CARE CENTERS

Developing a Vascular Access Program

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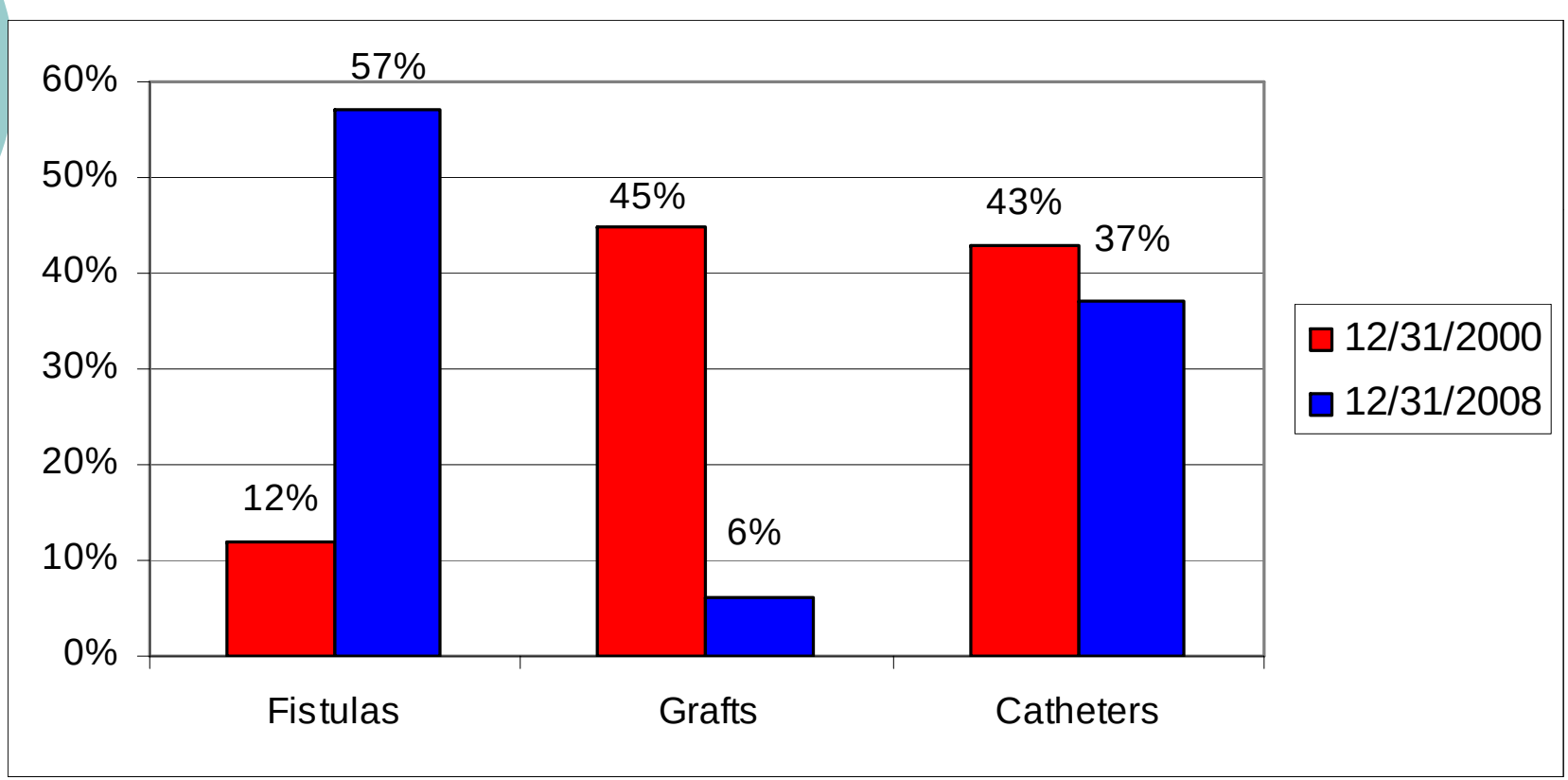
RAI Care Center: Muncie 2000-2008 Comparison



Objectives

- Build a program that would invite open communication and respect for all disciplines
- Develop algorithms to preserve, develop and maintain accesses.
- Implement policies and pathways so everyone has clear guidelines to follow when access problems arise.
- Follow QDOKI guidelines to decrease catheters and increase fistulas.

Identifying the Problems

- Poor communication
- Delayed access procedures
- Poor follow up
- Minimal Radiology intervention
- Poor cooperation between Surgeons and Radiologist.
- Too many catheters
- Need for more fistulas
- Staff frustration
- **Need for change**

Getting Started

Medical director:
Instrumental in starting the program
Appointed as the leader
Shared our concerns with Surgeons and Radiologist
Access Coordinator:
Scheduled monthly access meetings
Established communication between disciplines
Identified access concerns and collect data
Acute Manager:
Coordinating in hospital and post procedure care
Maintained open communication with the out patient center
Staff Educator:
Provided on going education to all care givers
Initiate Pre-renal program.

We were soon invited to join the "Fistula First" project

Established Protocols

Don't re-invent the wheel. Many of our protocols and pathways were adopted from Network resources. We modified them to suit our needs.

Catheter dysfunction:
To Specials for replacement

Clotted fistulas:
To Specials for declot within 24 hours

Clotted Graft:
Surgeon to decide if patient has declot in Specials or Surgery.
(Can't remember the last time patient was declotted in surgery)

Fistula or Graft dysfunction:
Access Coordinator schedules intervention after approval received from the surgeon.
Surgeon notified/time and date of procedure.

Cannulating new fistulas
Only master cannulators are assigned to start new fistulas utilizing the cannulation pathway

Incident Patients:
Have Access Management pathway initiated within one week

What Worked

- Scheduled meetings to accommodate the Surgeons and Radiologist
- Offered CMEs
- Plan to meet for one hour
- Reviewed six patients each meeting
- Have past access history available for patients being reviewed
- Memo sent to all disciplines prior to each meeting with a list of patients to be discussed
- Present articles, encourage new ideas
- Followed DOQI guidelines
- All disciplines agreed to follow the policies and pathways
- Involve Surgeons and Radiologist in the “Fistula First” projects
- Build a good rapport with the Surgical office staff and Radiology staff
- Most important…..Provide doughnuts and coffee at each meeting

Lessons Learned

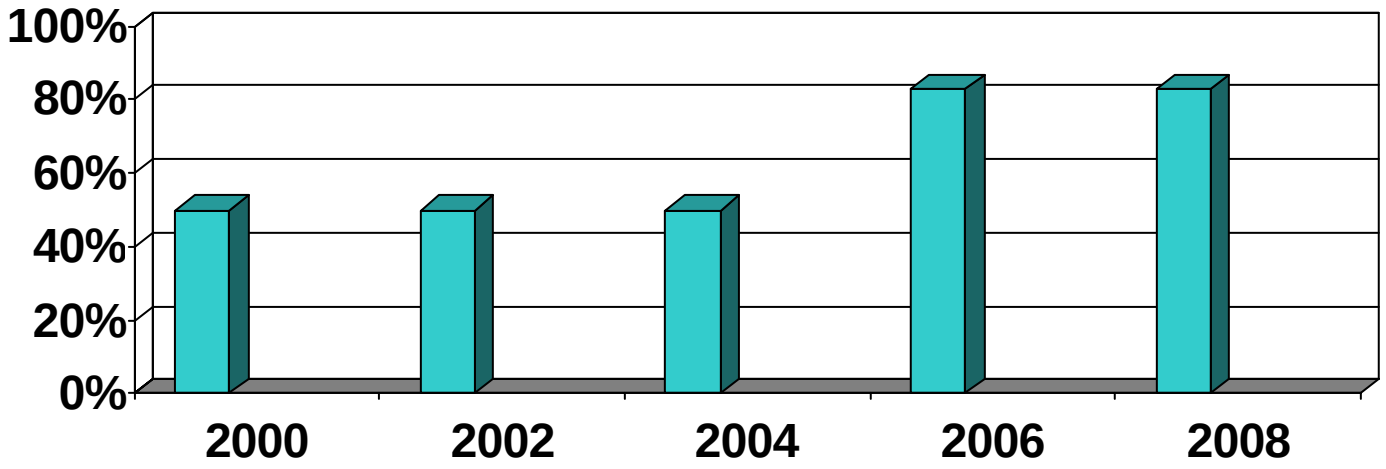
- Limit time spent reviewing stats, the docs would rather focus on the procedures and outcomes.
- Be prepared and organized
- Don’t take it personal, allow discussions and disagreements to happen, growth usually occurs

What Happened

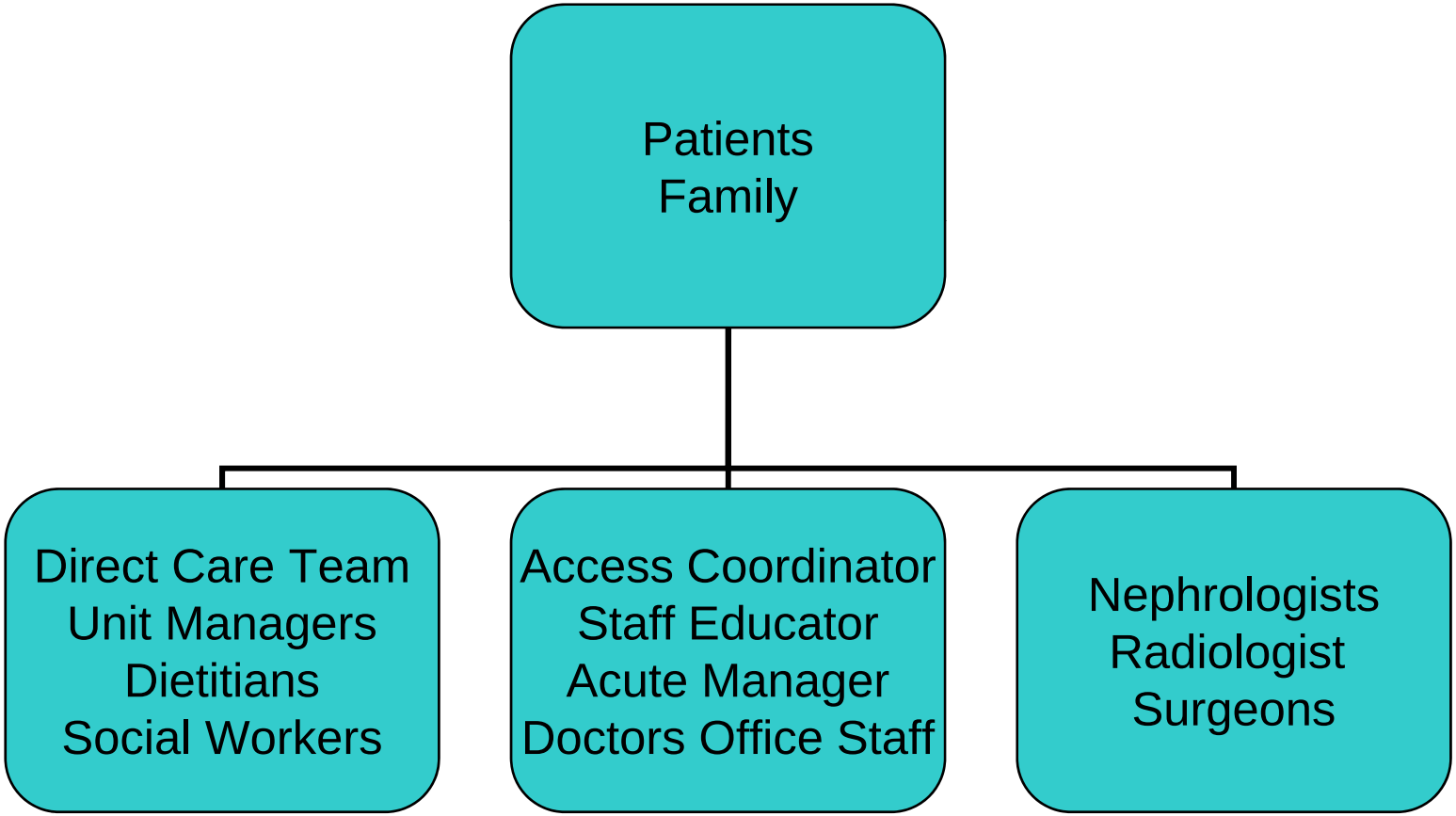
- Surgeons and Radiologist became Allies
- Meeting attendance grew
- All disciplines communicate
- Patients have better outcomes
- Fistulas placement increased
- Accesses are being salvaged
- Frustration has decreased
- Greater respect for nurses opinions
- We now work as a TEAM

Surgeon Attendance At Monthly Access Meeting

- RAI Muncie utilizes two surgical groups for access placement.
- Each surgical groups is comprised of 3 surgeons.



Our Team Today



How we stay connected

- Continuity of Care meetings are held weekly to discuss patient issues.
- Vascular Access meeting held monthly to review patient procedures, outcomes and decide if further intervention is needed.
- CQI meetings monthly
- Pre-Renal Program held quarterly
- Ongoing education programs for patients and staff.

How We Increased Our Fistula Rates

- Rapid referral to the surgeon for access evaluation
- Vein Mapping mandatory
- Only fistulas to be placed
- Follow up at 2-4 and 6 weeks to evaluate maturity
- Access monitoring and quick intervention to salvage fistulas
- Surgeons became more creative placing fistulas
- Education.....

Fistula Outcomes

50 fistulas placed 2008

- Fistula in use 26 52%
- Failed 5 10%
- Pt expired 6 10%
- Pt transplanted 1 2%
- Fistula maturing 12 24%

- Interventions 10 (20%)

7 currently in use; 3 still maturing

Barriers to Decreasing Catheters

32 catheters currently in use

- 19 permanent catheters 59%
- 7 bridge catheters 22%
- 6 waiting access placement 19%

Barriers

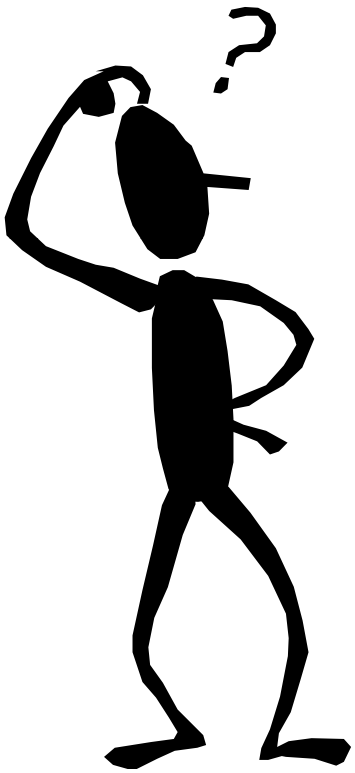
1. **15 of the 19 permanent catheters are pts that refuse permanent access placement.**

2. **Incident patients starting with only a catheter**

TAKE CHARGE!

- Quarterly Pre-Renal Education class.
- Referrals received from nephrologists.
- Participants contacted 1 week before class as reminder.
- Information presented by RN, MSW, RD.
- Class is approximately 1½ hrs in length.
- Follow-up letter with class roster to nephrologists.

TAKE CHARGE!



- Utilize PowerPoint presentation.
- Topics include
  - An overview of kidney function, causes of CKD
  - Modalities for treatment of CKD
  - Coping with CKD
  - Dietary considerations
- Access Coordinator attends.
- Props include CAPD exchange using dummy tummy, NxStage machine.

Impact of TAKE CHARGE!

- Slight increase in # of patients starting dialysis with permanent access in place.
- Increase in interaction among participants during the session.
- Some participants have scheduled to tour dialysis facility, talk with Home Therapy patient.
- Positive feedback on evaluations.

Accomplishments

Fistula rates for Indiana
RAI Care Centers

- Muncie 57%
- Daleville 61%
- Granville 46%
- New Castle 64%
- Winchester 82%