

A close-up photograph of a silver stethoscope resting on a medical chart with colorful tabs labeled with numbers and letters (5, 3, 1, 8, 3, 7, 5, 3, 4, 6, M).

# Quality and Safety Tools in Dialysis Practice

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*“(..) The healthcare system is extremely complex, and ensuring patient safety requires the ongoing, focused efforts of every member of the healthcare team (...)”*

Ulrich; Kear (2014)

*“(..) Every system is perfectly designed to achieve the results it gets (...)”*

Berwick

## **But what fails?**

# Patient Safety



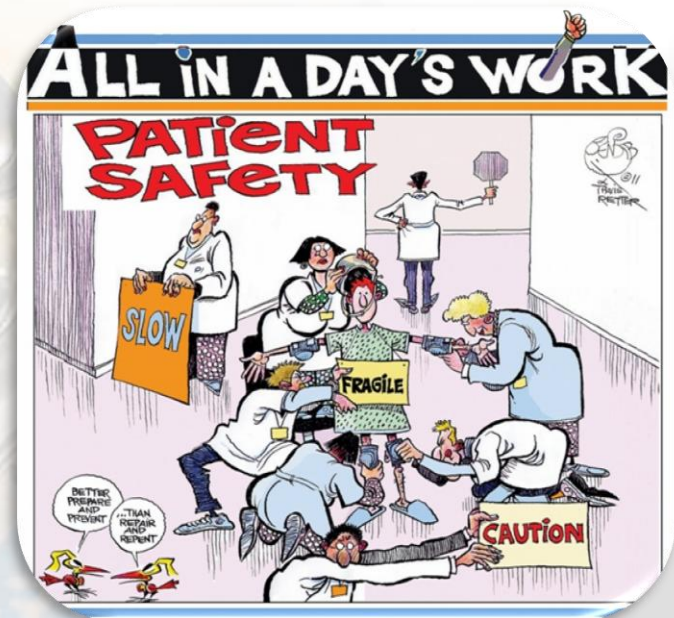


# Patient Safety

- **Patient Safety...**

- *“(...) is the prevention of errors and adverse effects to patients associated with health care. While health care has become more effective it has also become more complex, with greater use of new technologies, medicines and treatments.”*

WHO



# Patient Safety

Improving  
quality

Culture  
change

Process  
change

Risk  
reduction

Improved  
processes of  
care designed  
to reduce the  
risk of error and  
the effect of  
medical mistake  
of our  
patients...



# Dialysis Practice...

## WHAT CAN RISK MANAGEMENT OFFER?





# Dialysis Practice...

- Complex medical care and technology dependent
  - Routine processes of care are performed correctly and competently
  - Occurrence/recurrence avoidable harms are identified and prevented



**Haemodialysis is a technically complex procedure with many potential sources of error and harm to patients**

# Risk Management

- Managing all potential risks!
- Risks are associated to all aspects of healthcare, such as...
  - Organisational strategy, business and financial planning
  - Projects and service developments
  - Purchasing
  - Design of services
  - **Treatment and care delivery**

National Patient Safety Agency,



# Risk Management



# Risk Management



Identify

Assess

Analyse

Manage  
all  
potential  
risk

# Quality & Patient Safety in Dialysis Practice

“(...) even a “safe” organization is not error-free (...) Safe organizations anticipate “what-if” events and avoid blaming adverse events on an individual’s failure (...)”

Garrick et al (2012)

## What can be done?

- Development of a patient safety culture
- Recognizing the risk associated to dialysis practice
- Defending safety as a goal for all policies and procedures
- Commitment of all organization



# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT:

- Joint effort of the institution to identify incidents, their monitoring and analysis with consequent creation of norms and procedures.
- Promotion of added value for minimizing risk during clinical practice based on patient safety
- It implies anticipation, permanent adaptation and flexibility.





# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT:

Patient safety culture

Error orientation culture

Opportunity to learn

Error reporting

No blame system

Training policy

Adaptability and innovation capability

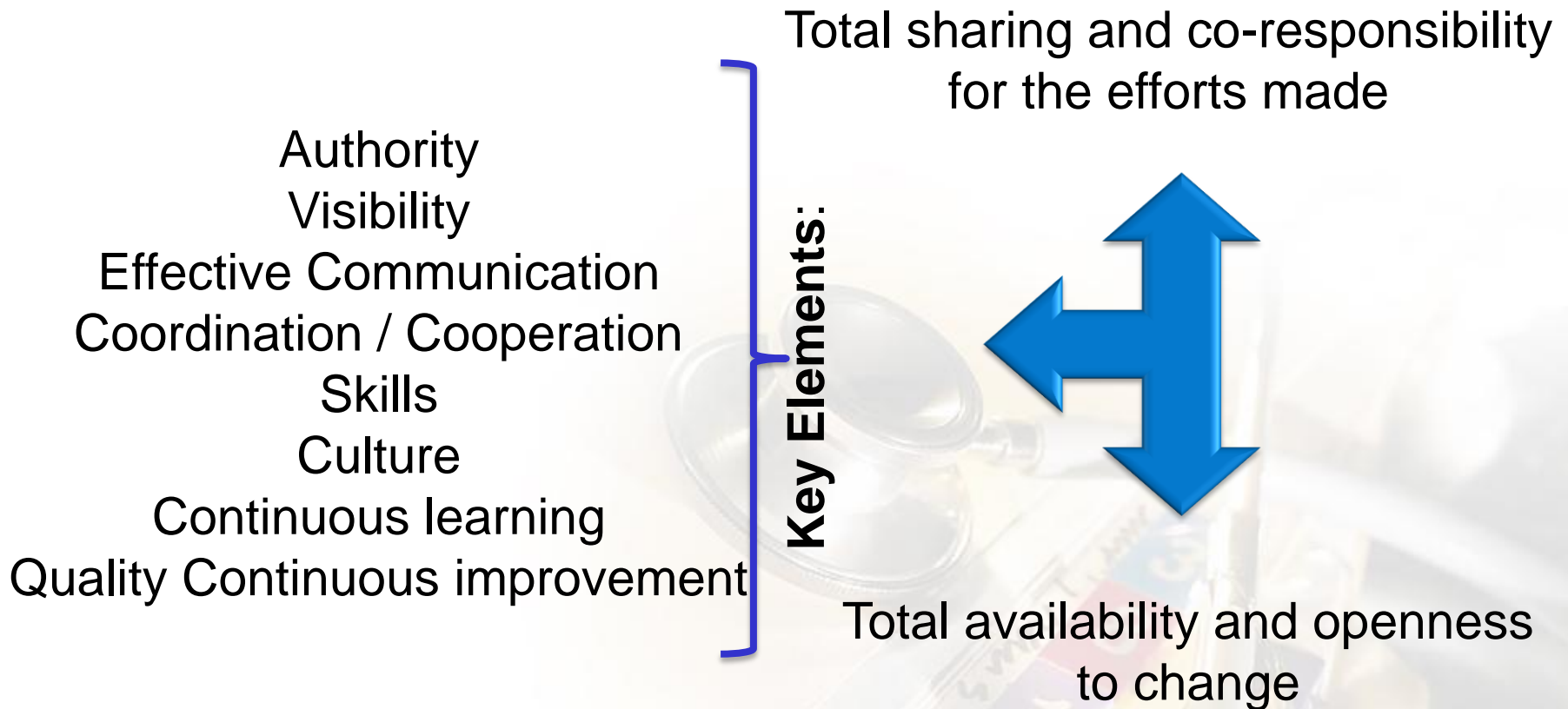
Persistence and strategic orientation

Education program



# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT characteristics :



# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT:

### Steps:



# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT



**Let's WORK!**





# Quality & Patient Safety in Dialysis Practice

## RENAL PATIENTS ...

- Are particularly at risk of complications because of:
  - Age
  - Associated comorbidities
  - Immunocompromised from renal failure or immunosuppression
- Receive complex treatments





# Dialysis Practice

- **Incidents** on renal units are most commonly related to:
  - Access related events
  - Blood incidents
  - Medications errors
  - Equipment and device failure
  - Health care associated infection
  - Patient falls



# Dialysis Practice - Incidents

## ACCESS RELATED EVENTS

- Access infiltration
- Clotting haemodialysis circuit
- Access needle dislodgment
- Poor blood flow
- Difficult cannulation
- Inadequately clamped access lines
- Failure to cap catheter ports



Safety  
first!



# Dialysis Practice - Incidents

## ACCESS RELATED EVENTS



- Vascular access is a critical issue
- Relatively simple seeming decisions about placement and use of hemodialysis access can have profound implications
- Staff tried more than twice to insert needles before getting assistance
- Access infiltration usually happens at the beginning of the treatment
- Dislodgement of the access needle and catheter disconnections are potentially life-threatening events

# Dialysis Practice - Incidents

## ACCESS RELATED EVENTS

### Risk Management Strategies:

- Reporting all the errors
- Staff and patient education
- Clear policies known by all healthcare team
- Training needling and fixing all the lines
- Audits / check list





# Dialysis Practice - Incidents



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first!

## BLOOD INCIDENTES

- Excess blood loss
  - Prolonged access bleeding after dialysis
  - Haemolysis associated with haemodialysis
- 
- High risk of inadequate tightening of the connector between the dialyser and the lines if the machine is not visible
  - High risk of exsanguination during washback procedure if the process is not carried out correctly
  - Bleeding can occur from fistula needling sites and from removal of femoral dialysis lines
  - Haemolysis is a potencial source of morbidity and could go unrecognised

# Dialysis Practice - Incidents

## BLOOD INCIDENTS

### Risk Management Strategies:

- Reporting all the errors
- Staff and patient education
- Training
- Protocols/practical guidelines for vascular access

Safety  
first!



# Dialysis Practice - Incidents

## MEDICATION ERRORS

- Deviation from dialysis prescription
- Allergic reactions and medication
- Medication omissions
- Errors of medication prescribing
- Errors of dosage

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first!



# Dialysis Practice - Incidents

## MEDICATION ERRORS

- Complex multidrug regimens
- High risk related with transitioning between health departments
- High risk medication – IV Heparin
- Necessary adjustment for medication – restrictions and dosing changes required for dialysis patients

Safety first!



# Dialysis Practice - Incidents

## MEDICATION ERRORS

### Risk Management Strategies:

- Reporting all the errors
- Staff education:
  - Communication, all team involved
  - Follow the right of medication administration
- Review of medication lists
- Medication reconciliation
- Double check
- Electronic medical records
- Patient education





# Dialysis Practice - Incidents

## EQUIPMENT AND DEVICE FAILURE

- Dialysis membrane bio-incompatibility
- Roller pump-induced hemolysis



Safety  
first!

- Sometimes treatments are finished earlier because of problems with the dialysis equipment



# Dialysis Practice - Incidents

## EQUIPMENT AND DEVIDE FAILURE

### Risk Management Strategies:

- Reporting all the errors
- Staff and patient education
- Training
- Check-list
- Praticce guidelines

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first!



# Dialysis Practice - Incidents

## HEALTH CARE ASSOCIATED INFECTION

- Bloodstream and other infections are leading causes of death and hospitalization among hemodialysis patients
- Improper hand and glove hygiene are troubling

Safety first!



# Dialysis Practice - Incidents

## HEALTH CARE ASSOCIATED INFECTION

### Risk Management Strategies:

- Reporting all the errors
- Staff and patient education:
  - Hand and harm hygiene policy and techniques improvement
  - Hemodialysis access procedures
  - Adherence to sterile techniques
- Training
- International procedures
- Check-lists



# Dialysis Practice - Incidents

## PATIENT FALLS

- Elderly patients – risk for fall more prevalent
- Associated risk factors such as:
  - Age
  - Diabetes
  - Motor strength
  - Medication used
  - Previous fall episodes
  - Visual impairment
- Orthostatic hypotension after dialysis



Safety first!



# Dialysis Practice - Incidents

## PATIENT FALLS

### Risk Management Strategies:

- Reporting all the falls
- Staff education
- Monitoring orthostatic blood pressure
- Transfers helps or assisting mobilization
- Environmental improvement



Safety first!



# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT

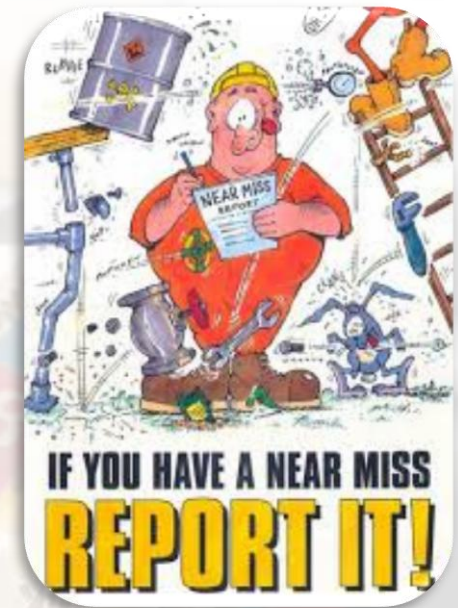
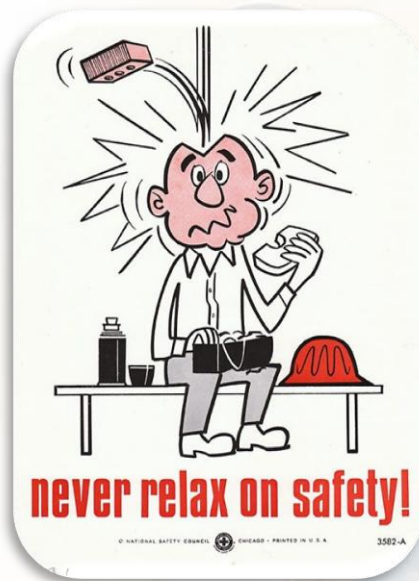
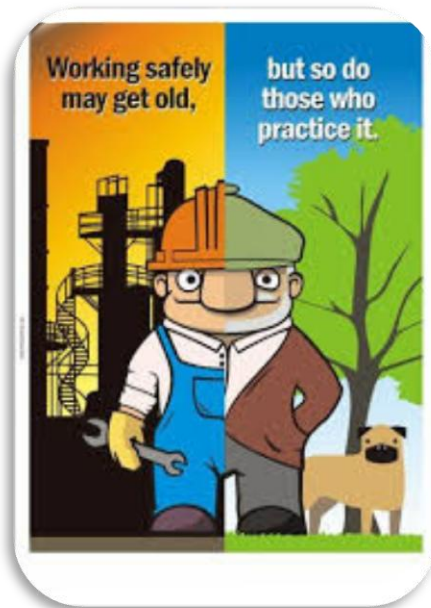


**In conclusion...**

# Quality & Patient Safety in Dialysis Practice

## RISK MANAGEMENT

- Errors in dialysis practice can cause harm and injuries
- All team must be involved in patient safety
- **Risk Management Department** must be implemented





# Quality & Patient Safety in Dialysis Practice

## **RISK MANAGEMENT Department**

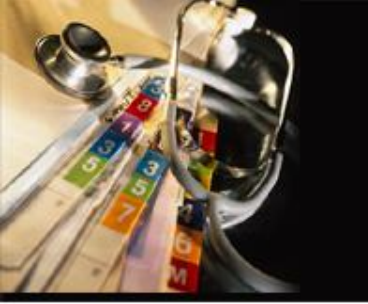
- Identification and evaluation of risks
- Incident reporting system and its analysis
- Quality and clinical internal and external audits
- Monitoring of clinical indicators
- Professional training:
  - Simulation
  - Multidisciplinary training
  - Crew resource management
- Implementation of national and international projects
- Development of human factors such as communication
- Patient Safety Goals: Development and monitoring

# Quality & Patient Safety in Dialysis Practice

**RISK MANAGEMENT Department**



**patient  
safety** 



*“(..) Knowledge does grow here and there by accumulation, but far often knowledge grows by the recognition of error (...)”*

Karl Popper

**Thanks...**