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Renal Replacement Therapy (RRT) Pathway

When eGFR ≤20 ml/min,
or
Patient predicted to be ≤1 year from requiring RRT

Refer to Transplant Team if appropriate

- Consider referral when eGFR≤**25** if suitable for simultaneous pancreas-kidney transplant
- Pt activated on list when eGFR≤15ml/min
- Pre-emptive if living donor available

Refer to Chronic Kidney Disease Team

- Referral to be completed by registrar or above
- Transplant suitability *must* be documented at time of referral
- Consider referral to low eGFR clinic

Treatment Options Education

Home Therapy (PD or HD) | **In-Centre Haemodialysis** | **Transplant** | **Conservative Care**

Acute starts visited 3 times to aid decision; outcome to be documented on cyberREN and patients named consultant to be informed

When eGFR≤15

Patient is for Renal Replacement Therapy

Peritoneal Dialysis

- If patient appears suitable for medical insertion of PD catheter under local anaesthetic, refer to Dr Menon for assessment.
- If patient not suitable for medical insertion, refer to Vascular Access Nurse for patient to be reviewed by the surgeons.

Haemodialysis

- Refer to Vascular Access Nurse for creation of fistula.

Transplant

- Alert transplant team, as patient is normally listed at this point.

Patient is for Conservative Care

Refer to GP for 'gold standard framework' when patient is considered to be within the last year of life.

Regular input from CKD nurses.

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Supporting information for CKD Pathway

1. Refer to CKD team for treatment options education when eGFR ≤ 20mls/min, or when patient is predicted to be within 1 year of requiring RRT.

2. Refer to the transplant team simultaneously if deemed appropriate. If the patient is potentially suitable for simultaneous pancreas-kidney transplant consider referring earlier - Manchester will activate patients for simultaneous pancreas-kidney transplant at an eGFR of 25 mls/min. Patients from South Cheshire will need to be referred to Dr De Takats. Patients from Stafford and Stoke are to be referred to Dr Tomlinson. ***Ensure transplant suitability is documented at time of referral to CKD team, even if the decision is 'not suitable' – this decision should not be deferred.***

3. Clinic referrals can be made by copying clinic letter with full details to CKD team. If the patient is referred from clinic ensure the patient is aware of the referral. Please ensure referral to transplant team at the same time if suitable with a copy of the clinic letter.

4. For urgent ward referrals use of the 'ward referral form' is mandatory (See appendix one). Please ensure all fields are completed.

5. One of the CKD nursing team will contact the patient directly once the referral form is received. If they are referred to the transplant team they will invite the patient to a seminar and arrange relevant tests.

6. When completing referral form or letter, please ensure in particular:
    a) Transplant status is assessed and documented (a reason must be documented if they are deemed not suitable);
    b) Hep B status is documented, and the patient is referred to the GP for vaccination if required;
    c) Contraindications to HD and PD are considered and documented.

7. Monitor eGFR closely, and refer for assessment for access when eGFR drops to 15, or earlier if patient is progressing rapidly.

8. If patient is suitable for home therapies the patient will be referred by the CKD team to home therapies for further information on PD and Home Haemodialysis. If the patient requires assisted PD the home therapies team or CKD Treatment Options nurse will assess ability to connect and disconnect.

9. Please consider referral to the 'Low eGFR Clinic' when eGFR <25mls/min for diabetic patients and <20mls/min for all other patients i.e at the same time as referral to the CKD team for education. This is a multi-disciplinary clinic with nursing and dietetic input, and can facilitate closer monitoring than is generally possible in a 'General Nephrology Clinic' setting.

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Appendix one:

RENAL WARD REFERRAL TO CKD/TRANSPLANT TEAMS

PATIENT DETAILS		
Name:	**Unit Number:**	**Date of Birth:**
Address:		**Contact number:**

PATIENT'S MEDICAL HISTORY (brief)

eGFR		**Known to Nephrologist**	**Yes/No**
Has the patient started dialysis:	**Yes / No**	**Access for dialysis Please state:**	

Started on ESA:	**Yes / No**	**ESA Dose:**	
Started on IV Iron:	**Yes / No**	**IV Iron Dose:**	
Referral for Aranesp training:	**Yes / No**	**Referral for Aranesp home delivery:**	**Yes / No**

Please visit to discuss treatment options for CKD:	**At home / on the ward**	**urgent / routine**
Refer patient to transplant team as unplanned starter:	**Yes / No**	

Is the patient clinically suitable for all treatments? If NO what are the reasons.		
Peritoneal Dialysis:	**Yes / No**	**If no, why:**
Medical PD Insertion:	**Yes / No**	**If no, why:**
Conservative Care:	**Yes / No**	**If no, why:**
Hospital Haemodialysis:	**Yes / No**	**If no, why:**
Home Haemodialysis:	**Yes / No**	**If no, why:**
Transplant:	**Yes / No**	**If no, why:**

Hepatitis B vaccination – Please refer to GP on discharge. See link below for protocol:
http://uhns/media/31927/Hep%20B%20Vaccination%20policy.pdf

Note to GP on discharge letter – please remember to immunise any patients with CKD 4 .	
Referring Doctor's Name:	**Referring Doctor's Signature**
Referring Doctor's Designation: ***(must be registrar grade or above)***	**Referring Doctor's Bleep:**
Consultant Initials:	**Referral Date:**

Please return to any member of the CKD or Transplant Team