

## 2022 ANNA NATIONAL SYMPOSIUM

### Tales from the Dialyzer: Becoming a High Reliability Unit

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Hemodialysis is a high risk and high stress procedure. Complexity in patients, dynamic environment and multitude of potential complications can lead to errors and nurse fatigue/burnout. Multi-disciplinary team identified red flag events which could lead to a life threatening situations and how to combat issues using communication tools and phrases.

**Purpose (What):** 16 bed inpatient hemodialysis unit in a large 1,272 bed teaching hospital. The nursing team has over 500 years of combined dialysis experience. With the COVID-19 pandemic, acuity of patient and need for dialysis at bedside increased while staffing did not. Need for triage process noted.

**Relevance/Significance (Why):** Increased patient acuity from COVID and other disease processes began to create concerns within the nursing team regarding appropriateness of some hemodialysis orders. Some patients were not stable enough to undergo hemodialysis treatment and this led to conflict between nurses and physicians. Daily patient capacity was reduced by the increased need for bedside treatments and increased nursing absences due to COVID infection or quarantine.

**Strategy/Implementation/Methods (How):** Utilizing our organizations existing safety program, a tool was created to guide nurses and physicians through conflict, or red flag communication regarding patients and hemodialysis orders. The tool utilized three steps of escalation, key phrases for each, and defined the proper chain of command. The tool also allowed guidance for an ultimate end result which did not include moving forward with dialysis treatment. This document was created by nursing, then presented to the Nephrology physician group for edits and/or approval. The final document was distributed among both teams, and posted throughout the dialysis unit for reference.

**Evaluation/Outcomes/Results (So what):** Through this tool, we aimed to create a culture of no blame in which a high level of trust and openness allows individuals to exchange opinions without feeling judgment. The tool was used to increase communication and collaboration for cases which occurred in normal operating hours, after hours/late add ons, and those which occurred on call, or emergent. The tool is referenced and utilized on a regular basis by the nursing team to guide conflict and red flag communication with physicians.

**Conclusions/Implications (And now):** The tool is utilized on a regular basis by the team to guide red flag communication with physicians. Daily chats are initiated by the charge nurse early in the shift to help plan for unit and travel capacity. Case review done with open discussion and encouragement of critical thinking.

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