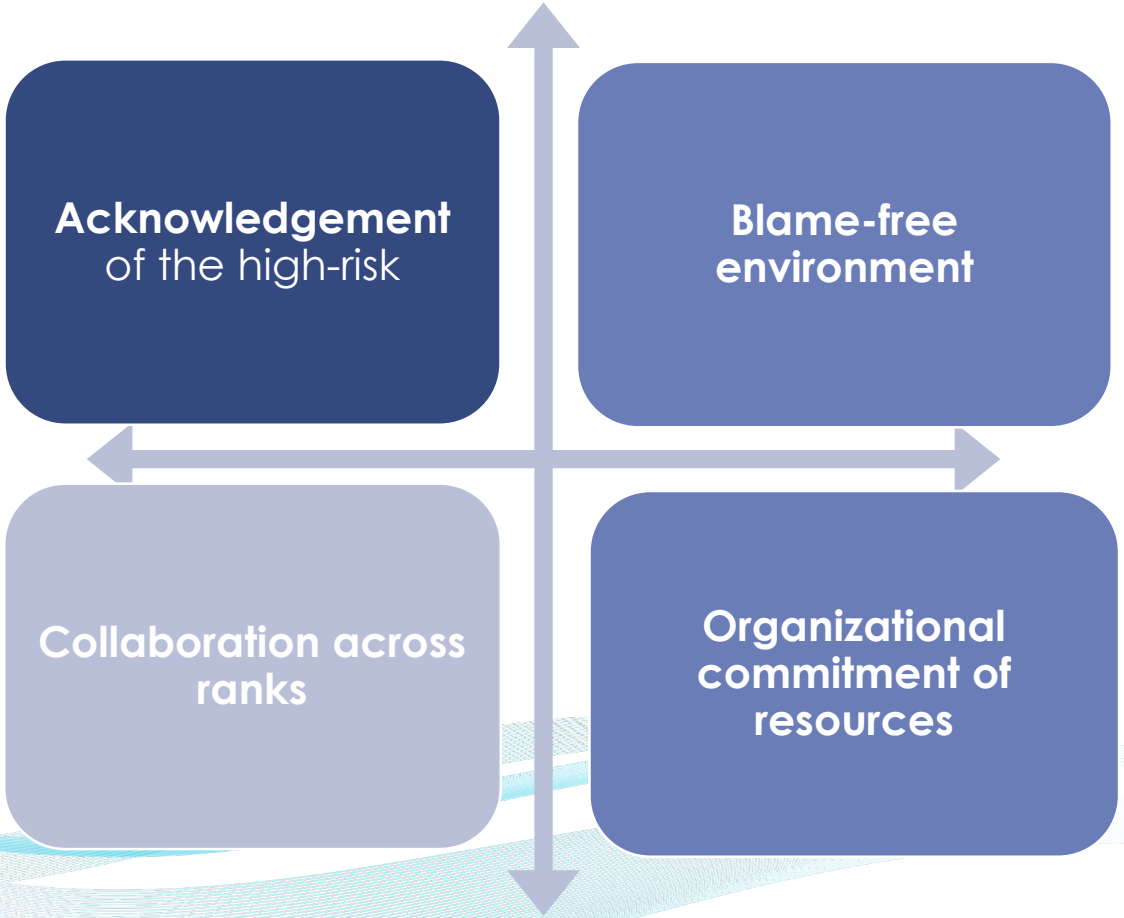
Safety Event vs Safety Hazard



Critical Elements of Culture of Safety



Critical Elements of Culture of Safety

- **Acknowledgement** of the high-risk nature of dialysis and **determination** to achieve consistently safe operations
- **Blame-free environment:** staff are able to report errors or near misses without fear of reprimand or punishment
- **Encouragement of collaboration** across ranks and disciplines to seek solutions to patient safety problems
- **Organizational commitment of resources** to address safety concerns

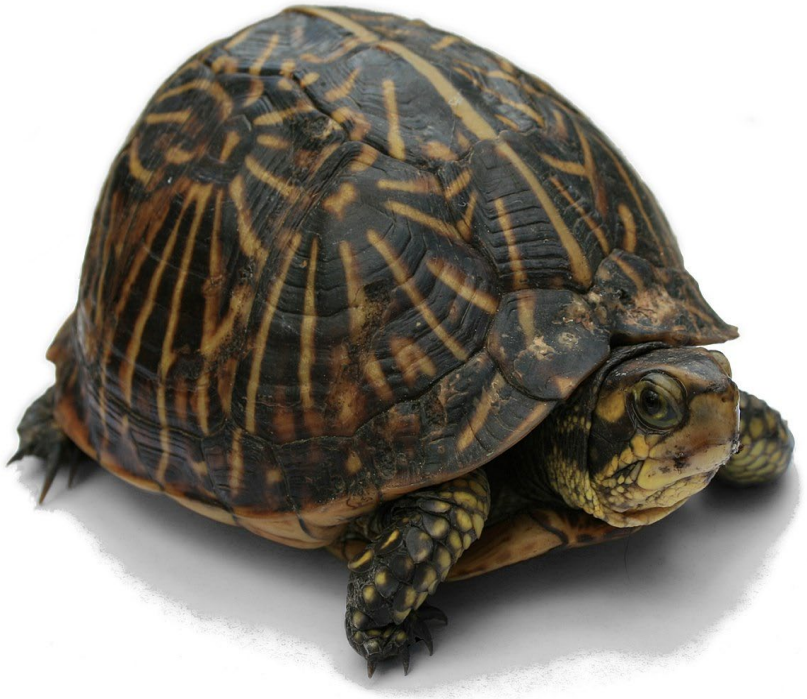
In the dialysis universe:

Acknowledgment of the high-risk nature of dialysis and determination to achieve consistently safe operations:

What could Go Wrong?

preoccupation with failure

If You Can't Think About It You Can't Fix It



Feeling that your work is high risk can be uncomfortable, but awareness of risk is important in anticipating and reducing it

A simpler way to think about risk:

Are we good?

Are we safe?

Are we ready?

A simpler way to think about risk:

Are We Good?

What does the data show?

- Clinical Outcomes
- Patient satisfaction
- Patient Engagement

Are we improving or slipping?

Am I Good?

A simpler way to think about risk:

Are We Safe?

What is does the data show?
Mortality?
Hospital Transfers from chronic Units?
Errors?
Deficient Practice?
Improving or slipping?

Am I Safe?

A simpler way to think about risk:

Are We Ready?

Are we prepared for clinical emergencies?
Are we prepared* for natural emergencies?
Are we prepared* for aggression?
Are we prepared for foreseeable hazards?

Am
I
Ready?

In the Dialysis Universe:

Blame-free environment: staff are able to report errors or near misses without fear of reprimand or punishment

Just Culture: Accountability ≠ Blame

Focus on eliminating system risks and robust reporting

Error Response in Just Culture

Human Error:

Console, build System Safety

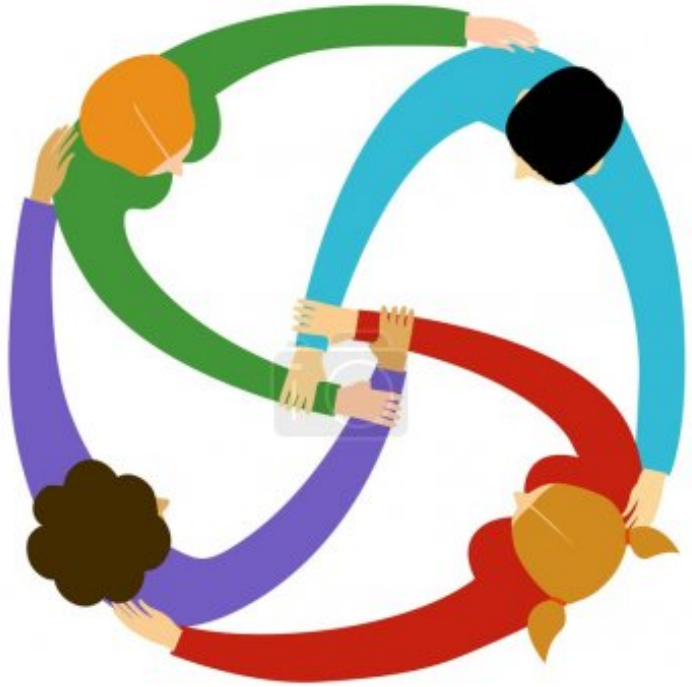
At-risk Error:

INTROSPECTION on training, value conflicts and messaging

Reckless Error:

Remedial action or punishment. Review vulnerabilities in supervision

In the Dialysis Universe



Encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems.

The power of teams

Key dimensions of effective teams:

team leadership
mutual performance monitoring
backup behavior
adaptability
team orientation

In the Dialysis Universe:

Organizational commitment of resources to address safety concerns

Efficiency is a legitimate part of decision making, ignoring what is inconvenient is not

Increased Safety , and…

Thank You!