ESRD patients – special considerations

Inpatient HD #26130 located 3D in Tower

Make contact with the renal fellow (dialysis) to let them know the patient is in-house and will need HD. They will figure out how and when the patient will dialyze. Providing the following information will help them make these decisions:

- What days does the patient usually dialyze?
- When the patient last dialyzed?
- What is the patient's volume status?
- Are patients electrolytes are deranged i.e. hyperkalemia?
- What does patient have for HD access?
- Will the fistula/graft be accessible after surgery or will they need alternative HD access placed?
- Please coordinate HD with OR schedule, i.e. do they want to do HD before or after OR?

If the patient will require IV antibiotics on discharge please discuss with the renal fellow (or HD charge nurse)so they can alert the outpatient HD center to give the antibiotic at dialysis if dosed on HD days. The renal fellow will need to know the antibiotic, dose and end date! They will do all the coordinating including monitoring of vanc troughs.

Renally dose abx and narcotics

Vanco trough should be done before the fourth dose AFTER HD. Some, not all vancomycin is removed with dialysis. Goal trough after HD should be between 15-20.

If patients require HD on the day of discharge, coordinate with the renal fellow so the patient is on for first run so their discharge is not delayed.

NEVER place PICCs – this potentially could cause stenosis in veins which may be needed later for fistula creation. Patients with CRI and ESRD will need tunneled lines if long term access for IV antibiotics is needed

NEVER replace mg or K

NEVER give IVF prior to OR or any other procedure

NEVER give lovenox

Almost NEVER give gadolidum contrast if GFR <30, the patient is at high risk for NSF (unless directed to by attending). If given, HD will need to be arranged soon after MRA to dialyze gadolidium.

For PD patients, please page the renal transplant fellow for PD.

If PD and diabetic then get endocrine involved early as patient can become hyperglycemic with glucose concentration in PD solution. This can exacerbate into DKA and cause reverse

flow of PD solution into the patient's vasculature.

CRI – special considerations

NEVER give gadolidium if GFR < 30, the patient is at high risk for NSF!

NEVER place PICC's – place tunneled line instead (PICCs can stenose veins which could be needed in the future for fistula placement)

*a renal consult can override this in special circumstances

Keep patient well hydrated to prevent AKI when receiving dye loads

Be conservative when replacing K and Mg