Vascular Access Day case Surgery rates

Pathway notes from Peer Sites

Meeting notes – 19th December

Participants:

- East and North Hertfordshire NHS Trust – Dr Praveen Jeevaratnam (Nephrologist and VA lead) Jeanette Cloran (VA nurse practitioner)
- New Cross Hospital, Wolverhampton – Helen Spooner (Nurse consultant and VA lead)

East and North Herts

Current population is 550 HD patients, 40 PD patients and 40-50 HHD.

Set up a dedicated renal day case unit 5 years ago and work on premise that all cases will be a as a day case unless good reason. This is currently at 80-90%

This is delivered through renal day case centre, co-ordinated day case unit and a Treatment Centre (the latter are a Trust wide resource)

Definition of day case: In and out the same day with lists staring at 830am and patients if have had a local out by midday. If GA given they are sent back to the ward and nurse discharge is carried out.

BVT/Graft with a GA is usually an overnight stay.

All RC are under local anaesthetic

The VA nurse coordinates all access lists through theatres and works closely with the surgeons and anaesthetists as part of the wider team to deliver timely access.

Surgeons provide a 1:4 assessment clinic and puts them on their own list for continuity

Patients are referred in general 6 months prior to RRT (monitored decline in eGFR) unless a diabetic and then aim for a year. This is not approached in a scientific way but is tailored to the individual rate of decline. RRT usually commences at eGFR 8 and if VA not done these then become a priority.

Praveen is very much in control of the listing and it is patient specific – sometimes uses delta model and different mapping/planning models.

Work well with anaesthetists who are committed to providing a good service as are RI colleagues.

Have a high risk anaesthetist clinic where all information pulled from referring centres and the risk quantified and shared with appropriate people.

Acute PD supported by medical insertion of catheters but with varying success. Possibly not the first port of call for access in the late presenter but would like to do more with this approach.

Reasons for tunnelled lines are:

Late presenters (15%) – if these are in hospital then will try and get VA slot before discharged

Patient choice/refusal – 10%

What works well:

- MDT approach that meet regularly and agree a plan which the nurse coordinates – nephrologist, surgeon, VA nurseion with IR and anaesthetic
- Really good relationships with surgeons who aren't just technicians but involved in the planning and after care
- Good communication with IR and anaesthetic colleagues
- Referring centres – patients may be offered a remote pre-assessment clinic if already been seen by a surgeon previously

Challenges:

VA capacity – probably need double amount of surgical capacity than is currently available

As a result have a waiting list which is reviewed regularly

New Cross Hospital

Total population comprises 350 dialysis patients with 35 on HHD and 60 on PD

Day case definition: ????????????? out the same day

Day case provision through a day case suite which is a hospital wide resource and another theatre that has a 23 hour ward facility attached to it.

Most surgery (80-85%) is as a LA although some as a GA. The difficulty with the latter is lack of anaesthetic lists for GA/surgeons.

VA hub is at Dudley although there are 2 surgeons based at New Cross.

There is no vascular ward which in a way determines the day case approach.

eGFR 15 is trigger for referral and access plan / Monitor decline eGFR to plan access 6/12 pre HD

If they hit eGFR without a plan they get listed as urgent but each case looked at individually

Late presenters have line inserted and brought back in for education rather than VA plan started immediately.

What works well:

- Good liaison with surgeons – team approach
- VA MDT every Monday morning including: radiologist, surgeon, VA nurse, nephrologist
- VA nurse goes through LCC lists with nephrologist each week and looks at all eGFR 15 –what are access plans, what is urgent and what can wait and has the absolute overview and coordinates accordingly

- VA report goes to the board monthly outlining the % lines/AVF etc (Helen to send an example of spread sheet to RG)

Challenges:

- VA hub in Dudley

Common themes:

- VA CNS key to success
- Team Approach (Neph/SX/CNS)
- Relations with IR/Anaesthesia
- Theatre capacity ?