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Patient Safety in Dialysis Access

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Contributions to Nephrology
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Foreword

Twenty-five years ago, the field of patient safety, apart from a number of early pioneers, did not exist, and the lack of attention to medical accidents could reasonably be described as negligent. Major progress has now been made in assessing the nature and scale of harm. The findings of the major record review studies are widely accepted, and numerous other studies have catalogued the nature and extent of surgical adverse events, infections, adverse drug events and other safety issues. Analyses of incidents are now routinely performed, albeit often in a framework of accountability rather than in the spirit of reflection and learning.

Substantial progress has been made in many clinical areas in understanding the causes of error and harm. Surgery, for instance, was long ago identified as the source of a high proportion of preventable adverse events. A decade ago, most of these would have been considered unavoidable or ascribed, generally incorrectly, as due to poor individual practice. Studies of process failures, communication, teamwork, interruptions and distractions have now identified multiple vulnerabilities in systems of surgical care. Many groups are now moving beyond the undoubted gains of checklists to a more sophisticated understanding of surgical teamwork in both the operating theatre and the wider health care system. A considerable number of interventions have shown that errors can be reduced and processes made more reliable in many other areas of health care. Interventions such as computer order entry, standardisation and simplification of processes and systematic handover have all been shown to improve reliability, and in some cases reduce harm, in specific contexts.

We are also learning that safety needs to be approached differently according to context. Each clinical activity poses its own particular risks to patients and the solutions must be customised and adapted for each setting. Some settings benefit from tight procedures and standardisation, whereas others require more flexible approaches to the management of risk and crisis.

Dialysis is of enormous benefit to patients and their families but, like other effective treatments, also poses risks. This book brings our understanding of patient safety to bear on the processes and systems of dialysis access, examining both the nature of the risk to patients and the means of managing them effectively. The book will surely be greatly welcomed by dialysis patients, families and all those who care for them.

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Preface

Patients with end-stage renal disease and its comorbidities have a high risk of suffering adverse events during their continuous treatment as in- or outpatients. Furthermore, dialysis access creation and maintenance are prone to complications. Therefore, specific strategies and various techniques to promote a patient safety initiative are of genuine interest.

Even 15 years after the publication of *To Err Is Human: Building a Safer Health System* by the Institute of Medicine, doctors and nurses are not always aware of the consequences of unsafe behavior. Today, we face the fact that knowing about the right thing is not a guarantee of doing the right thing. With this book, we aim to raise health care professionals' awareness of the aspects of patient safety, which combines medical education with evidence-based medicine. We are convinced that preventive strategies are key to avoid harm and to improve the outcome of the treatment of the growing number of patients with chronic kidney failure.

We are grateful that so many authors from different countries have contributed to this book. They give us a diversified insight into important concepts and technical tricks, which are essential to create and maintain a functional dialysis access. With checklists in our mind, we can be more precise in the timing and in the process of dialysis access creation. Besides simulation training, we also need a better focus on interdisciplinary and interprofessional communication. We are convinced that these efforts lead to more satisfaction amongst health care professionals and result in an improved medical outcome for our patients.

We thank the Vascular Access Society (www.vascularaccesssociety.com), the Vascular International School (www.vascular-international.org) and several industrial sponsors for their support when we started this patient safety project.

Please share your contributions with us at patientsafetyvas@insel.ch.

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