



Title:

*Establishing a permanent vascular access for hemodialysis treatment:
Catheter Reduction Policy.*

Purpose:

To increase the number of AV Fistula placement for new (incident) and existing (prevalent) ESRD patients and to decrease the number of patients with catheters in place over 90 days within the facility.

Policy:

1. Appoint a facility Vascular Access Coordinator.
2. Vascular Access Coordinator will work closely with Nephrologists and Vascular Surgeon(s) to ensure accomplishments of facility goals.
3. Nephrologists will refer newly diagnosed ESRD patients for AVF evaluation and placement while the patient is in the hospital and prior to discharge. If this is not possible prior to discharge, the Nephrologist will schedule an outpatient AVF evaluation.
4. The Vascular Access Coordinator will schedule the patient for an outpatient appointment with radiology or vascular access center for vessel mapping and coordinates with vascular surgeon for the best access options within one (1) week of facility admission.
5. Surgeon reviews the vessel mapping results and makes a determination for appropriate AV Access. A fistula is preferred if possible.
6. Facility will fax patient information to the surgeon's office.
7. VA Coordinator follows-up with the status of the patient's vascular access placement. The VA Coordinator will assess the maturation of the new vascular access and documents its progress every treatment with biweekly reviews with the Nephrologist if it is not maturing.
8. Arrange patient's follow up with the surgeon's office or a vascular access center within 4-6 weeks after surgery for evaluation of vascular access maturity and/or early intervention, if necessary.
9. All eligible prevalent patients who have not been previously referred for an AVF evaluation will be referred/scheduled for an evaluation and vessel mapping with the vascular surgeon. This includes:
 - a. Prevalent (existing) patients without a permanent vascular access in place.
 - b. Patients with failing AV Grafts (these cases can be identified through vascular access monitoring and surveillance).
10. Nephrologists and Vascular Access Coordinator must ensure that all patients receive proper education on vascular access choices (catheter complications and benefits of AVF for their quality of life and clinical outcomes).

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.

11. Vascular Access coordinator will discuss all catheter patients' status during the monthly CQI meeting.
12. The Facility's Governing Body will ensure all staff are educated on the following:
 - Proper technique for cannulation and handling of fistulas.
 - Identify and educate on types of fistulas, grafts and catheters
 - Importance of fistula creation as first choice
13. The Facility will establish appropriate goals for number of fistulas and permanent catheters (based on DOQI guidelines). Data will be reviewed at monthly QAI meetings.
14. Establish networking with dominant new patient referral sites (e.g. local hospital, nephrologist office, etc.) VA Coordinator to provide education to appropriate hospital staff.
15. The Facility will develop a Cannulation Protocol to include cannulation Guidelines, fistula protocol and graft protocol
16. The above criteria maybe modified based on the patients medical insurance situation. Guidelines become effective when insurance limitations are resolved.

Strategies and Processes to Increase Fistula Rate

1. Medical Director(s) and staff recognize the importance of fistulas as the first choice for vascular access and have implemented QI activity to meet the K/DOQI fistula targets.
2. Facility nephrologists are focusing additional attention on pre-ESRD fistula placement.
3. Medical Director/VA coordinator identifies a surgeon(s) willing and successful in placing fistulas and coordinate with nephrologists to encourage referrals.
4. Affiliated surgeon(s) requests and uses vessel mapping on 100% of patients.
5. Target for over 80% of fistulas placement.
6. Invite surgeon(s) to attend facility staff in-services.
7. Vascular Access team holds biweekly meetings to discuss patients' vascular access issues and discuss cannulation strategies.
8. Documenting patient vascular access status and plans in medical record and in CQI monthly facility report provides an ongoing support for team focus on vascular access.
9. Facility maintains a vascular access assessment and tracking log for each patient that includes access type, procedure, infections, dates, and physician.
10. Staff members act as a fistula advocates and encourage patient to consider them to avoid unnecessary hospitalizations, surgeries, and expenses.
11. Develop patient handout materials
12. Implement a documented plan for each current and new patient with a central venous permanent catheter to determine root cause leading the patient to dialyze via catheter.
13. Provide each patient with a vascular surgeon/patient appointment letter.