Patient Safety in Hemodialysis Wards: An Important Yet Neglected Issue in Medical Management

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Abstract:
Dear Editor,
Hemodialysis is a complex procedure with many potential errors and harms needs many steps that should be carried out safely and accurately in a setting with huge turnover and many potential sources of distraction.¹
Dialysis wards are complex departments that provide advanced technology to care for patients with chronic renal failure. As technology becomes more complex in dialysis facilities, the possibility for errors increases and potential risks must be identified and prioritized.²
The apparent risk in dialysis departments may be membrane reuse, water quality, and infection control for adverse events such as inadequate hand hygiene, machine and equipment disinfection and outbreaks of dangerous bio-pathogens that have been reported.³
Patient’s well-being sense is an important clinical index for the efficiency of safety medical treatments without any danger for the patients who experience decreased quality of life.³
However, data-based consideration can be useful to identify and determine safety efforts that may not be readily apparent. The top five safety items in hemodialysis departments are determined as follows: (1) patient falls, (2) medical errors (dialysis prescription mistakes, allergic reactions, and drug omissions or adherence), (3) access-related accidents (clotting, weak blood flow, and difficult cannulation), (4) dialyzer errors (inadequate dialysate and machine or equipment-related infection), and (5) prolonged bleeding or excess blood loss that should be notified for efforts based on patient safety.⁴
To conclude, medical managers and policy makers of dialysis facilities are responsible for providing a culture of safety and supporting practices that decrease mistakes and improve patient safety. Patient assistance protocols, risk assessment, and environmental improvements can be useful. Finally, communication lapses among health care providers and patients are the main source of adverse outcomes. Improve communication can progress patient safety. Patient participation in care processes may improve error detection and progress culture of patient safety.\(^5\)

**Keywords:** Patient Safety; Hemodialysis; Medical Management.

**Declaration of conflicting interests:**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding:**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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