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The Medical Director's Role in Managing the Dialysis Unit

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Abstract

The ESRD Conditions for Coverage specify the duties of a dialysis unit medical director, which cover a variety of quality, safety, and instructional areas. Many of these duties necessitate leadership abilities, which are neither innate nor learned as part of the medical director's education. An effective medical director can influence the culture of the dialysis facility to foster an environment where patients and staff can voice concerns about subpar procedures without fear of retaliation, and where quality improvement and safety are continuously iterated processes that value feedback from all stakeholders. As a result, fewer shortcuts and workarounds that could jeopardise patient safety and quality are used since regulations and procedures make it simpler to act morally.

Keywords: Dialysis • Medical • Environment

Introduction

Every institution must have a medical director according to the ESRD Conditions for Coverage (CfC) for dialysis centres. The medical director of the dialysis center needs to have looked after dialysis patients for at least a year. The medical director is required to assume a wide range of responsibilities under the CfC, which were previously studied in depth2 and are described in the most recent 2008 amendment. The CfC advises the medical director to devote 25% of his or her total work hours to the dialysis facility medical director function in order to carry out these duties. Because they call for the medical director to guide and motivate other facility staff members, a few responsibilities of the medical director merit a more thorough explanation.

Review Literature

Responsibilities of the medical director

The medical director's leadership and active engagement in the quality assessment and performance improvement (QAPI) process may be his or her most significant duty. The QAPI meetings' emphasis on population management enables the interdisciplinary team to see patterns and pursue appropriate remedies.

Metabolic metrics, adverse events, infection management, and vascular access opportunities are a few topics the team may look over. Root cause analyses for adverse occurrences may be necessary, and the medical director should actively participate in the procedure with the team. The medical director's leadership and active engagement in the quality assessment and performance improvement (QAPI) process may be his or her most significant duty. There are various and possibly lethal outcomes to inadequate water quality. Water quality ought to be examined at the month to month QAPI gatherings with the goal that various colleagues have the chance to raise concerns. The steady following, reporting, and noticing engaged with office water the executives are essential to dialysis patients' wellbeing. It is normal for Government health care state assessors to ask the clinical chief or any staff part to play out a water quality check [1].

Poor water quality has many negative effects, some of which are lethal. The monthly QAPI meetings should include a topic on water quality so that all team members can voice their concerns. The careful monitoring, recording, and observing required for facility water management are crucial to the wellbeing of dialysis patients. Medicare state surveyors frequently request a water quality check from the medical director or any other staff member. The medical director is also informed when there are deviations in water protocols or quality, and it is up to him or her to decide how to handle patient care in the event of a deviation [2].

In terms of infection control, the medical director should be knowledgeable about how the facility stacks up against national averages for blood stream infections and be able to address staff concerns, such as isolation procedures for specific infections, boosting hand washing compliance, and raising immunization rates. The Nephrologists Transforming Dialysis Safety initiative has made the medical director's leadership in infection safety a key component of reducing hospitalization and mortality rates for dialysis patients.

The dialysis facility's governing body and the medical director collaborate frequently. The medical director, the facility administrator, and a regional administrator may all be members of the governing body, depending on the corporate structure. The governing body of the dialysis facility meets on a regular basis to discuss the clinical treatment standards as well as the financial situation of the dialysis unit, including any staffing requirements or staff performance issues. The other nephrologists who care for patients at the facility are now unable to perform the administrative and business functions of the dialysis unit without the assistance of the medical directors.

The medical director as leader

The dialysis center is a distinct, somewhat autonomous center for the delivery of healthcare that necessitates intensive coordination among various parties. Managing health-care transitions, objective criteria like laboratory values, and quality of life assessments are all important components of providing dialysis patients with the best possible care. Although the complexity of this coordination of care is touched upon in the literature on medical director leadership, a newer paradigm of leadership is required to accommodate the present health-care environment [3,4].

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Most dialysis medical directors probably might benefit from more professional development in their leadership abilities. Numerous health care leadership initiatives have been introduced, but none of them are particular to nephrology. The National Health Service of the United Kingdom, the medical system in Canada, and big institutions like the Cleveland Clinic and Kaiser Permanente in the United States are a few examples of health-care leadership initiatives.

John D, et al. describes the National Health Service Medical Director's Clinical Fellows scheme, which is a component of the Faculty of Medical Leadership and Management [5]. Under this programme, clinical advisers are excused from their clinical duties for a year so they can work full-time in a variety of high-level health organizations while completing a formal leadership development course. There appears to be a gap between the management training received by dialysis organization leaders and that received by medical directors of dialysis units. It would be advantageous if both were more consistent.

In a review of the ideal qualities of physician leaders at the hospital level, the significant obstacles that still stand in the way of clinical leadership, including insufficient incentives, low confidence, clinician cynicism, inadequate communication, inadequate preparation, curriculum gaps at the undergraduate level in medical and health professional courses, poorly built and inadequately funded programmes, lack of vision and communication [5].

Margarate HM, et al. [6]point out that although doctors are trained to be independent, autonomous, and decisive, these traits can be in conflict with those of a desired medical leader, who might be more oriented toward collaborative approaches. Nagel and colleagues emphasized the need of emotional care, presence, and awareness in leaders.

Transparency and psychological safety are also crucial; regardless of perceived rank, every member of the dialysis community should be able to voice concerns without worrying about being punished. Plans to advance quality and patient safety must involve all staff members; else, the system is likely to fail Engagement of patients and their families are essential to advancing the goal of patient safety [7-9].

The nephrologist is motivated and a dialysis unit's culture is improved by having the ability to alter protocols, work directly with personnel, and engage in quality improvement. The effectiveness of dialysis organizations might be increased by sharing procedures between different organizations. The process of creating protocols duplicates work that could be done in other areas, like patient safety and care transitions.

Allowing for a more multidisciplinary approach in which the dialysis unit might act as a medical home for patients may increase patient satisfaction. One possible implementation strategy is to have the patient's main care physician double as the physician extender. According to this plan, the dialysis center would include suitable exam rooms and would promote improved patient and family involvement.

Conclusion

The medical director is a physician leader who could use more leadership education or at the very least, a more effective paradigm, to promote a positive dialysis culture. Determining leadership qualities and obstacles aids in redefining the position. Medical directors may experience disengagement or overwhelm, which can be explained by pointing out their lack of formal training and the conflicting priorities they face. Mentorship, communication, approachability, emotional intelligence, and medical expertise are qualities of effective leaders.

Conflict of Interest

There are no conflicts of interest by author.

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