

Medical Review Board Statement Recommendations on use of Clinical Care Guidelines in Dialysis

The Medical Review Board (MRB) of ESRD Network 18 supports and formally recommends the Renal Physician Association's "RPA Position on the use of Clinical Care Algorithms or Pathways in the Delivery of Quality Renal Patient Care" (7/03).

1. MRB unequivocally supports the use of algorithm orders to achieve excellence in patient care, to implement the goals of evidence-based guidelines thereby enhancing quality, and to promote patient safety by avoidance of medical errors.
2. MRB believes that individual nephrologists must decide whether an algorithm is appropriate for each patient and, if so, to authorize the use of the algorithm for that patient.
3. MRB believes that an order for regular periodic laboratory tests generated by an algorithm should be executed without further authorization or signature.
4. MRB believes that a change in dose generated by iteration of an algorithm should be instituted promptly without prior signature by the physician.
5. MRB believes that all changes in dose should subsequently be signed to confirm awareness and approval of the changes in accordance with individual facility/organization policy or within a reasonable period.
6. MRB believes that the principles of continuous quality improvement should be applied to the direct outcome of treatment algorithms. Individual nephrologists and medical directors of dialysis facilities should regularly review outcomes not only to assess patient progress, but to making appropriate changes to existing algorithms to incorporate new recommendations from published studies. Failure to achieve desired clinical practice goal should result in algorithm reexamination and revision.
7. MRB believes that algorithms should be reviewed and updated as needed, at least yearly.

Adopted: MRB 12/10/2003
Revised: MRB 12/05/2007

Medical Review Board Statement Patient Treatment Options Procedure Recommendations

The Medical Review Board of ESRD Network 18 recommends implementation of the following procedures as an easy way of insuring that patients and families are informed about different treatment options in end-stage renal disease.

1. “When” and “Where” to begin education/counseling sessions with patients and family?

The suggested times to begin introducing patients and families to treatment options depends on the type of chronic facility:

- a. Hospital-based unit – These facilities often have access to patients during the “pre-ESRD” treatment period (up to 6 months prior to the start of acute/chronic dialysis). There is no defined “optimal time” for presenting information to patients (see page on “Patient Education”). To allow for some internalization and retention, patients should be given information at least two office/clinic visits prior to planned treatment access surgery.
- b. Freestanding facility – There are two basic settings and time frames for providing patients and families with information in these units:
 - i. Nephrologist’s office (pre-dialysis) – Information could be given in the primary nephrologist’s office prior to starting dialysis. Communication between the physician and dialysis unit is important. If scheduled as a specific office visit, physician (or designee) can do teaching/counseling, and charge for visit as “consultation services”.
 - ii. On-site (dialysis unit) – Information should be given as part of a pre-dialysis tour and orientation at the unit.

2. “Who” should be responsible for presenting information to the patient/family?

Ideally, the physician would be involved in presenting information to the patient: the nephrologist in a chronic facility; the transplant surgeon in a transplant center.

The physician can also indicate a qualified professional “designee” to do the actual education/counseling on treatment options with patients.

“Qualified professional designee” is defined as a master’s prepared, or licensed health care professional who is familiar with treatment methods for ESRD and/or has experience with presenting such information to patients. In most treatment settings, a renal social worker (preferably LCSW) or registered nurse (nurse manager, charge nurse, transplant coordinator, patient educator, etc.) would be the most qualified individual.

3. “What” type of information should be presented?

At minimum, information on the three main types of ESRD treatments should be reviewed: hemodialysis (home and in-center), peritoneal dialysis (CAPD and CCPD), and transplant (living or cadaveric donors). In addition, “no treatment” or “withdrawal of treatment” should be included as a possible category.

Basic information should include the location of the modality (home or in-center). Presentation should be geared to the patient’s educational level, and cultural language differences need to be taken into account. Pediatric patients have special needs.

Brochures on “advance directives” are already available for patients interested in a further explanation of what an “advance directive” is, and how to complete one. Hospital admission departments may have ready-made copies. Facilities may also create their own forms.

4. “How” should information be presented?

Many resources for presenting patient information are already available in the renal community. A list of patient resources is available on the Network 18 web site.

Presentation of information to patients should be based on their assessed “readiness to learn” (see sheet on Education Guidelines).

Selection of Patients for: The ESRD Program

Standard

All patients prior to transplantation, or patients in a maintenance dialysis program for three months or greater will have confirming documentation on end-stage renal disease.

Criteria

1. The medical record of the dialysis or transplant facility will indicate that the patient has “permanent” or “irreversible” renal failure or “end-stage renal disease” (ESRD).
2. The medical record of the dialysis or transplant facility and the CMS Medical Evidence form (2728) will document any one of the following prior to transplant or prior to maintenance dialysis:
 - a. Ccr less than 10cc/min
 - b. Serum creatinine greater than 8mg/dl
 - c. Symptomatic Uremia (specified)
 - d. Unsatisfactory control of CHF
3. Record of a nutritional assessment by a qualified dietitian.
4. Record of an evaluation by a qualified social worker.
5. There will be a patient Long-Term Program signed by the patient or responsible party and the professional team, and any follow-up documentation, which indicates that the patient/responsible party has:
 - a. Been informed of therapeutic options
 - b. Been informed of realistic expectations (e.g., risks and complications)
 - c. Accepted treatment

Revised: 12/05/2007

Selection of Patients for: Home Hemodialysis

Standard

All patients in the ESRD Program who request home hemodialysis will be evaluated for this modality as a possible candidate by facilities offering the option.

Criteria

1. The dialysis facility medical record will reflect that a professional team has evaluated the patient's suitability as a candidate for home hemodialysis.
2. The dialysis facility medical record will indicate that the patient is in a home training program or on home hemodialysis unless one of the following is documented:
 - a. The patient does not have a suitable and/or willing assistant.
 - b. The family relationships are not stable.
 - c. The physical environment at home is not adequate and cannot be modified.
 - d. The patient's medical condition is unstable.
 - e. The patient's psychosocial condition is unstable.
 - f. The patient refuses home dialysis.
3. If the dialysis facility offers a home hemodialysis program, the facility should have a policy specifically outlining the exclusionary reasons.

Revised: 12/05/2007

Selection of Patients for: Home Peritoneal Hemodialysis

Standard

All patients in the ESRD Program will be evaluated for home peritoneal dialysis.

Criteria

1. The dialysis facility medical record will indicate that the patient is in a home peritoneal (CAPD; CCPD; CAPD) training program or on home peritoneal dialysis unless one of the following is documented:
 - a. The physical environment at home is not adequate and cannot be modified (e.g. cleanliness, storage space for supplies, telephone access).
 - b. The patient's medical condition is unstable or a contraindication exists.
 - c. The patient's psychosocial condition is unstable.
 - d. The patient refuses peritoneal dialysis.
 - e. The patient is currently receiving training for home hemodialysis.
 - f. The patient cannot maintain prescribed PD treatment outcomes related to clinical indicators (e.g. adequacy of dialysis, nutrition, anemia, etc.).
2. The dialysis facility must be certified, and have written policies covering this program. Guidelines for participation must be outlined, including patient education and the expectations/treatment goals to be met in order for the patient to remain in the program.

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Selection of Patients for: Renal Transplantation

Standard

All patients with ESRD (including pre-ESRD patients) are eligible for a transplant evaluation, which will determine their candidacy for transplantation. Modern surgical and immunosuppressive techniques and therapies now allow many patients previously believed to be unsatisfactory transplant recipients to be dramatically rehabilitated, with excellent outcomes.

Criteria

1. The dialysis or transplant facility medical record will reflect that the professional team has evaluated the patient's suitability as a candidate for transplantation.
2. The dialysis or transplant facility medical record will indicate that the patient is in the process of medical evaluation or on a transplant list. Contraindications are ultimately determined by the transplant physician or transplant surgeon, and may include but are not limited to the following:
 - a. Chronic unresolved infection
 - b. Recent malignancy
 - c. Psychiatric illness, requiring custodial care
 - d. Inability to follow transplant regimen and lack of support to meet these needs
 - e. Severe cardiovascular, pulmonary, or gastrointestinal disease
 - f. A specific contraindication is documented by the transplant surgeon
 - g. The patient refuses transplantation
 - h. No insurance coverage or funding source to cover transplant
3. The transplant surgeon has the option to designate an individual ("designee") at the facility to evaluate patients for the modality of transplantation, providing that the formal designation is in writing, including any specific contraindications or instructions, and is on file at the facility.
4. The nephrologist and facility Medical Director are responsible for providing/assuring transplant referrals are processed in a timely manner.

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Reviewed: MRB 4/01/1992
Reviewed: MRB 05/1997
Revised: MRB 2002
Revised: MRB 12/05/2007

Minimum Standards for Social Worker Involvement in the Care of ESRD Patients

Standards

1. Evidence of a psychosocial evaluation by a qualified social worker will be documented in the patient's medical record* not later than one month after initiation of dialysis.
2. Participation of a qualified social worker in the development of the Comprehensive Multidisciplinary Patient Assessment (CMPA) will be documented by signature on the CMPA and in the medical record, within one month of initiation of dialysis.
3. Evidence of participation by a qualified social worker in each patient's written plan of care. The written patient plan of care must be individualized for the patients, built on the comprehensive patient assessment, and include at minimum: problem(s) identified at assessment/reassessment, measurable goals/outcomes, interventions for achieving the goals, timetables and reassessment date(s). Implementation of plan of care should be demonstrated in the treatment records, progress notes, laboratory results. The Plan of Care for patients whose condition is unstable is reviewed at least monthly while annual updates are acceptable for stable patients. Refer to V520 of the ESRD Conditions for Coverage for the minimum criteria for stable versus unstable patients. The Plan of Care is revised as necessary to ensure that it provides for the patient's ongoing needs
4. Progress notes by a qualified social worker will be in the medical record and written at least quarterly (every three months). If more frequent intervention is indicated or assistance required, the social worker will document this in the medical record on an "as needed" basis. This will also be reflected in the social work treatment plan, which may include one or more of the following:
 - a. Communication with staff concerning the patient's attitude behavior toward his/her illness and treatment modality
 - b. Communication with patient and/ group therapy
 - c. Referral to community agencies.

Psychosocial evaluation is defined as:

The social worker's written professional assessment of the patient/family, which may include the patient's strengths and weaknesses, problem definition, and attitude toward illness. The assessment is based upon a study of the patient/family current life situation and pertinent aspects of his/her past life. Psychosocial treatment plans and goals are developed based on this evaluation.

"Qualified social worker" is defined in the Federal Regulations, Section 494.140 (d) (1): as:

The facility must have a social worker who (1) holds a master's degree in social work with a specialization in clinical practice from a school of social work accredited by the Council on Social Work Education; or (2) has served at least 2 years in social work, 1 year of which was in a dialysis unit or transplantation program prior to September 1, 1976, and has established a consultative relationship with a social worker who qualifies under paragraph above.

*Confidential material will be available to the professional staff but will not be in the bedside chart.

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Minimum Standards for Dietitian Involvement in the Care of ESRD Patients

Standards

1. Evidence of nutritional assessment by a qualified dietitian will be documented in the patient's medical record not later than one month after initiation of dialysis and/or prior to transplantation.
2. Dietary recommendations based on nutritional assessment and on prescribed diet will be documented by a qualified dietitian in the medical record not later than one month after initiation of dialysis and/or prior to transplantation.
3. Participation of a qualified dietitian in the development of the Comprehensive Multidisciplinary Patient Assessment (CMPA) will be documented by signature on the CMPA and in the medical record within one month of initiation of dialysis and/or prior to transplantation.
4. Progress notes by a qualified dietitian will be in the medical record and written at least quarterly (every three months). If more frequent intervention is indicated or assistance required, the dietitian will document in the medical record on an "as needed" basis. This will also be reflected in the treatment plan of care, which may include one or more of the following:
 - a. Communication with staff and patient and/or family concerning monitoring of the patient's dietary compliance, response to diet and nutritional status
 - b. Patient and/or family education and counseling.
5. Evidence of participation by a qualified dietitian in each patient's written plan of care. The written patient plan of care must be individualized for the patients, built on the comprehensive patient assessment, and include at minimum: problem(s) identified at assessment/reassessment, measurable goals/outcomes, interventions for achieving the goals, timetables and reassessment date(s). Implementation of plan of care should be demonstrated in the treatment records, progress notes, laboratory results. The Plan of Care for patients whose condition is unstable is reviewed at least monthly while annual updates are acceptable for stable patients. Refer to V520 of the ESRD Conditions for Coverage for the minimum criteria for stable versus unstable patients. The Plan of Care is revised as necessary to ensure that it provides for the patient's ongoing needs.

"Qualified Dietitian" is defined in the federal regulations, Section 494.140 (c) (2): as:

The facility must have a dietitian who must (1) be a registered dietitian with the Commission on Dietetic Registration; and (2) have a minimum of 1 year professional work experience in clinical nutrition as a registered dietitian.

Approved: MRB 8/23/1988
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Reviewed: MRB 12/17/2007

Minimum Recommendations for Technological Staff Support in the Care of ESRD Patients

Medical Review Board Statements

Standards

1. Evidence of the Medical Director's involvement with the technological operation of the unit will be documented on a monthly basis.
2. Preventive maintenance of dialysis and dialysis related equipment will be performed per manufacturer's recommendation. Documentation of work will be maintained.
3. Compliance with minimum standard and recommended practice as established by the Association for the Advancement of Medical Instrumentation (AAMI) will be maintained and documented.
4. Evidence of completion of the facility training curriculum for technological staff will be documented.
5. A master technological manual will be maintained, to include technological policies and procedures, training curriculum, competency tools, Quality Control log sheets.

“Technological Staff” is defined as and limited to individuals who meet the following requirements:

- Is trained and responsible for the operation, maintenance and repair of dialysis and dialysis related equipment;
- Is responsible for compliance with the current AAMI standards and recommended practices, and local, state and federal regulations
- Is involved in the troubleshooting of unusual events as it relates to equipment, the extra corporeal circuit (including the dialyzer), water treatment and reprocessing
- Understands and applies standard precaution and aseptic technique
- Understands the consequence of water quality not meeting AAMI standards
- Understands and applies the concept of Quality Improvement / Quality Control.

“Training Curriculum” will include at least the following information:

- a) The operation and maintenance of the facility's dialysis and dialysis related equipment via factory training and/or via a factory trained and certified individual.
- b) Basic documentation.
- c) AAMI Standards and Recommended Practices: RD5: Hemodialysis systems; RD47: Reuse of Hemodialyzer (if appropriate); RD52: Dialysate for hemodialysis; RD61: Concentrates for hemodialysis and RD62: Water treatment equipment for hemodialysis applications.
- d) Emergency procedures as required by the facility.
- e) The principles of dialysis.
- f) The risks and hazards of poorly maintained water treatment systems.

Changes to the Conditions for Coverage Regarding Patient Care Technicians

Reference: Conditions for Coverage 494.140.e.1-4, April 15, 2008

Qualifications	<ol style="list-style-type: none"> 1. Meet all state requirements. 2. High school diploma or equivalent. PCTs with greater than 4 years work experience as of October 14, 2008 who are lacking evidence of a high school diploma may use that work experience in Lieu of the requirement for high school diploma. 3. Complete a training program that is approved by Medical Director and Governing Body and is under the direction of a registered nurse. <ol style="list-style-type: none"> a. If the PCT has worked in the dialysis facility for longer than 2 years, retraining is not necessary, however the PCT must take and pass a skills test that has been developed by the facility and includes all elements of the new training program. b. If the PCT has worked in the dialysis facility for less than 2 years, the PCT must go through the new training program. 4. Be certified under a state certification program or a national commercially available certification program
Training Program	<p>Curriculum must include:</p> <ol style="list-style-type: none"> a. Principles of Dialysis b. Care of patients with kidney failure including interpersonal skills c. Dialysis procedures and documentation (initiation, cannulation, monitoring, and termination of dialysis) d. Potential complications of dialysis e. Water treatment and dialysate preparation f. Infection control g. Safety h. Dialyzer reprocessing if applicable. <p>Specific information regarding available training programs:</p> <ol style="list-style-type: none"> a. This program can be facility specific but the curriculum should be in writing with evidence of review and approval by medical director and governing body b. Tools available <ol style="list-style-type: none"> i. Core Curriculum for the Dialysis Technician <ol style="list-style-type: none"> 1. Download and print entire book or chapters at www.meiresearch.org 2. Printed copies available from Amgen: call 1-800-77AMGEN. ii. Standardized Training Program for the Patient Care Technician in Hemodialysis - Instructor's Guide and Standardized Training Program for the Patient Care Technician in Hemodialysis - Learner's Guide <ol style="list-style-type: none"> 1. Available through the American Nephrology Nurses Association 2. Order on website – www.annanurse.org 3. Instructor's guide - \$18.00; Learner's guide - \$28.00
Certification	<p>Nationally available certification programs:</p> <ol style="list-style-type: none"> a. Nephrology Nursing Certification Commission – Certified Clinical Hemodialysis Technician (CCHT) NNCC – 888-884-6622 www.nncc-exam.org b. Board of Nephrology Examiners for Nurses and Technicians (BONENT) – Certified Hemodialysis Technician (CHT) 202-462-1252 www.BONENT.org c. Professional Testing Corporation – Certified Clinical Nephrology Technician (CCNT) 212-356-0660 www.ptcny.com
Timeline	<ol style="list-style-type: none"> 1. All patient care technicians must pass facility or college training program as outlined above. Facilities should maintain documentation of this training. 2. Currently employed PCTs must pass certification exam (listed above) within 18 months after October 15, 2008, i.e. by April 15, 2010. 3. All PCTs employed after October 15, 2008 must be certified within 18 months after hire date.

**The summary is contributed by ESRD Network 11

Forum of ESRD Networks Medical Record Model

Note:

The Forum of ESRD Networks, working through the Quality Improvement Directors, has developed and endorsed this Medical Record Model for use by dialysis facilities. The goal of this Model is to enhance quality care by promoting consistent content for medical records. Although use of this Model is not mandatory, it is hoped that dialysis providers will voluntarily adopt the Model for use within their own programs.

The Medical Record Model defines the components necessary to achieve a consistent approach to ESRD medical records, thereby decreasing the fragmentation that frequently occurs in the medical records of ESRD patients.

It was developed using existing guidelines, standards and ideas regarding medical records, with input from the major nephrology professional organizations, the 18 ESRD networks, and dialysis facilities around the country.

All medical records should be completed in accordance with applicable state laws.

Developed: 4/1993
Revised: 8/2001
Approved by BOD: 10/2001
The Network 18 Medical Review Board revised this document to meet current community practice & language: 12/05/07
Revised: 12/15/2008

Recommendations: Content of Active Records

Identifying Information:

- Name
- Address
- Telephone #
- Date of birth
- Sex
- Race
- Ethnicity
- Primary ESRD diagnosis and Secondary diagnosis
- Current co-morbid conditions
- Attending nephrologist name & phone number
- Facility patient registration #
- Date/type of first renal replacement therapy (first acute, chronic, location)
- Date of admission to current facility
- Next of kin/significant other
- Emergency contact person & phone number
- Social security #
- HIC (Medicare) #
- Copy of patient's driver's license and Medicare or insurance card
- Allergy stickers/information

Computerized Records

- Acceptable, if they meet all requirements of paper records (i.e. confidentiality and retention laws)

Consents and Notifications

- Informed consent for treatment
- Informed consent for reprocessed dialyzer (if applicable)
- Informed consent for blood transfusion
- Receipt of "Patient Rights and Responsibilities"
- Receipt of "Patient Grievance Form" and process information
- Receipt of ESRD Network grievance / contact information
- Release of records form
- Medical records request form
- Advance directives forms (e.g. DNR), or documentation that issues have been discussed and/or information received when applicable
- Hepatitis and other vaccination consent forms (if applicable)

History and Physical (done by physician extenders)

- Initial H&P to include:
 1. Previous health history, including hospitalizations, procedures and other medical diagnoses
 2. ESRD history, including predialysis lab data (BUN, Cr, electrolytes, serum albumin, hemoglobin/hematocrit minimum), uremic symptoms, justification for need for renal replacement therapy

- Annual exam by primary/attending physician, including review of systems and current problems
- Current history and physical should be included within 2 weeks of initiation of renal replacement therapy and/or admission to the facility, and included in the patient's record. (Also include amputations)

Assessments/Evaluations

- Initial: within 30 days of admission to facility
- Nursing, social worker, dietitian
- Annual update by social worker & dietitian

Transplantation Status

- Treatment options discussed & documented
- If patient not candidate, reason/choice documented on record

Hospitalization Records

- Admission history and physical
- Hospital discharge summary (If not obtained, a physician summary of each hospitalization should be completed.)

Language Translation

- In some states/counties, health facilities are required to provide information/education to patients in their native language. Check for state and local requirements.

Miscellaneous

- Medical record checklist
- CMS 2728
- Insurance information
- Correspondence
- Transient dialysis information

Progress Notes

Progress notes should provide an accurate picture of the patient, which reflects changes in patient status, plans and results of changes in treatment regimen, diagnostic testing, consultations, unusual events, etc. Either single discipline or integrated multidisciplinary progress notes may be utilized. The following are minimum entries:

- Each discipline (physician, nurse, social worker, dietitian) should record the progress of the patient at regular intervals or more often per facility's policy:
 1. Monthly: Unstable patients*
 2. Quarterly: Semi-annually
(6 months) - Stable patients*
(*as defined by facility or physician)
- Patient condition and response to treatment noted on daily treatment record
- Regular review of abnormal labs/clinical findings and any action taken

- Monthly review of laboratory results (including adequacy) & hepatitis status
- Vascular Access Assessment

Patient Education (routine or facility-specific)

- Disease, treatment, modality options, access care
- Services available
- Emergency preparedness: initial, quarterly or semi-annual
- Vaccine Information Statements (VIS) - required

Problem List (optional)

- Initial
- Updated as needed, at least minimum annual review
- Either separate or integrated cumulative list of patient's medical, psychosocial, nutritional problems

Comprehensive Multidisciplinary Patient Assessment (CMPA) and Patient Plan of Care

- CMPA
 1. Initial (within 30 days)
 2. Reassessment (within 90 days)
 3. Current year, annual update
- Patient Plan of Care
 1. Reflects interdisciplinary approach and based on CMPA findings
 2. Monthly for unstable patients
 3. Annual updates are acceptable for stable patients (refer to V520 for the minimum criteria for stable vs. unstable patients).
 4. The implementation of updates to the plan of care must be completed within 15 days of the reassessment.
 5. Prior 12 months in active record
- Significant change in medical status or modality
- Advanced care planning, clinical end of life directives annual update
- Patient's signature (or responsible party) – reflects participation

Physician Orders

- Standing Orders (i.e. emergency procedures, cramp management): (initial, annual update minimum)
- Dialysis prescription and medication update (initial, annual minimum). Include EPO/iron
- Post-hospitalization update (current 6 months of orders in active record minimum)

Medication Record

- Initial
- Update
 1. Whenever changes occur
 2. After hospitalization
 3. Annually (minimum)

4. Reviewed at monthly intervals, including:
5. Name of drug
6. Dose
7. Route of administration
8. Date ordered
9. Any changes to be dated
10. Drug allergies
11. All facility administered medications will be updated in the medical record, flowsheets, if such flowsheets are utilized by the facility (medication lists for outpatient, home meds may be separated from in-center meds)
12. Other allergy alerts (e.g. latex, food, etc.)

Daily Treatment Records

- May be kept separately
- Current year readily available (past 12 months)
- Filed separately for each individual patient

Consults

- Reports/letters from consulting physicians (past 12 months or readily available)

Vascular Access Record

- Type of access (if catheter, specify type, length, etc.)
- Date of insertion/creation/revision/declotting
- Reports on any access surgeries or interventions
- Name of surgeon(s)/Interventional Radiologist
- Diagram of location, flow direction, configurations
- Monitoring records (e.g. pressure run charts, recirculation, etc.)

Laboratory

- Past 12 months on active chart (or readily available)
- Cumulative lab records acceptable, original reports must be included in a permanent record if cumulative record is not generated by original laboratory. (Lab normals/reference ranges)
- Flowsheets (e.g. clotting times, adequacy of dialysis testing, recirculation studies)
- Patient-specific run charts (optional), and adequacy calculations

Transfusion Record (past 12 months)

Diagnostic Studies (past 12 months)

- Radiology, nerve conduction, bone densitometry, EEG, current and prior EKG

Preventive Care Measures

- Vaccination Status (HBV, pneumococcal, flu)
- Exams: mammography, PAP smears, retinal & foot exams (diabetics), etc.

Transient Records

- Identifying information (refer to Active Records)
- Most recent physician's orders, to include dialysis prescription (dialyzer type, reuse practice, BFR/DFR, treatment time, dry weight), EPO dose and route, dosages of other intradialytic medications)
- Most recent progress notes
- Most recent problem list (include special needs)
- Current history and physical (include cause of ESRD)
- Medication record
- Most recent laboratory (past 2 months), to include: albumin, alkaline phosphatase, BUN, Ca++, Cl-, C02, creatinine, LDH, SGPT, SGOT, total protein, Hgb, glucose or HgbA1C (if diabetic), PT (if on Coumadin), Hepatitis status (within 12 months)
- Last six treatment records
- Most recent comprehensive multidisciplinary patients assessment (CMPA) and Patient Plan of Care
- Most recent psychological (or social worker) evaluation
- Insurance information
- Chest X-ray and EKG (within last 12 months)
- Facility-specific forms for reporting transient dialysis experiences back to home unit
- HBV status (antigen positive or immune)
- Type of vascular access, location, flow diagram
- Emergency contact (local)
- Phone number of primary nephrologist
- Allergies
- Advance directives

Closed Records (transferred, transplanted, recovered function, withdrew from therapy, expired)

- All Records, must include:
 1. Treatment records and thinned records
 2. Additional confidential files (e.g. HIV if kept separately)
 3. Business file may be kept separately
- File Chronologically in sections, as outlined in Active Record Recommendations
- Discharge Summary - Clearly identifies the disposition of the patient (final diagnosis/cause of death, date of discharge/death, location of death, CMS 2746)

Maintained per state law, and actual chart (or copies for satellite facilities) should be available within two weeks. Check state law for minimum requirement for record retention time frame (7 years in California, longer for minors).

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Medical Review Board Statement for Inter-Facility Transfer of Patient Records

Federal “Interpretive Guidelines” (used by state surveyors): 42 CFR 405.2137, states “When a dialysis patient is transferred, the dialysis facility releasing the patient must send all requested medical record information to the receiving facility within one working day of the transfer”. The intent is to maintain continuity of care whenever patients leave the facility temporarily (e.g. vacation, business, hospitalization) or transfer permanently to a new facility.

Standard

When a patient is transferred from one renal care facility to another within ESRD Network 18 (as a transient or permanent transfer), the following medical record forms (or copies as appropriate) must be sent to the new facility:

1. Patient insurance and other identifying information
2. Medical Evidence Form (CMS #2728)
3. Comprehensive Multidisciplinary Patient Assessment (CMPA) and Patient Plan of Care
4. History and Physical (current)
5. Recent lab report (prior month), diagnostic tests (e.g. chest x-ray, EKG)
6. Recent (last six) dialysis treatment records
7. Recent (within 3 months) multi-disciplinary progress notes (dietary & psychosocial evaluations)
8. Current physician orders
9. Current medication record
10. Current problem list
11. Any other facility-specific forms for reporting transient dialysis facility experiences to home unit

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Medical Review Board Statement Maximizing Primary Arteriovenous Fistulae for Pre-ESRD and Dialysis Patients

1. The Medical Review Board (MRB) of ESRD Network 18 supports the practice of constructing autogenous arteriovenous (AV) fistulae whenever possible in all new ESRD patients electing hemodialysis as their initial renal treatment modality (see #2 for exceptions). The MRB recognizes that some patients will not be good candidates for the procedure. However, current research (upon which the K-DOQI Clinical Practice Guidelines are based) demonstrates that native accesses have the best 4-5 year potency rates and require fewer interventions and hospitalizations than other accesses.
2. The MRB supports the K-DOQI recommendation of a 65% primary AV fistula construction rate for incident dialysis patients. Patients should be considered candidates for this procedure, unless one of the following is documented in the medical record:
 - a. The patient has a physical problem precluding an AV fistula, as documented (after a formal evaluation) by a vascular surgeon
 - b. Probability of a Living Related Transplant within 3 months
 - c. The patient refuses the procedure
3. The MRB also recommends that all prevalent patients who had a failed AV graft or catheter be re-evaluated for possible construction of a primary AV fistula.
4. In addition, the MRB concurs with the K-DOQI recommendation that each facility should establish a system for tracking types of accesses created and complication rates.
5. The MRB recommends that all physicians and facility staff use access-related terminology consistent with the K-DOQI guidelines. Specifically, the following terms/descriptions are appropriate:
 - a. Arteriovenous fistula - This term (a.k.a. AVF, AV fistula) applies to native access only (e.g. Cimino, brachiocephalic)
 - b. Graft - This term applies to any type of non-native or prosthetic access (e.g. PTFE, bovine)
 - c. Catheter - This access should be described as either temporary or permanent, and by location (e.g. internal jugular, etc.)
 - d. "Shunt" - This term is outdated, and is not an appropriate generic term

Approved: MRB 09/15/1999
Revised: MRB 04/12/2000
Reviewed: 12/05/2007
Revised: 12/17/08

"The basic tenet for vascular access monitoring and surveillance is that stenoses develop over variable intervals in the great majority of vascular accesses and, if detected and corrected, under-dialysis can be minimized or avoided (dialysis dose protection) and the rate of thrombosis can be reduced." (K/DOQI 2006 Updates)
FLOW METHODS IN DIALYSIS ACCESS (STENOSIS MONITORING)"The basic tenet for vascular access monitoring and surveillance is that stenoses develop over variable intervals in the great majority of vascular accesses and, if detected and corrected, under-dialysis can be minimized or avoided (dialysis dose protection) and the rate of thrombosis can be reduced." (K/DOQI 2006 Updates)

Medical Review Board Statement Vascular Access Surveillance (VAS) Program

The Medical Review Board (MRB) of ESRD Network 18 supports the K-DOQI guidelines on vascular access related to arteriovenous grafts. Specifically, this includes:

1. Each hemodialysis facility should establish a formal, organized vascular access monitoring/surveillance system, to track types of patient vascular accesses, location, and any type of diagnostic and treatment/intervention procedures done.
2. Regular assessment of clinical parameters should be done on each hemodialysis patient, particularly patients with AV grafts, to include access physical assessment and dialysis adequacy.
3. Results of any vascular access assessment should be documented on the patient record, and be included in an ongoing tracking system for the facility QAPI program.
4. Any of the K-DOQI recommended surveillance techniques might be included in the formal VAS program.
5. Persistent abnormalities in any of the monitoring/surveillance measurements should result in prompt patient referral for some type of formal diagnostic procedure (venography, angiography or fistulography).
6. Appropriate treatment/intervention in a timely manner is required when any significant stenosis is found, as a result of diagnostic procedures or other medical assessment.
7. Each hemodialysis facility should establish formal policies and procedures as part of the formal VAS program.

Approved: MRB 02/06/2002
Reviewed: MRB 12/05/2007
Revised: MRB 12/17/08

Medical Review Board Statement Influenza Vaccination Tracking

1. The Medical Review Board (MRB) of ESRD Network 18 endorses the Centers for Disease Control recommendations regarding influenza vaccination for dialysis patients.
2. The MRB also recommends that all facilities in Network 18 maintain an influenza vaccination tracking system, to ensure that all dialysis patients have either been given the vaccine in-center, or been referred for vaccination to a clinic, doctor's office, HMO or other outside provider.
3. All patients scheduled to receive an influenza vaccination are required to receive a formal "Vaccine Information Statement" from the Centers for Disease Control, to be given out by the appropriate provider at the time of vaccination (copies available from the Network).
4. Once a year, at the end of the influenza season (approximately March), facility staff should query all dialysis patients about their influenza vaccination status, and document responses in the individual patient record and/or on a summary log sheet.
5. The MRB suggests that facilities interested in providing in-center influenza vaccinations contact their local health department regarding vaccine availability.

Medical Review Board Statement Hepatitis B Vaccinations for Pre-ESRD, Transplant and Dialysis Patients

1. The Medical Review Board (MRB) of ESRD Network 18 supports the practice of vaccinating all ESRD patients against Hepatitis B (HBV). The MRB recognizes that some patients will have variable responses to the vaccine. However, infection control/disease prevention is a major responsibility of dialysis and transplant facilities, and HBV vaccination is an integral part of a quality improvement program.
2. The MRB supports the goal of a 100% patient vaccination rate. Patients should be immunized, unless one of the following is documented in the medical record:
 - a. The patient has already received a complete course of vaccine (including boosters), but has failed to seroconvert.
 - b. The patient has positive antibodies from a prior HBV infection.
 - c. The patient persistently remains HBsAg+.
 - d. The patient refuses the vaccine.
3. Following CDC protocol, the MRB recommends that patients who received the full vaccine series be tested for anti-HBs 1-2 months after the last vaccine does. If patients do not respond to the vaccine (defined as anti-HBs >10 mIU/ml) should be revaccinated with three (3) additional doses, and retested for response. No additional doses of vaccine are warranted for those not responding to the second series. If patients who initially responded to a vaccine series, but their anti-HBs drop below 10mIU/mL, administer one booster dose and continue annual retesting.
4. The MRB recommends that immunization begin during the early stages of renal disease, before the immune system becomes impaired.
5. The MRB recommends that the FDA-approved guidelines (product package inserts) be explicitly followed to insure that the patients are receiving the correct dosage of vaccine, based on the product used.
6. The MRB recommends that all pre-ESRD and pre-transplant patients receive HBV vaccinations as early as possible.



Southern California
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ESRD NETWORK 18 ESRD

Emergency Preparedness & Response Network 18 Role and Responsibilities

In preparation for an emergency ESRD Network 18 will:

- Encourage dialysis facilities to plan for emergency situations
- Provide technical assistance in the development of emergency plans
- Provide educational materials to the patient and provider community on topics related to emergency/disaster preparedness
- Develop an internal Network Plan for preparedness and response, including arrangements with back-up Networks if local operations are impaired

During an emergency response, and per HIPAA and CMS policy, ESRD Network 18 will:

- Disseminate central contact numbers for dialysis providers in the affected area, to assist patients and providers in coordinating the provision of dialysis services
- Reflect nature of disaster on the ESRD Network 18 website at www.esrdnetwork18.org and list the closed facilities in the area
- Post information regarding open and closed status of facilities on the www.dialysisunits.com website
- Assist patients in contacting dialysis providers to arrange treatment
- Assist Family members in locating displaced patients
- Assist treating facilities to obtain necessary information to care for patients
- Work with the Centers for Medicare and Medicaid Services (CMS) or its contractor to maintain a database tracking system for patient whereabouts (dialysis centers and/or shelter locations)
- Host conference calls with CMS, Kidney Community Response Coalition (KCER), providers, vendors, and other entities to coordinate care for the patients
- Implement arrangements with a back-up Network if the operations of Network 18's office are compromised

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Medical Review Board Statement Emergency Call Systems

In 1999, the Medical Review Board, in conjunction with the ESRD Network 18 Patient Advisory Committee, undertook a study on emergency call systems in chronic hemodialysis centers. The study originally arose from a number of patient calls to the Network about the absence of call lights at the “bedside” (i.e. dialysis chair).

A brief survey of facilities showed that just over half of the respondents had call systems at the bedside. In addition, the facilities with call systems had lower mean standardized mortality ratios (SMR) and standardized hospitalization ratios (SHR) than the facilities without call systems.

Although not a rigorous scientific study, the MRB felt that the results of this survey should be made available to all facilities. The MRB also recommended that all new facilities, and facilities undergoing remodeling consider installing emergency call systems at each patient (bedside) station during the construction period.

Medical Review Board Statement

Dialysis/Transplant Information Exchange

The Medical Review Board of ESRD Network 18 recommends implementation of the following steps to improve communication between dialysis facilities and transplant centers to facilitate the transplant referral process.

From dialysis units (nephrologists) to transplant programs

1. With the initial referral to the transplant program, all pertinent clinical information that has already been done. i.e. H & P, X-rays, laboratory, etc.
2. Notification to the transplant program of any of the following changes of those patients on the waiting list:
 - a. Patient moved out of area
 - b. Patient's death
 - c. Any major change of physical condition. i.e. CVA or major surgery.
 - d. Insurance changes.
 - e. Any significant psychosocial changes.
3. Early referral to transplant program with any transplant organ dysfunction.

From transplant program to dialysis unit (nephrologists)

1. Regular reports on the status of the patient with the transplant program. i.e. finished consultation phase, transplant work-up phase, listed (active vs. in-active), not a candidate, transplanted.
2. Results of clinical testing from the transplant work-up. i.e. cardiac, G.I., neurological testing, laboratory results, psychosocial evaluation, etc.
3. Comprehensive report after the transplant before the patient returns to the nephrologists.

Note: Since every transplant center and dialysis unit are unique, one point of needed clarification is who is primarily responsible for ordering and obtaining the results of the transplant work-up? Is it the transplant program, dialysis unit, nephrologists, or a combination of these? The Medical Review Board suggests that your facility communicates with your corresponding transplant center(s) regarding it and complete forms and return them to the requesting party in a timely manner.

Below are the examples of communication elements between dialysis facilities and transplant centers to maintain accurate/updated status of the patient on the transplant wait list.

Transplant Control Form

- Patient is new to dialysis. Date of first dialysis treatment: _____
 Patient is not a transplant candidate due to the following medical conditions: _____

Signature: _____, MD Date: _____

- Patient has been evaluated, but found not eligible for a transplant due to the following medical condition: _____

Signature: _____, MD Date: _____

- Patient is not interested in this option at all.
 Patient is not interested in this option at this time.
 Patient would like to be evaluated for a transplant/referred to a transplant center. Date: _____
 • Transplant Center: _____ Phone: _____
 Patient is currently being evaluated for transplant at: _____ Date: _____
 Patient is currently being evaluated for transplant at: _____ Date: _____
 • Contact Person: _____ Phone: _____
 Patient is currently listed on a transplant waiting list(s) at: _____ Date: _____
 • Contact Person: _____ Phone: _____

Monthly Follow-Up

Month	Date	Comments	Initial
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

It is recommended that transplant assessment/education start upon admission and revisited 90 days after the start of dialysis and monthly/quarterly/annually thereafter per the facility's protocol.

This material was prepared by Network 18 under contract # HHSM-500-2006-NW018C and Network 12 under contract #HHSM-500-2006-NW012C with the Centers for Medicare and Medicaid Services (CMS). The contents presented do not necessarily reflect CMS policy.



Transplant Center: _____

Annual Anniversary Review

Date:

Re: Patient Name: _____

Date of Birth: _____

Dear Dr./Dialysis Center,

We would appreciate a brief medical update on your patient who is currently on the waiting list for a transplant at the University of California, Irvine Medical Center Division of Transplantation. Updated medical information will help ensure a safe and successful transplant experience. During the past year, has your patient had:

- | | | | |
|-------------------------------|-----------------------------|------------------------------|-------|
| Patient's current dry weight | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Chronic infection of any type | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Cancer diagnosis | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Cardiac issues | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Stroke, TIA or seizure | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Serious hospitalization | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Dialysis access problems | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Change in dialysis center | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |
| Change in insurance | <input type="checkbox"/> NO | <input type="checkbox"/> YES | _____ |

Serious mental, emotional or compliance problems NO YES _____

Wait changes > 10% over last year NO YES _____

Gain/loss Intentional/unintentional

BMI: _____

Dialysis Representative Signature: _____

Nephrologist Signature: _____

Date completed: _____

Is there any reason that this patient should not be active on the transplant wait list?

NO YES Why? _____

The completion of this form is very much appreciated.
This form may be faxed to (XXX)XXX-XXXX

Patient Barriers to Transplant Evaluation

This form is to be completed by eligible patients *who decided not to proceed* with a transplant evaluation.

Please answer the questions below to the best of your knowledge. Please note that this survey is anonymous and if you don't feel comfortable answering any of these questions, you may leave them blank.

1. Gender: Female Male

2. Age: 15-20 21-30 31-40 41-50 51-60
 61-70 71-80 >81

3. Residency Status: U.S. Resident NON U.S. Resident

4. Education: Grade 1-6 Grade 6-12 Some College
 College Graduate Masters

5. Race: (Check all that apply.)
 American Indian/Alaskan Native Black/African American
 Asian Native Hawaiian/Pacific Islander
 White Latino

6. Are you currently working? Yes No

7. What County do you live in?
 Imperial Inyo Kern Kings
 Los Angeles Orange Riverside
 San Bernardino San Diego San Luis Obispo
 Santa Barbara Tulare Ventura

8. What type of healthcare coverage do you have? (Check all that apply)
 Medi-Cal Emergency Medi-Cal Employer based coverage
 Medicare (Basic, HMO, PPO) Private Insurance
 None

9. Do you speak English? Yes No A Little
 If No, what language do you speak? _____
 Do you have someone who can translate for you? Yes No

10. Were you informed about transplantation as a treatment choice?

- Yes (Proceed to question 11) No (See below)

- If you *were not* informed about transplantation as a choice, would you be interested in finding out more information?

- Yes No

11. If you have *not been evaluated* for a transplant what is the reason for not proceeding with the process?

- Was not aware I had treatment choices
- Need more information. (I don't understand what transplantation means for me.)
- I'm not interested
- Do you consider transplant too expensive?
- Yes: Please explain: _____
- No
- Unable to attend all required evaluation appointments due to:
- Unable to take time off work
- No transportation
- No family support
- Religious beliefs
- Physician feels I'm not a candidate
- I have other medical conditions that disqualified me for a transplant
- Describe: _____
- Other: Please state: _____

Barreras Camino a Ser Evaluado Para Trasplantes

En Español

Este formulario debe ser llenado por pacientes elegibles para trasplantes que decidieron no proceder con la evaluación.

Por favor conteste las siguientes preguntas. Nota: este cuestionario es anónimo y si no se siente cómodo contestando las preguntas, puede dejarlas en blanco.

1. Sexo: Femenino Masculino

2. Edad: 15-20 21-30 31-40 41-50 51-60
 61-70 71-80 >81

3. Estatus Legal: Residente Legal No Soy Residente Legal

4. Educación: Grado 1-6 Grado 6-12 Algo de Universidad
 Grado Universitario Master

5. Raza: (Marque todas las que aplican)
 Indo-Americana/Nativa de Alaska Negra/Afro-Americana
 Asiática Nativa de Hawaii/Pacífico-Isleña
 Blanca Latina

6. ¿Está trabajando? Si No

7. ¿En qué condado vive?
 Imperial Inyo Kern Kings
 Los Angeles Orange Riverside
 San Bernardino San Diego San Luis Obispo
 Santa Barbara Tulare Ventura

8. ¿Tiene seguro médico? Si (siga a la pregunta 9) No

9. Si tiene seguro médico, ¿qué tipo de seguro médico tiene? (Marque todos los que aplican)
 Medi-Cal Medi-Cal de Emergencias Seguro por empleador
 Medicare (Básico, HMO, PPO) Seguro Privado

10. ¿Habla inglés? Si No Poco
En caso de No, ¿ Tiene alguien que puede traducirle?
 Si No

MRB Statements & Resources- Transplant Referral

11. ¿Estaba informado(a) sobre el trasplante como una opción de tratamiento?

- Si (siga a la pregunta 12) No (lea abajo)

Si no fue informado(a) sobre el trasplante como una opción, ¿Le interesa tener más información?

- Si No

12. Si *no ha sido evaluado (a)* para un trasplante, ¿porqué no ha seguido con el proceso?

- No sabía que tenía opciones de tratamiento
 Necesito más información. (No sé que significa un trasplante para mí)
 No me interesa
 ¿Considera que el trasplante es demasiado caro?
 Si: Por favor explique: _____
 No
 No pude asistir a todas las citas requeridas para la evaluación porque:
 No puedo tomar tiempo libre de mi trabajo
 No tengo medio de transporte
 No tengo apoyo familiar
 Creencia de religión
 El médico opina que no soy candidato(a)
 Padezco de otras condiciones médicas que me descalifican para el trasplante
Describe: _____
 Otra: Por favor explique: _____

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
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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

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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