

Checklist for renal services in respect of the COVID-19 pandemic

General principles

- Ensure that there is a senior operational group for COVID-19 within the renal service. This should comprise:
 - Clinical Director
 - Renal service Matron
 - Renal service operational manager
 - Nephrologist and nursing leads for each modality
 - Infection prevention/control lead for department
- Ensure regular rolling meetings and support virtual meetings for colleagues who are offsite and to avoid larger meetings
- Set up an administrative hub for COVID-19 within the renal service
- Ensure clear delegated responsibilities and accountabilities for the leadership team
- Develop a devolved leadership model (e.g. give named individuals specific responsibility for specific areas in respect of COVID-19)
- Register all contact details (including mobile phone numbers, and email addresses where available), for all dialysis, transplant, other immunosuppressed and low clearance patients, to ensure failsafe communication lines, and enhance the potential for virtual or distant disease management
- Ensure that the service is appropriately represented at a senior level in the organisation and that there is a clear organisational understanding of the essential nature of dialysis care, the expertise required, the structural considerations and the time-dependent urgency of care for patients with renal disease. These issues are often not understood outside of renal services
- Identify a reliable point of contact within executive management where possible
- Identify contact within incident planning group within Trust and update them proactively of your plans

- Identify contact within Trust infection control leadership
- Regularly ask the question around what is the perceived risk/trajectory of new cases in our local catchment area
- Define where you need clear policies and protocols. How do you enable them? Focus on short, practical, documents that are realistic for delivery. Ensure these are stored electronically and easily accessible eg. hospital intranet, shared department network drive – if none available consider setting up own Dropbox/similar
- Have a mechanism for regularly assessing advisory information (e.g. Public Health England, UKKA website) and updating protocols, policies, and communication strategies
- Have a communication structure in place to support staff, focusing on ensuring that national and local guidance on infection control is understood and staff are supported to follow this guidance. There should be regular updates
- Inform patients as to how the unit is dealing with COVID-19. Provide regular updates. These can be written, web pages, or through social media
- Information for patients will be placed on the Kidney Care UK website, the NKF website and the Kidney Research UK website and updated regularly and can be used as a template for local communication
- Ensure that patients know what to do if they have symptoms that could be due to COVID-19
- Ensure that staff know what to do if they have symptoms that could be due to COVID-19
- Have clear contacts in place with all partners in the provision of care; e.g. supplies, technical support, transport providers, catchment area renal services, catchment area ITU and acute care services
- Clarify with any transport provider whether they will be able to bring COVID-19 positive cases/suspected cases to your dialysis units (some private providers have stated that they will not provide this service) - establish contingency plans
- Cleaning services – ascertain point of contact if rapid deep/terminal cleans are required
- Identify key supplies, and ensure supply lines maintained. This is particularly the case for renal unit haemodialysis supplies. It is assumed that peritoneal and haemodialysis (hospital and home) suppliers will have contingency plans in place for a pandemic, but it is advised that renal units check that these are in place with their suppliers
- Model how PPE supply will increase based on number of cases being managed. Identify a point of contact within trust procurement and ask about plans for contingency stock if high number of cases
- Have a risk register in place for all structural, staffing and supply areas of the service

- Have a mechanism for ensuring that all protocols are signed off at a Trust level
- Renal services are advised to follow the KQuIP COVID-19 haemodialysis patient safety working group recommendations on best practice to minimise the risk of transmission which can be [accessed here](#)
- Consider setting up a rapid access and assessment hub for patients with renal disease. This may be important for the accurate management and minimising risk of spread.
- Perform hand hygiene and infection control audits of all areas (outpatient, inpatients, dialysis, procedures) and reinforce need to all staff and patients

COVID-19 treatments

- Ensure that patients have been informed about the criteria for COVID-19 treatment for non-hospitalised patients
- CEV lists will need updating and patients with CKD 4 will need to be made aware of their eligibility for newer therapies
- Brief all renal unit staff so that all are aware of the criteria for eligibility of treatment
- Have clear lines of communication within your COVID-19 Medicines Delivery Units (CMDUs); remember that these units are responsible for the catchment area of a CCG/ICS so you may be liaising with multiple CMDUs
- Many CEV lists are now out of date and although inclusion of the CKD 4 patients in the list of those entitled to extended therapies is welcome, these patients are not currently identified in CEV lists

In centre and satellite haemodialysis services

- When a patient calls the unit have a checklist in place for key questions around contact and symptoms that can assess the likelihood of COVID-19
- Ensure that you are aware of the current PHE advice on how to deal with suspected COVID-19 infections. As numbers increase consider discussing at a service level how you set up a single pathway for patients who require dialysis treatment
- Assess the geography for all your units. Define how services should be considered for the following scenarios: (i) single case; (ii) multiple cases; (iii) patients who have had contact with an individual with COVID-19. Identify sites from triage away from treatment floor, all possible routes of entrance/exit in order to maximise separation of suspected cases from

other

- Consider setting up triage at the front door if local situation escalates
- Limit visitors and all non-essential employees
- Consider how patients are isolated, or cohorted, within the physical footprint of your service, and what may be required if you are unable to manage isolation, or cohorting, within the service
- Ensure that all staff in your organisation who are currently not working in a dialysis area but are able to carry out dialysis are identified. Have a mechanism in place for refresher courses for these staff
- Have a mechanism to address those areas where Trust policy may not be consistent with the management needs for patients with end-stage renal failure requiring haemodialysis

Home therapies

- Ensure supplies of consumables are in place. Ensure that regular medications are available.
- Review models of care - utilising virtual reviews
- Message that the aim is to continue patients who are receiving home therapies are on home therapies
- Consider a dedicated contact line for home dialysis patients
- Ensure a local policy around infection control for patients receiving home therapies and staff who may have to visit those patients
- Consider the options for utilising all approaches for home therapies. This will be centre specific. For example, some centres are suspending home haemodialysis training but focusing on fast-tracking peritoneal dialysis training.

Inpatients

- Agree proportionate admission thresholds.
- Mechanisms for rapid discharge and follow up where necessary should be established.
- Staff may need to acquire additional skills at short notice for helping with the care of critically ill patients, many with acute respiratory failure, as intensive care units may be overwhelmed.
- Such additional training might include the administration of non-invasive ventilation. Identify within the organisation what skills could be made available to renal service staff

- Understand geographic footprint of your wards. Consider possible isolation areas. Consider all areas where RO water is accessible
- Identify all alternative areas around hospital where RO water might be accessible eg. ITU
- Consider whether a portable RO unit could be installed to increase potential HD capacity
- Consider feasibility of obtaining machines with online water purification capacity for use in acute setting and staffing
- Patients who require an inter-hospital transfer may be at particular risk. Agree a priority transfer policy for patients who are receiving dialysis treatment who are admitted away from base. All dialysis patients who require hospital admission should be cared for in a hospital with in-centre dialysis unless they require intensive care unit level care and are unfit to travel

Outpatients

- Have a mechanism in place to identify which patients can be postponed, or have a virtual review (video or telephone)
- Start notes review of all patients coming to OPD – develop standardised criteria to determine which patients could have virtual review eg. Delta creatinine/eGFR over past 24 months, kidney failure risk equation (KFRE) thresholds, complexity of case.
- Develop a structure to support virtual clinic review
- Identify a mechanism for patients who need blood tests to have these done remotely and for the results of these to be reviewed and communicated
- Ensure that patients have adequate supplies of medication, in particular immunosuppression
- Consider a dedicated contact line for outpatients, for larger service this may be sub-specialty specific (e.g. transplantation, advanced CKD)

Transplantation/general nephrology patients on immunosuppression therapy

- Develop and utilise virtual models of care
- Consider stratification dependent on level of risk
- Define where patients have their blood taken. There are different options for this, from

dedicated phlebotomy hubs through to agreement for testing in primary care clinics

- Set up a dedicated communication pathway for transplant patients
- Ensure that patients have at least a one month stock of immunosuppression medication available at any time and identify mechanisms for ensuring that patients are able to have their prescriptions renewed
- Consider review of local protocols for immunosuppression used for treatment of newly presenting vasculitis, lupus etc.