SKU plans for managing outpatients 16.3.20 VI V1

Haemodialysis: Advice to all patients is that they must continue to attend. Risk to them and others will be minimised with triage and cohorting. Algorithms documented on cohorting streams of patients, updated 17.3.20. Updated letter for patient 17.3.20

Also identifying patients now that could reduce to 2x per week HD and those that can

Peritoneal dialysis:

All routine home visits will be suspended and telephone consultations arranged with the patients. There will a potential need to re-deploy staff to assist the ‘assisted APD’ patients in the community on a daily basis. If Baxter the healthcare provider cannot provide this connect-disconnect service for our patients and therefore patients would be unable to do PD which would be life threatening, additional SKU nursing input would be required to perform this in the community.

All routine peritoneal dialysis clinics can be suspended and the telephone triage system adopted.

Only

* Patients highlighted in the and monthly named nurse bloods review who have problems need attend
* New starters to PD
* Patient failing PD with possible need to switch to HD or considering withdrawal
* Patients with a new PD regime requiring clearance evaluation
* Recent or suspected exit sit and tunnel infection or peritonitis
* Patients with drainage problems not managed with laxatives in the community

We aim to continue to train patients for peritoneal dialysis during this time if we can, as this will minimise the need for HD and they can have therapy at home as long as there is adequate staffing for the training

General plan for all OPD clinics

* Consultant to review clinic list 1-2 days prior to clinic
* Outcome of telephone consultation
  + - A) Clinic review completed. Letter to GP generated. Blood forms posted to patient for interim review bloods. Outcome sheet with F/U arrangements
    - B) Patient identified as needing face to face review. Review arranged.

**Sub-speciality clinics:**

**Transplantation**

Transplant Clinic appointments can be substituted with Telephone Consultations in a number of circumstances involving mainly long standing, stable kidney transplant recipients. The decision for a telephone consultation lies with the patient’s Consultant. This decision can be guided by the following criteria:

* Transplant recipients should be frequently seen in person and have blood tests for the **first 3 months post transplantation**. They should be reviewed in Clinic every week for 3 months post transplantation and also have blood tests at least weekly.
* All transplant recipients with **kidney allograft dysfunction** should be seen in Clinic and have the appropriate investigations / blood tests.
* Transplant patients with **complications related to immunosuppression** (eg neutropenia)  should be assessed in person and have appropriate investigations and treatment
* All transplant recipients who are **stable and at least a year post Transplantation** can be offered telephone consultations as per their Consultant
* Some recipients with **stable kidney function and no other current medical issues** can be considered for telephone consultation 3 months post transplantation, provided they have blood tests regularly and as per the SKU guidance.
* **Live donor post nephrectomy follow ups** can be done with telephone consultation and remote blood test review.

**Vasculitis or immunosuppression clinic**

**Advanced kidney care/ Low clearance patient**

The following should attend ***unless they are confirmed for MCC***

1. First low clearance appointment if not previously attending another SKU clinic
2. eGFR < 10
3. unanticipated fall in eGFR of 5
4. K > 6.5
5. Precarious fluid balance defined as a change in diuretic on both of last 2 appointments
6. No bloods since last clinic
7. Complex comorbidities where assessment based on symptoms without examination comprises a risk  (judge case by case but severe HF for example)
8. GP letter received since last appointment which raises concerns needing assessment in person

We would not anticipate bringing MCC patients up unless phone conversation raises concern that can’t be resolved

**General Nephrology Outpatient Clinics**

* Consultant to review clinic list 1-2 days prior to clinic
* Identify patients who need face to face review. PA to ring patients suggesting after cons review they do need to attend clinic.
  + Recently instituted high dose diuretics
  + Decline in eGFR requiring start of prepare for RRT pathway.
  + Significant symptoms at last review
  + AKI
  + New patients with unclear diagnosis
* Identify patients for whom telephone consultation might be appropriate. Ask PA to ring patients offering telephone consult.
  + eGFR declining at expected rate
  + None of the above

**Tuberous sclerosis**

For TSC patients who are not on an mTOR inhibitor: renal unit guidelines for gen nep clinic opd review

For patients on Everolimus or Sirolimus there are two issues.

1. A significant minority are variably immunosuppressed and this can be difficult to detect or predict except from their clinical history. WC counts are often normal and it does not correlate with blood levels.
2. If they are taking it for solid tumours (AMLs or SEGAs) then we think it is safe to stop the mTORi or reduce the dose for a while (Weeks to months) as the tumours regrow very slowly. However, we have almost no data to guide us. Just clinical experience from individuals where we have stopped for side effects or to navigate through peri-operative periods.

Consequently I am contacting all of them with the attached letter. The advice may change. This is part of a joint St Georges / Brighton approach. We have consulted nationally and worldwide – but most other national and international centres following our lead.

For someone needing to start there is a risk – benefit conversation to be had. Ditto if progression of their lung disease (LAM) has been halted by the mTORi or if their refractory seizures have improved.

Hence most advice is on a case by case basis.

**Hypertension**

We advise carrying out a face to face review in the follow circumstances

* New referrals where severe HT (BIHS definition) is the indication for GP referral
* New referrals following an attendance at A&E/ admission for HT (including first visit if we were involved during admission)
* Patients being assessed for phaeochromocytoma  (not other 2e HT subject)
* Patients on complex drug therapy (eg which GPs can’t prescribe)
* Patients in whom home / self monitoring is not practical

**Renal Genetics and ADPKD patient virtual outpatient management options - COVID 19** - AIA

Patient categories:

* **ADPKD Patients on Tolvaptan less than 18 months.**

Newly started have monthly prescriptions for the first 18 months that is dispensed by Pharm@sea. These appointments are shared between Sarah Trust and myself.

Patients require monthly consults for LFT result review, and monthly prescription if no adverse effects have occurred. Sarah does this usually by alternating teleconsults with face-to face each month for 3 months then myself month. This cycle is ongoing for the first 18 months.

Patients could be offered teleconsult appointments for the next 3 months both for monthly reviews with Sarah and 3 monthly reviews with myself if they do now wish to attend the OPD.

Delivery could be arranged delivery from Pharm@sea for monthly prescriptions (patients less than 18 months) or 3 monthly prescriptions (patients greater than 18 months).

* **ADPKD Patients on Tolvaptan >18 months**

Reviewed by Consultant only (myself and CK) every 3 months in clinic

For next 3 to 4 months patients could be offered teleconsult appointments if they do now wish to attend the OPD.

Delivery of tolvaptan could be arranged with Pharm@sea providing LFTs normal and patient is well.

RE: home delivery of Tolvaptan: We do currently deliver to some patients but not very frequently. I will confirm with Sarah about regular deliveries more frequently and more teleconsults when she is back at work tomorrow.

• New diagnosis of inherited renal disease – primarily PKD also other monogenic diseases. Need to be seen and assessed in clinic. Usually not urgent from a clinical perspective, more a management issue if patients wish to delay their clinic appointments.

• FU patients– diagnostic results, management going forward often needs detailed patient focused discussion because of their many concerns and questions. This uses a lot of visual aids such as looking at investigation results, & scans, patient education aids etc with patients that they usually want to see and find helpful. Very difficult to do this over the phone or video link. However, the majority are not urgent and if a patient is concerned about attending, appointments at later date could be offered to them.