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MANITOBA RENAL PROGRAM

SUBJECT ▪ Protocol for Transfer of Patients between Dialysis Units and/or Sites within the Manitoba Renal Program	**SECTION**	70.10 Protocols – Manitoba Renal Program General
	CODE	70.10.04
AUTHORIZATION ▪ Professional Advisory Committee, Manitoba Renal Program ▪ Professional Advisory Council, St. Boniface Hospital	**EFFECTIVE DATE**	January 2000
	REVISION DATE	October 2012 December 2014

PURPOSE:

1. To ensure that complete and accurate health information is present in the patient's Manitoba Renal Program (MRP) health record and the health information is communicated between dialysis units and/or sites within the MRP prior to the permanent or temporary transfer of a patient.

POLICY:

1. Complete, current and accurate health information must be present in the patient's MRP health record and the health information must be communicated between the sending and receiving dialysis units / sites prior to a patient transfer.

2. The sending unit's Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse is responsible for ensuring Form # W-00226 *Transfer of Renal Patients between Renal Sites Checklist* (see Appendix A) has been completed and is present in the patient's MRP health record prior to sending the health record to the receiving unit.

3. The sending unit's Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse is responsible for providing a verbal report of the patient's health information to the receiving unit's Clinical Resource Nurse or Charge Nurse.

4. The sending unit's Nephrologist is responsible for ensuring a case summary (completed within the last year) or a medical summary (completed if the patient transfer was temporary and the result of a patient's hospitalization) is completed and present in the MRP health record prior to transferring the patient.

5. The receiving unit's Nephrologist is responsible for ensuring a hemodialysis patient's 'Chronic Hemodialysis Orders' (Form # W-00109) are reviewed and reordered at the time the patient is transferred.

A. PROTOCOL FOR THE PERMANENT TRANSFER OF A DIALYSIS PATIENT WITHIN WINNIPEG

1. With a goal to facilitate successful transfers of dialysis patients between units and / or sites within Winnipeg, the receiving unit and / or site can not reject a patient when the sending unit and / or site has adhered to the Patient Selection Process (outlined in 2. immediately below) and the Medical Criteria (outlined in 3. immediately below).

2. Patient Selection Process

a. All MRP patients will be informed in writing (see Appendix B) that they may be required to transfer

between MRP dialysis units and / or sites in order to receive renal care and treatment.

b. Priority for any Winnipeg site will be given to those patients with postal codes in close proximity to that site.

c. Patients on a Local Centre Dialysis Unit waiting list will be given priority for transfer to Health Sciences Centre.

d. Patients from the same personal care home should be dialyzed at the same Winnipeg site and at the same time (i.e. the same hemodialysis schedule) to facilitate communication and transportation.

e. The most stable patients, those able to tolerate HD treatments in a HD chair, should be transferred to the Sherbrook Centre Dialysis Unit (SCDU).

f. In the absence of the above patients, the most recently initiated chronic dialysis patient will be transferred to where capacity exists. Unless deemed by the site health care team (comprised of the Clinical Resource Nurse, Social Worker and Nephrologist) to be detrimental to the patient, the patient will not be given the choice of declining the transfer.

To ensure the most recently initiated chronic dialysis patient does not have acute social issues that would mitigate a transfer to another site, the Social Worker will be consulted.

An ad hoc committee comprised of the Site Medical Director, the Patient Care/Team Manager, a designated Social Worker, and a patient representative may be convened to initiate and undergo an appeal process if necessary. Pending this review, the patient will transfer to the receiving unit.

g. An updated case summary (completed within the last year) must be present in the patient's MRP Health Record.

The case summary must include all pertinent information. Details of bloodwork and dialysis are optional if the same information is available elsewhere in the MRP Health Record.

If the case summary was completed prior to dialysis initiation, the date and circumstances of the initiation must be added. Any additions or modifications may be hand written in order to facilitate prompt transfer.

h. When a patient transfer is required between Winnipeg units / sites, the unit's Clinical Resource Nurse or Charge Nurse will review their patient list and select a patient for transfer and then notify the sending unit's Nephrologist and Social Worker.

When a patient has been selected for transfer, the sending unit's Nephrologist will review the patient's case summary to ensure the health information is current and accurate. If it is not, that Nephrologist will ensure it is updated (either by updating it himself/herself or by allocating the task).

The sending unit's Nephrologist will contact the receiving unit's Nephrologist to provide a verbal report.

The sending unit's Social Worker will verify that the patient does not have acute social issues that require ongoing Social Work intervention and preclude them from transferring.

i. The sending unit's Clinical Resource Nurse or Charge Nurse will review the MRP electronic scheduling system for all the units and sites within the MRP. Once capacity has been found in another unit, he / she will notify the selected receiving unit's Clinical Resource Nurse or Charge Nurse that a patient will be transferred to their unit.

If the electronic scheduling system is not available, the sending unit's Clinical Resource Nurse or Charge Nurse will contact the Clinical Resource Nurses or Charge Nurses of the various dialysis units and/or sites within the MRP by phone.

The receiving unit will hold the patient's spot in the schedule for 72 hours. If the receiving unit is in a position where they must utilize this spot, the Clinical Resource Nurse or Charge Nurse should contact the MRP Transition Coordinator to facilitate resolution.

j. The sending unit's Clinical Resource Nurse or Charge Nurse will inform the patient that he/she is transferring the patient's care to another dialysis unit and / or site.

k. Both the sending and receiving units' Clinical Resource Nurses, Charge Nurses, or assigned Registered Nurses or Licensed Practical Nurses will follow the processes outlined in the *'Permanent Transfer of a Dialysis Patient Algorithm'* (see Appendix C) when transferring a patient between dialysis units and/or sites within the MRP.

When these processes cannot be adhered to for whatever reason, the sending and / or receiving units' Clinical Resource Nurses, Charge Nurses, or assigned Registered Nurses or Licensed Practical Nurses will contact the MRP Transition Coordinator for direction / clarification.

l. Prior to the patient's first hemodialysis treatment in the receiving unit, the sending unit's Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse will:

- ensure the '*Transfer of Renal Patients between Renal Sites Checklist* ' is completed
- document the plan in place on the '*Transfer of Renal Patients between Renal Sites Checklist* ' to collect / locate / capture any outstanding health information
- fax the '*Transfer of Renal Patients between Renal Sites Checklist* ' to the receiving unit
- place the completed '*Transfer of Renal Patients between Renal Sites Checklist* ' in the MRP health record
- provide a verbal report using the SBAR (Situation, Background, Assessment and Recommendations) communication technique to the receiving unit's Clinical Resource Nurse or Charge Nurse
- inform the receiving unit's Clinical Resource Nurse or Charge Nurse if there is outstanding health information as per the '*Transfer of Renal Patients between Renal Sites Checklist* '

m. Within 24 hours of the patient receiving his/her first hemodialysis treatment in the receiving unit, the Clinical Resource Nurse or Charge Nurse will send the MRP health record to the receiving unit.

n. The receiving unit's Clinical Resource Nurse or Charge Nurse will notify the receiving unit's Pharmacist.

The Pharmacist will complete medication reconciliation.

3. Medical Criteria

a. Patients selected for transfer between dialysis units / sites must meet the following medical criteria:

- No active major infections.
- No active bleeding.
- Working vascular access.
  - No history of past aggressive behavior
  - No acute social issues that require ongoing Social Work intervention

In addition to the above criteria, patients selected for transfer to the Sherbrook Centre Dialysis Unit must be able to receive hemodialysis in a treatment / reclining chair.

B. PROTOCOL FOR THE TEMPORARY TRANSFER OF A DIALYSIS PATIENT

1. Temporary Transfer of Patients

a. Prior to temporarily transferring a patient to a receiving dialysis unit and / or site, the Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse will:

- provide a verbal report using the SBAR communication technique to the receiving unit's Clinical Resource Nurse or Charge Nurse.
- send the MRP Health Record to the receiving unit.

b. Prior to the patient returning to their home unit and / or site, the Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse will:

- document a general summary of the care the patient received at the temporary unit and / or site in the Integrated Progress Notes using the SBAR communication technique.
- provide a verbal report using the SBAR communication technique to the receiving unit's Clinical Resource Nurse or Charge Nurse.
- send the MRP Health Record to the home unit.

c. And in addition to a. and b. above, if the temporary transfer was a result of a patient's hospitalization, upon discharge and prior to the patient returning to their home unit and / or site:

- the Nephrologist will document a medical summary in the MRP Health Record
- the Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse will notify the notify the sending unit's Pharmacist, copy pertinent health information, results, reports and the Medication Administration Records (MAR) from the in-patient health record and place the copies in the MRP Health Record, update the MRP Medication Flow Sheet and send the MRP Health Record to the patient's home unit and / or site.
- the sending unit's Pharmacist will complete medication reconciliation
- until such time as the Nephrologist and Clinical Resource Nurse, Charge Nurse, or assigned Registered Nurse or Licensed Practical Nurse have collected and documented / copied the above health information in the MRP Health Record, the patient will continue to receive dialysis in the temporary dialysis unit until instructed to return to their home unit. Exception: when continued treatment in the temporary dialysis unit causes undue burden (such as financial) to the patient.

C. PROTOCOL FOR THE TRANSFER OF A PATIENT TO A LOCAL CENTRE DIALYSIS UNIT, PERITONEAL DIALYSIS OR HOME HEMODIALYSIS

1. Transfer of Patient to a Local Centre (LC) Dialysis Unit

- The transfer of an established hemodialysis patient to HSC (CDU) and then to a planned LC Dialysis Unit includes a trial period of up to 30 days. The LC Dialysis Unit receiving the patient may request an extension beyond 30 days for extenuating circumstances (e.g. hospitalization).

- If the patient fails the LC Dialysis Unit trial period (prior to 30 days), the patient will be transferred back to his/her originating site. If the originating site has no capacity, they will transfer a patient out to create capacity.

- If the patient fails the LC Dialysis Unit trial period (after 30 days), the patient returns to HSC regardless of his/her originating site.

- Items **A. 2. g.** and **3.** above also apply to LC Dialysis Unit transfers.

2. Transfer of Patients to Peritoneal Dialysis (PD)

- The transfer of an established hemodialysis patient to a MRP site for PD, from another MRP site, includes a trial period of up to 30 days. The PD site receiving the patient may request an extension beyond 30 days for extenuating circumstances (e.g. hospitalization). If PD fails during this time, patient returns to originating hemodialysis site.

- After 30 days, should PD fail, the patient should remain at the MRP site providing the PD and commence hemodialysis. Items **A. 2. a.** and **b.** above apply to PD patients.

- If PD is the primary modality, and it fails, the MRP site providing PD care will be responsible for initiating hemodialysis regardless of duration of time the patient has been on PD unless alternate arrangements are made. A pre-dialysis patient/renal health patient accepted for PD will become the responsibility of that MRP site even if the patient ultimately declines PD.

3. Transfer of Patients to Home Hemodialysis (HHD)

- The transfer of an established hemodialysis patient to a MRP site for HHD, from another MRP site, includes a trial period of up to 30 days. The HHD site receiving the patient may request an extension beyond 30 days for extenuating circumstances (e.g. hospitalization). If HHD fails during this time, patient returns to originating hemodialysis site.

- After 30 days, should HHD fail, the patient should remain at that MRP site and commence in-centre hemodialysis. Items **A. 2. a.** and **b.** above apply to HHD patients.

- A pre-dialysis patient/renal health patient accepted for HHD will become the responsibility of that MRP site even if the patient ultimately declines or fails HHD.

4. Exceptions to all patient groups

- If the patient requests to return to a specific site, every effort will be made to accommodate that request.

- Acute medical condition(s) requiring care not available at the patient's current site.