



**NEPHROLOGY PROGRAM
DEPARTMENT POLICIES AND PROCEDURES**

**Hemodialysis - Section 03 - Patient Assessment & Management - Neph 3-22
Guidelines for Accepting Transient Hemodialysis Patient
No.: 01152 (TOH Standardized Policy Number)**

ISSUED BY:

Corporate Hemo Management Committee

DATE OF APPROVAL:

2010/06

APPROVED BY:

Nephrology Steering Committee

LAST REVIEW/REVISION DATE:

2018/07

CATEGORY:

Patient Assessment and Management

IMPLEMENTATION DATE:

2010/06

POLICY STATEMENT:

- To outline the criteria that a transient patient must meet in order to be accepted for dialysis at the Ottawa Hospital

BACKGROUND STATEMENT

- The Nephrology Program encourages transient patients to dialyze at The Ottawa Hospital and its satellites assuming they meet the criteria as identified below for dialysis
- The Program Delegate is the person responsible for facilitating the transient patient visits to TOH
- This policy does not apply to patients coming to Ottawa for access related interventions
- This policy is subject to review should any Communicable/Infectious Disease challenges arise that affects any corporate patient admissions policies to TOH (e.g.: Pandemic)

DEFINITION(S): N/A

ALERTS: N/A

PROCEDURE: GUIDELINES

1. Criteria for Patient Acceptability for Hemodialysis

- Patients must have an adequately functioning vascular access for hemodialysis
- Patients should be able to undergo hemodialysis treatments in a chair. In special circumstances, transient patients requiring a bed will be accepted only if the specific unit has beds available and there is the operational ability to accept the patient.
- Patients must be medically stable on hemodialysis, not requiring major interventions on a regular basis to correct intradialytic complications, such as low blood pressure, cramps, etc
- Patients who are booked for more than 6 treatments require the Nephrologist to review the medical summary in order to decide if blood work is necessary during their stay

2. In Addition, The Patient must meet the following criteria

- Patients must be able to provide all medical information 2 weeks prior to their arrival in order to be reviewed and accepted
- Patients from the province of Ontario will have their Erythropoietin or Aranesp and parenteral iron provided by TOH during their stay; they remain responsible for bringing all other dialysis medications. Patients from outside of Ontario are responsible for bringing ALL dialysis medications INCLUDING Erythropoietin and parenteral iron
- Notify Infection Prevention and Control (IPAC) of all patients with Antibiotic Resistant Organisms (ARO) (e.g. MRSA, ESBL, MDRO and CPE)
- Policy Neph 3-13 (No.: 01361) must be followed for required placement and management of ARO transient patients during their stay in the hemodialysis unit.
- Patients from outside of Canada must provide screening results of ESBL and CPE within the last month.
- Hepatitis B positive patients will be accepted only in special situations and there is the operational ability to accept the patient.

3. Guidelines outlining process

- Patients from Ontario and outside of Canada will be initially referred to the Independent Health Facilities hemodialysis unit in the region. If these units are unable to accommodate these transient patients, TOH would then be consulted. Canadian patients outside of Ontario will be referred to TOH.
- Attempts will be made to accommodate one transient patient per day at TOH. This treatment may be at any of the campuses or satellite hemodialysis units. Additional patients will be accepted if space is available. Effort will be made to give the patient his/her first choice of TOH campus depending on availability. The campus will be chosen after consultation with the Care Facilitator
- The number of transient patients accepted to dialyze at TOH over peak periods will be based on the number of vacancies available and after consultation with the clinical manager of each campus. Acceptance of patients for the Christmas period will be determined by November 1st of each year.

- The Program Delegate will be contacted by patient, family member or dialysis unit requesting transient dialysis
- Dates requested will be entered into the calendar. If dates are unavailable, alternate dates are offered or the patient's name can be placed on a waiting list and it will be confirmed closer to the travel date
- Patient is told that his/her dialysis will not be confirmed until all medical information has been received, reviewed and accepted
- TOH Referral for Transient Hemodialysis Forms will be faxed to the Referring Centre.(See Appendix A-sample Transient Hemodialysis Form)
- For patients from outside of Canada: Transfer Forms, Nonresidents of Canada Governing Law and Jurisdiction Agreement and Hospital Fees for Services forms will be faxed to referring unit. This Agreement Form and Hospital Fee Form will need to be signed and faxed to us before pt arrives in Canada
- Program Delegate will review all medical information as it arrives and will document all pertinent information in NephroCare
- Medical acceptance of the transient Champlain LHIN patient is not required as long as the patient is stable and the referring Nephrologist has deemed patient well enough to travel. All other transient patients require Nephrologist review and acceptance.
- Hemodialysis orders will be approved by TOH Medical Director/Delegate of Hemodialysis
- Campus, date and time will be chosen after consultation with Care Facilitator.
- All transient medical information will be faxed to the appropriate Campus as soon as orders have been entered in NephroCare
- Patient will be notified of the time of dialysis and Campus as soon as it has been confirmed
- On patient's arrival for their first treatment, he/she will need to see the clerk to confirm their demographic information and the Provincial Health Card number. The Transition Nurse or delegate will assist the out of country patients to ensure that arrangements for payment with the Finance Department have been made
- Transient patients will sign consent for Hemodialysis before their first treatment if not completed already

Electronic Medical Record (EMR):

- The Program Delegate will ensure that the patient is discharged, modality changed to transient and that the orders have been inactivated once patient has left TOH.
- Faxed copy of Transient package is sent to the Queensway Carleton Hemodialysis Unit. Patient packages that also qualify for TOH encounters are sent to Medical Records.

RELATED POLICIES / LEGISLATION: N/A

REFERENCES:

1. The Ottawa Hospital, Nephrology Program, Hemodialysis Management Committee



Hemodialysis Unit _____
Attention: _____ **Date:** _____
Patient _____ **has requested dialysis treatment at**
The Ottawa Hospital on _____
Provide the following documentation at least two weeks before their arrival in Ottawa:

Transient Hemodialysis Referral form	Medical Summary note indicating patient is fit to travel
Hemodialysis Orders	Patient medication list including vaccination status
Most recent monthly blood work reports	Most recent progress notes
Oral anticoagulation/dosage/INR range if applicable	Chest x-ray (within 1-2 years if no respiratory symptoms)
ECG (within 1-2 years if no cardiac symptoms)	3 most recent dialysis run sheets
Hepatitis C report (within last 6 months)	MRSA (nasal, rectal, CVC, any wounds) within the last month
Outside Champlain LHIN: <ul style="list-style-type: none"> ○ Provide results Hepatitis B surface antigen and antibody done within the last month Part of Champlain LHIN & patient status is: <ul style="list-style-type: none"> ○ Immune: Provide results of Hepatitis B surface antigen and antibody done within last 6 months ○ Not immune: Provide results of Hepatitis B surface antigen within the last 2 months 	
ESBL and CPE for patients from outside of Canada within the last month	
<p>All dialysis catheters are locked with 4% Na Citrate.</p> <p>Eprex/Aranesp will be provided to Ontario residents only as required. Visitors must bring all dialysis medications as required during their stay.</p> <p>Tinzaparin (Innohep) is used as the anticoagulant in this unit.</p> <p>The Ottawa Hospital (TOH) requires that a “Consent to Treatment” form be signed by both the transient patient and the referring physician prior to the patient receiving Hemodialysis treatment at TOH. Please have this consent signed and returned with the package.</p> <p>While every attempt will be made to accommodate the dates and times requested, it may be necessary to schedule your patient on different dates and/or times due to our own patient schedule. There is also a possibility that there will not be spots in Ottawa and that the patient will need to travel to one of our Satellites.</p> <p>Program Delegate, The Ottawa Hospital Nephrology Program Phone: 613-721-2000 Ext. 5802 Fax: 613-721-2034</p>	



The Ottawa Hospital Nephrology Program Referral for Transient Hemodialysis	
Patient Name:	
Date of birth (d/m/y):	
Height (cm):	
Dates Requested:	
Usual Dialysis Days:	
Referring Institution:	
Institution Name:	
Telephone:	Fax:
Contact Person:	
Referring Nephrologist:	
Reason for Request:	
Patient Demographics:	
Language:	
Current Address:	
Telephone:	
Health Card Number:	Expiration date:
Family Physician:	
Telephone:	
Emergency Contact:	
Relationship:	Telephone:
Local Contact Person:	
Relationship:	Telephone:
Local Address:	

Page #2 of Referral for Transient Hemodialysis	
Patient Name:	
<i>Specified Information:</i>	
Primary Renal Diagnosis:	
Date of First Dialysis (d/m/y):	
Allergy Status/Sensitivity:	
Advanced Directives (if yes, enclose additional information): <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobility: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Needs Assistance	
Required during Treatment: <input type="checkbox"/> Bed for medical reasons, if yes please specify:	
Antibiotic-Resistant Organisms (e.g. MRSA, ESBL, MDRO, CPE) _____	
Isolation Precautions:	
Special Considerations:	
Dialysis Complications:	
Resuscitation:	
<i>Current Vascular Access:</i>	
<input type="checkbox"/> Fistula <input type="checkbox"/> Graft	Location: _____ Needle gauge: _____
Date of insertion: (d/m/y): _____	
Hemodialysis catheter: <input type="checkbox"/> Tunneled <input type="checkbox"/> Temporary	Location: _____
Date of insertion: (d/m/y) _____	
Special Considerations:	
Active Potential Transplant Recipient: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>Hepatitis B Vaccine:</i>	
Currently receiving vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last dose (d/m/y): _____	_____
<i>Additional Comments:</i>	



HEMODIALYSIS ORDERS

Patient's Name:		Date (dj/mm/yyaa):	
Dry Weight			
Duration of Dialysis			
Dialysate Temperature			
Dialyzer	<input type="checkbox"/> FX 800 <input type="checkbox"/> FX 1000 <input type="checkbox"/> Phylther 17SD		
Dialysate Potassium	mmol/L		
Dialysate Calcium	mmol/L		
Dialysate Bicarbonate	mmol/L		
Base Sodium			
Blood Flow	mL/min		
Dialysate Flow	mL/min		
Innohep (Tinzaparin) TOH uses Innohep only	<input type="checkbox"/> 2500 units <input type="checkbox"/> 3500 units <input type="checkbox"/> 5000 units Note: Suggested conversion scale is 50% of TOTAL Unfractionated heparin dose		
Sodium Citrate Locks (Tunneled Catheter)	Volume of Catheter lumen: Arterial ___ mLs, Venous ___ mLs		
Medications on Dialysis			

	Print Full Name	Signature
Nephrologist		
Nurse		



The Ottawa Hospital | L'Hôpital d'Ottawa

Civic
 TRC

General
 CC

Riverside

CONSENT TO TREATMENT

I, _____ agree to have:
PATIENT NAME/SUBSTITUTE DECISION MAKER

The treatment/operation/procedure:

Patient is aware of risks associated with a Hemodialysis treatment and that the procedure and risks are, in general, similar to those at the patient's usual dialysis unit.

to be done by _____, and will allow
HEALTH PRACTITIONER

- Anaesthetics, other medications and/or blood or blood products, if needed;
- Any other treatments, operations or procedures needed in an emergency;
- The Health Practitioner to use the help of other Health Practitioners, including residents, and students;
- The disposal of any tissue or parts that have been removed during the treatment/operation/procedure.

I confirm that _____
HEALTH PRACTITIONER

- Has explained the treatment/operation/procedure to me, and the risks, side effects and expected benefits of the treatment/operation/procedure;
- Has answered my questions about the treatment/operation/procedure;
- Has told me about other possible treatments; and
- Has told me about the possible effects if the treatment/operation/procedure is not done.

I understand these explanations and I am satisfied with them.

Patient or Substitute Decision Maker (SDM)	Signature	Date (yyyy/mm/dd)
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TO BE COMPLETED BY PHYSICIAN/HEALTH PRACTITIONER

(Please note as per TOH Consent to Treatment policy section 3.6.4, "treatment may be delayed in the absence of the Health Practitioner's signature.")

I confirm that I have explained the nature of the treatment(s), expected benefits, material risks, material side effects, alternative courses of action and the likely consequences of not having the treatment. I have responded to requests for additional information regarding above.

Health Practitioner/Physician	Signature	Date (yyyy/mm/dd)
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Name of Interpreter (if required)	Signature of Interpreter	Date (yyyy/mm/dd)
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TELEPHONE CONSENT

Name of Substitute Decision Maker (SDM)	Signature (staff confirming tel. consent)	Date (yyyy/mm/dd)
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