

Fistula First Newsletter

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Network 11 Fistula First Task Force

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LOOKING AT THE DATA



As many of you are aware, collection of data for the Fistula First project has begun. CMS collaborated with the Large Dialysis Organizations to collect vascular access data electronically for their dialysis facilities. The independent facilities are collecting data on disk and submitting it to the Network 11 office via FAX. We appreciate the cooperation of all those dialysis facilities who are collecting the data for this project. On page 2, you will see where Network 11 stands compared to the other Networks and to the United States as a whole.

CHANGE CONCEPT

Routine CQI of Vascular Access

Change concept #1 concerns making vascular access a part of your facility quality improvement program. If you do not have a tracking system, the data collection disk sent out by Network 11 could be used for this purpose. If you have questions please contact the Network office for assistance.

CHANGE CONCEPT # 1

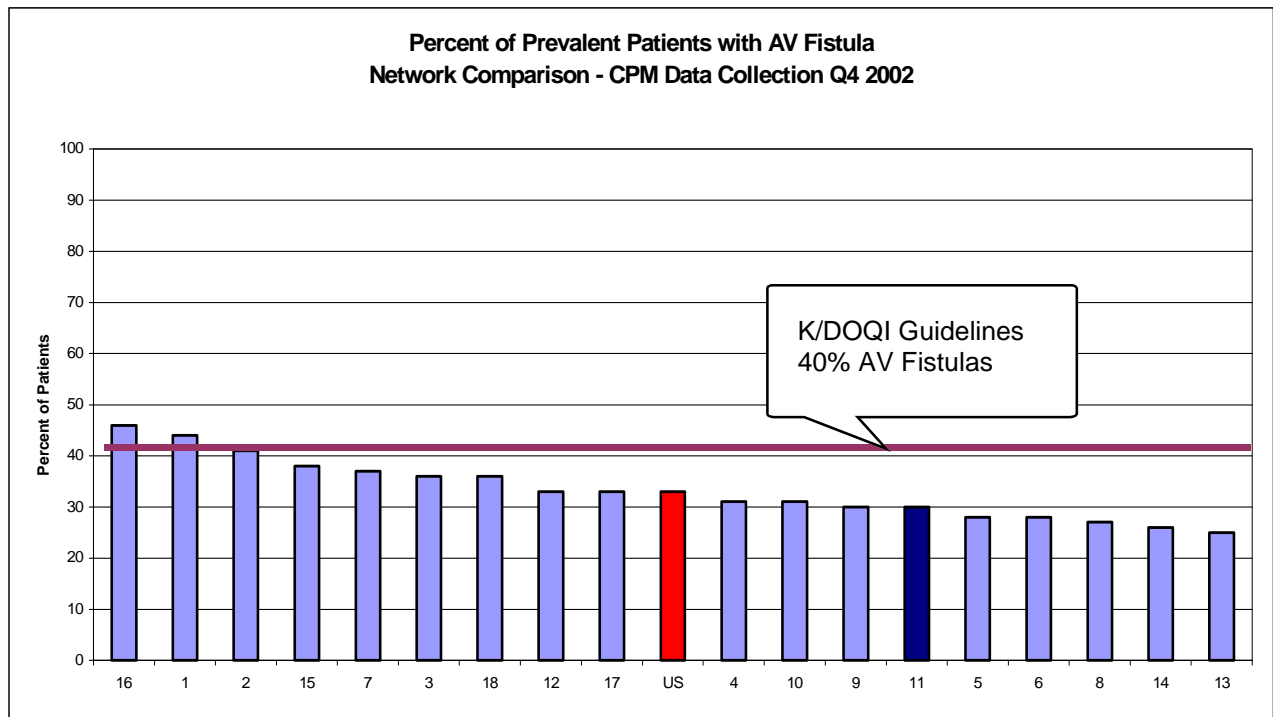
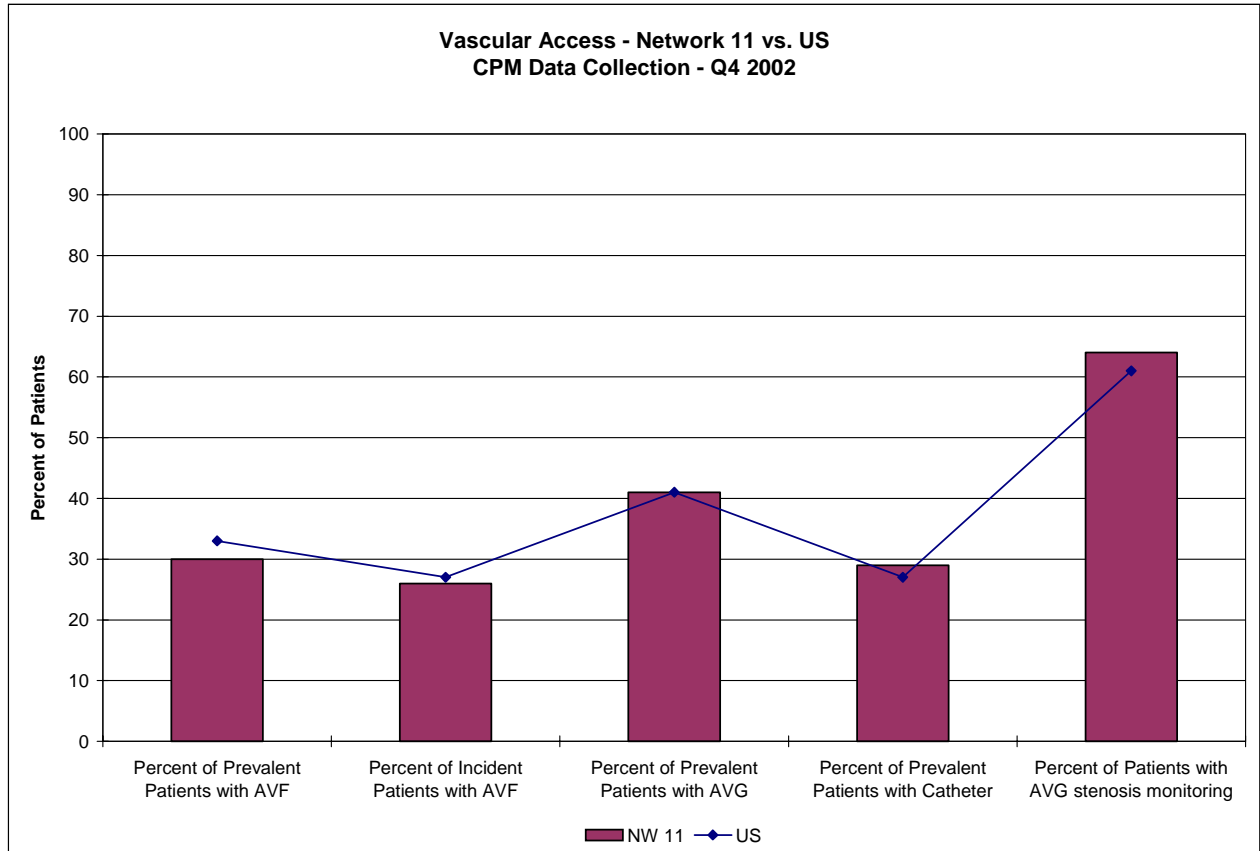
- Designate staff members in dialysis facility responsible for vascular access CQI.
- Assemble multi-disciplinary vascular access CQI team in facility or hospital.
 - Minimally: Medical Director and RN (VA CQI Coordinator)
 - Ideally: Representatives of all key disciplines including access surgeons and interventionalists.
- Investigate and track all non-AVF access placements, and AVF failures.
- Review data monthly or quarterly in facility staff meetings. Present and evaluate data trended over time for incident and prevalent rates of AVF, AVG, and catheter use.

Tools

Dr. Lawrence Spergel has developed a flow chart for vascular access monitoring and surveillance. Check it out at the Network 11 web site:

www.esrdnet11.org

The State of Network 11: Looking at the Data



Vascular Access Care Team

Rebecca Rehak, Vascular Access Care Coordinator Gambro Healthcare, Southeastern Wisconsin

In today's busy hemodialysis units, specific staff members are often designated to monitor certain patient outcomes for the unit. A specific staff member or team of staff members often manages anemia, phosphorus, and dialysis adequacy goals. This allows for a greater continuity of care and for centralized data gathering for QA and CQI reporting. Vascular access care should also be a part of this approach. The creation of a patient's dialysis access and the continuing patency of that access are primary concerns for caregivers. Some patients may go years without access problems, while others have repeated hospitalizations due to access dysfunction. Access dysfunction also affects other outcomes, such as dialysis adequacy and anemia management.

There are a variety of vascular access monitoring approaches. K/DOQI guidelines recommend a combination of static or dynamic venous pressure, intra-access flow, access recirculation, and negative arterial pre-pump pressure measurements. In addition, physical assessment of access sites and unexplained URR or Kt/V drops should also be monitored. Designating staff to monitor these signs on a routine basis is proactive care. It allows access dysfunction to be identified early, minimizing diminished adequacy of treatments and lessening the risk of access loss due to thrombosis.

All staff members need to be aware of venous and arterial pressure measurements and can routinely record them for each patient. A patient care technician (PCT) can be trained to perform monthly testing for intra-access flow and access recirculation. Dietitians can help track low URR's or Kt/V's. Physical changes of a patient's access site or access limb should be reported to the charge nurse for further evaluation. This creates a team approach that places a strong emphasis on vascular access care. Access dysfunction can be caused by multiple factors, evidenced by multiple symptoms, and affect multiple dialysis outcomes. The

vascular access care team must work together to provide the most complete picture of each patient's access status and should have input into patient care planning and the facility's QA and CQI program.

The Gambro Healthcare, Southeastern Wisconsin clinics have developed a program to tie all these factors together to improve both individual patient care and overall outcome management. In our clinics, two vascular access care coordinators oversee the program. Originally, we were PCT's who performed monthly access testing at a single clinic. Because of the success of this program, we wanted to expand the testing to our other units. We looked at the cost of training and scheduling designated staff and the initial costs to acquire equipment to do monthly testing in multiple clinics. Based on the close proximity of the clinics, we determined that it would be more cost effective to share resources for vascular access staff and equipment among the locations.

This approach has worked well for over three years. The Vascular Access Care Coordinators rotate through the clinics, performing access testing for each patient on a monthly basis. This allows us a specific time each month to focus on the patient's access care by combining test results with other monitoring data. We track each patient's Access History for problems and interventions. We attend QA, CQI, and patient care planning meetings at each clinic and help provide a complete view of access management and outcomes for the unit.

Designating staff for vascular access care is a step that can improve patient outcomes. It creates a focus on quality access management. Whether staff is specific to one unit or shared among multiple units, patient care is improved.

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We're on the web!
www.esrdnet11.org

We want to hear from YOU!

- Do you have a successful method of tracking vascular access?
- Do you have a successful method of referring patients for fistula placement?
- Do you have a plan for involving the multi-disciplinary team in access management?

We want to hear from you. Contact Network 11 by phone (651) 644-9877 or email info@nw11.esrd.net and let us know. We may feature your idea in a future issue of the Fistula First newsletter.



Recommended Reading

■ ***A Multidisciplinary Approach to Hemodialysis Access: Prospective Evaluation*** by M Allon, R Bailey, R Ballard, MH Deierhoi, K Hamrick, K Oser, VK Rhyne, ML Robbins, S Saddekni and ST Zeigler. From *Kidney Int* 1998 (Feb); 53(2): pp 473-9 (Abstract. Full text available on line).

Developing a Critical Pathway for Vascular Access Management by R. Breiterman-White. From *ANNA Journal*, 1997 Feb; Vol 24 (1): pp 70-76, quiz on 77.

How a Multidisciplinary Vascular Access Care Program Enables Implementation of the DOQI Guidelines. Part I by CR Duda, LM Spergel, J Holland, CT Tucker, SJ Bander and JP Bosch. From *Nephrology News Issues* 2000 Apr; 14(5): pp 13-7.

Lessons Learned. Implementing a Vascular Access Quality Improvement Program Part II by CR Duda, LM Spergel, J Holland, CT Tucker, SJ Bander and JP Bosch. From *Nephrology News Issues*. 2000 May 14(6): pp 29-32,37.

The Value of a Vascular Access Coordinator by LC Dinwiddie. From *Nephrology News Issues* 2003 May: pp 49-53.

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