Inpatient Issues Access and Lines

1. If we are called by noon in a straightforward case appropriate for the OR (ie NPO) we will have the catheter in, in time for dialysis the next afternoon. We will strive to have it in by the next am.
2. If we are called after noon, or before in a patient not NPO, we will have the catheter in by the end of next working day. We will strive to have it in before 3pm the next day.
3. Of course we will be happy to discuss more urgent, non-straightforward cases.
4. If a patient needs a temporary line, the nephrologist or nephrology fellow will place it. If the fellow is not yet up to speed and/or the attending is not comfortable or credentialed with the procedure, we will provide supervision for the fellow, or place the lines ourselves.
5. We will take first calls for all dialysis lines. This a collaborative effort. IR and surgery are not to be played off each other.
6. New starts with a catheter in the hospital will have outpatient follow-up arranged by the surgical team with the surgeon who placed the catheter. The goal is to be seen within two weeks.
7. Chronic access consults for new access will not be undertaken in the hospital except under extraordinary circumstances and after an attending to attending conversation. To facilitate chronic access on a patient who did not get started in the hospital but who is anticipated to need access soon, a consult may be called to the access surgeon on call who will facilitate outpatient appointments. The goal is to be seen within 2 weeks.

Outpatient Issues

8. We will distribute new referrals evenly between Drs Hawkins, Blazick, Whiting, and Herbert.
9. We will only consider direct referrals with an attending to attending conversation.
10. Patients will not be sent for consideration of both peritoneal and vascular access without an attending to attending conversation.
11. All patients referred to MMP surgical care for access will have first gone thru the educational intervention at the dialysis centers/Maine Nephrology.

Communication

12. Time dependent consults (ie. Lines) will be done by attending to attending calls. The surgical attending will respond back to the nephrologist the plan for the line within an hour or so.
13. MMC is a learning institution but there are limits. Communications between services more than one rung up the hierarchy will be done with DIRECT supervision only, communications one run up the hierarchy may be done with indirect supervision. (eg. A medical student calling an attending will only be done if a supervising individual is directly available at their elbow, a resident or fellow calling an attending is fine if the issue has been discussed previously with their supervising attending. Same for a medical student calling a resident)
14. Teams need to communicate within teams before going outside their team (ie there should not be multiple team members from within a team contacting multiple team members outside a team with the same information). This goes for all teams. See fig 1.

15. Complex vascular issues will be delineated in the “encounter for vascular access problem” in Epic whether or not the problem is used for billing or other purposes. This problem is the domain of the surgeons, interventional nephrologists and dialysis docs.
16. We will use one of the vascular indications conference at 10 am on Thursdays, quarterly, for access cases. All nephrologists, fellows and residents will be invited, (hospitalists if they want, too)

Who you gonna call?

17. There will be a new line in Amion on the Vascular Surgery Schedule for “Access”. Staff and providers alike are expected to use it. It is for lines, urgent access issues and emergent access issues.
18. Patients will be “owned” for elective problems by their original access surgeon for as long as the patient wants.
19. Patients will be “owned” for urgent issues by their original access surgeon until the access is successfully being used, or 3 months, whichever comes later. After that urgent access issues are “owned” by the team and on call access surgeon.
20. There are surgeons who are not part of the core access surgical team but who take call. They may choose to hand off access cases after their call is over or they may maintain ownership. It’s up to them.
21. Emergent issues will be taken care of by the access surgeon on call.

Miscellaneous

22. The four surgeons doing access will strive to provide: 1. consistent care, 2. an outpatient appointment within 2 weeks of referral, 3. Surgery within 2 weeks of the access visit.
23. Some sort of outcome monitoring will be done and shared

Figure 1