

## **Medical Review Board Statement Right to Choose a Physician**

### **Purpose**

As the quality management body representing ESRD Network 18, the Medical Review Board (MRB) would like you to be aware of your right to choose a physician and/or dialysis facility.

### **Statement**

You have a voice in choosing your physician and/or dialysis facility. There may be other restrictions involved (such as location, insurance coverage, limited services available) that affect the final decision about your placement, but your preferences must be taken into account. If your physician decides to leave your current dialysis facility, you have the following options:

1. Keep your current physician, but leave your current facility and transfer to the new facility
2. Change your physician and stay at your current facility
3. Change your physician and transfer to an entirely different facility.

We realize that these may be difficult choices for you. We want to reassure you that we are here to make sure that any decisions you make are done without duress or pressure from facility staff, physicians, or any other outside source.

If you have any questions or problems, please feel free to call the SCRDC Patient Services Coordinator, at 1-800-637-4767.

Formulated: MRB 1994  
Reviewed: MRB 1997  
Reviewed: MRB 12/05/2007

## **Medical Review Board Statement Care of Aids and/or HIV+ Patients Requiring Dialysis**

Patients with Human Immunodeficiency Virus (HIV) antibodies or Acquired Immune Deficiency Syndrome (AIDS) can be dialyzed safely if one adheres strictly to universal infectious disease precautions as outlined by the Centers for Disease Control (CDC). All patients undergoing dialysis therapy should be considered as potential HIV carriers. The HIV virus is a much more fragile organism than the Hepatitis B virus. Universal precautions already in use in dialysis centers to prevent transmissions of Hepatitis B should be adequate to prevent transmission of HIV to staff and patients, providing that personnel caring for patients rigorously follow these infection control practices.

Facilities must provide policies and procedures, resources, materials and supplies, and the appropriate environmental conditions to allow staff to effectively practice universal precautions on a consistent basis.

Confidentiality of medical records remains imperative; however, the results of a blood test to detect HIV antibodies to the probable causative agent of AIDS may be disclosed to providers of health care who perform direct patient care and treatments. Routine testing of all patients and staff is not necessary for infection control purposes. Voluntary HIV testing in a high-risk patient may be helpful for medical management and counseling. No HIV testing is to be done without written consent and documentation in the patient's medical record.

The Medical Review Board agrees that patients who are HIV positive, or have AIDS, have equal access to health care facilities, including those providing dialysis services. Patients cannot be discriminated against in the provision of dialysis care, or be denied admission to dialysis facilities on the basis of HIV testing or the lack thereof.

Approved: MRB 08/20/1990  
Reviewed: BOD 09/07/1990  
Distributed to Council Member: 10/04/1990  
Reviewed: MRB 06/17/1991  
Revised: MRB 05/21/1997  
Reviewed: MRB 12/05/2007



Southern California  
Renal Disease Council  
INCORPORATED

ESRD NETWORK 18

## MEDICAL REVIEW BOARD STATEMENT REPORTING OF INVOLUNTARY PATIENT DISCHARGES

### Purpose

As the quality management body representing ESRD Network 18, the Medical Review Board (MRB) would like to accurately monitor and track the incidence of Involuntary Patient Discharges (IVD) and clarify the responsibility of the ESRD providers.

### Statement

The issue of under-reporting involuntarily discharged patients in Network 18 is a concern to the Network staff, Medical Review Board, and Board of Directors (BOD). Network 18 is committed to assisting with conflict and patient discharge situations, but can only do so when made aware of the concerns in advance.

As the CMS business rule on the Patient Activity Report (PAR) for the Networks related to Involuntary Discharge-Transfer out-Category C reads “Patient has been discharged from the facility *against his/her will*”. A patient is considered involuntarily discharged if they have received written or verbal notice that they will no longer be allowed to receive dialysis at your center. If the patient transfers to another facility without interruption to service, it is still to be reported as an involuntary patient discharge.

In the event that the decision to involuntarily discharge a patient is made, the MRB is asking ESRD providers to carry out the following reporting guidelines:

1. Notify the Network 18 Patient Services Director (PSD) of the decision to involuntarily discharge a patient prior to the actual discharge. In the case of immediate discharge due to violence or threats of violence contact PSD as soon as possible.
2. Be prepared to answer questions related to the events leading to the decision to involuntarily discharge the patient and interventions used to address the issue(s) prior to the discharge. If necessary, a request for documentation may be made.
3. Report the involuntary discharge on the monthly Patient Activity Report (PAR) under event “6C” (Transfer Out-Category C) in the losses column and indicate the reason for the discharge in the last column of the PAR.

MRB Approved: December 12, 2008

### Mission Statement

*To provide leadership and assistance to renal dialysis and transplant facilities in a manner that supports continuous improvement in patient care, outcomes, safety and satisfaction.*

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## **Patient Education Guidelines**

In order to help patients maximize functioning and adaptation to life on dialysis, patient teaching is one of the most important aspects of renal care. Unfortunately, there is no recommendation for the “best time” to institute dialysis patient teaching. With adult learners, there are many factors to consider, and patients must be assessed individually for their readiness to learn.

### **Steps in the Teaching Process:**

1. Assess the patient and family for readiness to learn: areas to review are physical abilities, ability to speak and understand English, general comprehension level, attitudes and health beliefs. (See Problem/Solution table below.)
2. Set up goals/objectives for patient, based on behaviors and attitudes patients should exhibit, either during or after the teaching program is completed.
3. Present the information. Whenever possible, use resource material geared to the patient’s age, level of understanding (or language), and interests/concerns. Give patients written material to take home and review as needed. Use of visuals (pictures, diagrams, videotapes, etc.) and activities where the patient can participate (e.g. discussion or question/answer sessions) produces greater retention than non-participative listening.
4. Evaluate how the patient is doing during presentations, as well as at the end of the program. Patient progress (attainment of objectives) can be checked by verbal questioning, written questionnaires where patients are asked to respond, classic “post-tests”, and activities where patients can demonstrate new skills.
5. Document patient progress, preferably in the medical record.

1. *Potential Problem*

Physical Condition – Anemia and uremia cause comprehension difficulties. Patients with these physical problems cannot understand complicated or lengthy instructions.

*Suggested Solution*

If patient is ill, give simple, basic information and “need-to-know” instructions. Include family members. Give information to take home for review later.

2. *Potential Problem*

Comprehension problems during dialysis treatment – Studies show that patients may have diminished cognitive function and retention during hemodialysis procedure.

*Suggested Solution*

Whenever possible, see patient BEFORE dialysis treatment begins. If done during dialysis, information should be repeated and reinforced.

3. *Potential Problem*

Denial of disease – If patient not accepting disease, in-depth teaching will not be retained. Information will only be communicated when patient is able to listen.

*Suggested Solution*

Assess patient attitude. Give only basic facts. Include family members in teaching. Save formal teaching sessions until patient indicates readiness to become involved.

4. *Potential Problem*

Anger and depression – Hostile patients are capable of learning, but are disruptive in-group situations. Minor depression usually does not interfere with learning, but severe depression blocks learning and retention.

*Suggested Solution*

Angry patients should be taught individually rather than in-group settings. With mildly depressed patients, stress how information will help them cope. Severe depression should be reported to physician for treatment.

5. *Potential Problem*

Poor attitude toward health care – Lack of trust in health care professionals can lead to noncompliance and resistance to any recommendations.

*Suggested Solution*

A coordinated, communicative team approach in planning and implementing a dialysis-teaching program for the resistant patient usually achieves best results.

## Documentation

Initial documentation of any teaching/counseling on the patient record should include what information was given to the patient and family, who presented it, where and when it was presented, and patient statements or reactions to the information. This can be done on any facility-generated chart form (e.g. social worker evaluation, patient care plan, etc.). If a formal education program is in place, documentation can include what learning objectives were chosen for the particular patient, which methods of evaluation were used to meet the objectives, and how the patient responded.

Any follow-up teaching/counseling done with the patient, and changes in treatment modalities should be documented in the progress notes or facility teaching forms. Changes in treatment modality must also be reported to Network 18 on the Monthly Patient Status Report (MPSR), and should be reflected in the annual Life Plan.

Reviewed: MRB 12/05/2007

## **Patient Participation in Vocational Rehabilitation**

### **Standards**

1. 100% of all patients in the ESRD Program will be screened for a vocational rehabilitation referral.
  - a. 100% of all new patients entering the ESRD program will be screened for vocational rehabilitation referral, no later than three months after initiation into the program.
  - b. 100% of all eligible patients now in the ESRD program will be screened for vocational rehabilitation referral annually.
  - c. Follow-up on the vocational rehabilitation status of 100% of all patients will be done annually and noted on the Long-Term Program form in the medical record.
2. The medical record of the dialysis or transplant facility will reflect that the professional team has evaluated the patient's suitability as a referral for vocational rehabilitation.

### **Criteria**

1. The patient is already working and plans to continue employment.
2. The patient is a student and plans to continue.
3. The patient is a homemaker and plans to continue as a homemaker.
4. The patient is retired and chooses to continue retirement.
5. The patient has a severe medical disability, which is documented in the medical record.
6. The patient is under 16 years of age (pediatric patient).
7. The patient is evaluated as not being suitable for vocational rehabilitation referral by the team, and it is documented in the medical record.
8. The patient has been referred for vocational rehabilitation and met with a vocational rehabilitation counselor within the past 12 months.
9. The patient has been accepted into the California vocational rehabilitation program within the past 12 months.
10. The patient refused referral and has signed the Life-Plan form, which is kept in the medical record.

Reviewed: MRB 12/05/2007

## **Board of Directors Statement Harassment, Abuse and Threats**

All individuals have the right to be safe and protected from harassment, abuse and threats. It is the responsibility of those who own, manage and provide professional services in dialysis centers to safeguard the health, welfare, and rights of their patients, employees, medical staff, and visitors.

The following actions are intolerable if they result in real or perceived harm to the victim, bystanders and witnesses:

1. Acts of physical violence
2. Actual or implied threats
3. Sexual or emotional harassment

Prompt recognition and response by the Medical Director and/or Chief Executive Officer is critical to protect all concerned individuals and the orderly provision of dialysis services.

The Board of Directors of the Southern California Renal Disease Council, Inc. recommends that dialysis facility management provide the following:

1. Organizational commitment to a policy of zero tolerance for workplace violence, verbal and nonverbal threats, and related actions
2. A policy on prohibition of weapons and firearms
3. Dissemination of such policies to staff and patients/patient representatives
4. Initial orientation and ongoing training for all staff in violence prevention programs
5. Guidelines for patient rights/responsibilities that establish clear behavioral expectations
6. Guidelines for procedures not to initiate treatment, to terminate treatment and/or to terminate the relationship with violent/abusive patients
7. Procedures to summon local police or private security personnel when appropriate

OSHA provides voluntary, generic safety and health programs management guidelines for all employers to use as a foundation for their safety and health programs, which should include a work place violence prevention program. \*OSHA Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, US Department of Labor, Occupational Safety and Health Administration. OSHA 3148, 1996.

Medicare regulations address patient transfers and discharges: 42 C.F.R 405. 2138(b)(2) "All patients treated in the facility...[a]re transferred or discharged only for medical reasons or for the patient's welfare, or that of other patients, or for nonpayment of fees (except as prohibited by title XVIII of the Social Security Act), and are given advance notice to ensure orderly transfer or discharge."

Reviewed: MRB 12/05/2007

## **Medical Review Board Statement Laboratory Testing for Dialysis Patients**

The MRB obtained reports about monthly blood testing on hemodialysis patients concerning an HMO refusing to pay for or to accept results on blood drawn in the hemodialysis unit, and requiring patients to travel to an HMO-designated lab for monthly testing. MRB member expressed several concerns including:

1. This practice represents misunderstanding on the part of the HMO, and might be amendable to the educational efforts
2. The standard of care internationally is to use labs drawn at the start point of the hemodialysis procedure
3. Hemodialysis patients are already burdened with frequent travel to dialysis, and should not have to go elsewhere unnecessarily
4. Needle sticks other than those necessary for dialysis increase the risk of vascular access compromise, with increased morbidity and cost
5. Using multiple laboratories in a single dialysis unit increases the difficulty of interpretation and quality assurance.

### **Standard**

The MRB affirms that the standard of care in the community is to obtain all blood specimens drawn on hemodialysis patients in the hemodialysis unit at the time of dialysis.

In addition, dialysis patients will not be required to transport their own blood specimens to an outside laboratory at any time. HMO and other treatment providers will provide appropriate transportation to deliver blood and other specimens to the designated laboratory in a timely manner.

Approved: MRB 8/19/1992

Reviewed: 12/1994

Reviewed: 05/1997

Reviewed: 12/05/2007