**Title:** Care of patients withdrawing from outpatient haemodialysis

**Introduction:** For inpatients there is a robust process for discharging patients and managing end of life care in the community. It was recognized that there was a gap in managing those patients who were withdrawing from outpatient haemodialysis.

**Problem:** With this in mind there was a clear gap in communication with community teams and other health care professionals within the renal team, availability of appropriate medications and suitable guidelines for managing these patients.

**Purpose:** Families had fed back that it was difficult to understand the transition from hospital outpatient to primary care. Staff in the renal service did not know where to direct queries about end of life care.

These patients sometimes make the decision to withdraw from dialysis at short notice with little opportunity to plan for their care. Due to the nature of the patient’s condition, end of life is anticipated within of a few days. This led to a feeling of crisis management of the patient’s needs at the end of life.

**Design:** We process mapped the management of patients who make a decision to withdraw from haemodialysis as an outpatient. (as opposed to an inpatient setting).

We collected all our current information:

* Treating the symptoms of kidney failure (Patient Information)
* Conservative Management of Uraemia (Information for Health Professionals)
* Symptom control in the last days of life

Our proposals for change were discussed at the renal developments meeting.

**Findings:** The gaps identified were based on previous experience and current practice.

These included:

* Acknowledgement from the renal consultant/duty consultant of dialysis withdrawal
* Ensuring current addresses/GP records and all contact details are up to date and correct on CPD and other databases (especially if patient transferred recently to residential/nursing home care)
* Timely communication from the consultant to the GP
* Timely communication with district nurses/community palliative care teams
* Ensuring there is a current DNACPR with the patient
* Late rationalisation of medicines and continuation of pain relief
* Lack of early availability of appropriate medications in the community
* The anticipatory medicine chart/ syringe driver chart was not used

Based on the gaps identified we produced a pathway for the management of these patients withdrawing from outpatient dialysis.

**Conclusion:** A withdrawal from dialysis pack has been produced which is kept on the renal dialysis unit and includes:

* A clear pathway for all staff to follow
* The anticipatory syringe driver chart
* Details on what to prescribe on an outpatient prescription
* Patient information documents to be given to patient and family
* DNACPR documentation

**Relevance:** All members of the renal team are aware of the processes to follow if a patient chooses to withdraw from dialysis as an outpatient. Although the pathway has been produced for haemodialysis patients it could be transferred to patients withdrawing from peritoneal dialysis at home.

Nurses on the renal unit and district nurses have reported a safer transfer to primary care. That the needs of patients and carers are better supported.