RVH Royal Victoria Regional Health Centre Order sets are a clinical decision aid based on best practice. All orders should be reviewed carefully and individualized where appropriate.	Addressograph/Label

Hemodialysis Treatment for Admitted Patients Order Set

Admission	Diagnosis:					
	Attending Physician:		Time Notified:		Admit to:	
	Weight (kg):_____Height (cm): _____					
	ALLERGIES ☐ NO KNOWN ALLERGY ☐ MEDICATIONS ☐ FOOD ☐ ENVIRONMENTAL ☐ LATEX					
	MEDICATIONS/FOOD		**REACTION**			

TO ACTIVATE ORDER, PLACE AN X or CHECK IN BOX or FILL IN BLANK. **PRE-CHECKED UNWANTED ORDERS MUST BE FULLY CROSSED OUT** All orders shall be DATED, TIMED, and SIGNED – All orders shall be either typed or written legibly in black ink. Action Legend: EOL-Entered online PMO-Profile Made Out K-Entered on Kardex N-Noted		Action	Initial Date Time
Dialysis Prescription	Hemodialysis treatments_____times per week. Length of treatments:_____hours ☐ Dry Weight_____kg **or** ☐ Ultrafiltration goal _____ ☐ Isolated ultrafiltration x_____hours(s) for a total of_____L PRN Dialyzer ☐Fx600 ☐Fx800 ☐ Fx1,000 ☐ Other _____ Sodium (Na+) Profile_____mmol/L Potassium (K+) bath ☐ 1 K+ ☐ 2 K+ ☐ 3 K+ Calcium (Ca++) bath ☐ 1 mmol/L ☐1.25 mmol/L ☐ 1.5 mmol/L Bicarbonate (HCO^3) ☐ 35 mEq/L ☐ 38 mEq/L ☐ Other:_____mEq/L Pump speed (QB)_____mL/minute Dialysate flow (QD) ☐ 500 mL/minute ☐ 800 mL/minute ☐ Other mL/minute _____ Temperature ☐ 36.5º Celsius ☐ Other_____ºCelsius Hemocontrol® ☐Yes ☐ No ☐ PRN		
Treatment and Monitoring	☒ For symptomatic drop in systolic BP • Turn off ultrafiltration • Administer 0.9% sodium chloride (NS) 200 mL via dialysis line • Apply oxygen with appropriate delivery device as required to achieve oxygen saturation greater than or equal to 90% • If asymptomatic after 5 minutes, resume ultrafiltration		

Prescriber's name (print):_____Signature: _____

Date: _____ Time: _____
(dd/mm/yy) (2400hr)

Hemodialysis Treatment for Admitted Patients Order Set

	• If no increase in BP in 5 minutes or a decrease in LOC, infuse an additional 0.9% sodium chloride (NS) 300 mL and notify Nephrologist		
Medications	**Circuit Anticoagulation** ☐ dalteparin 2,500 units IV via arterial port at start of each hemodialysis treatment **or** ☐ dalteparin_____units IV via arterial port at start of each hemodialysis treatment **or** ☐ heparin (1,000 units/mL) bolus_____units at the start of each hemodialysis treatment THEN ☐ heparin (1,000 units/mL) IV infusion via hemodialysis machine _____units per hour ☐ Stop heparin infusion_____minutes before end of treatment **or** ☐ 0.9% sodium chloride (NS) 200 mL IV every 30 minutes for the duration of hemodialysis treatment to maintain circuit patency **or** ☐ Anticoagulant free and 0.9% sodium chloride (NS) free each treatment **Hemodialysis Central Venous Access Device (CVAD) Locking Solutions** ☐ 0.9% sodium chloride (NS) to lumen volume in each hemodialysis CVAD lumen ☐ sodium citrate 4.0% fill to lumen volume plus 0.1 mL in each hemodialysis CVAD lumen ☐ heparin 1,000 units/mL fill to lumen volume in each hemodialysis CVAD lumen **Hemodialysis Central Venous Access Device (CVAD) Dysfunction** ☐ alteplase 2 mg IV PRN per lumen volume of hemodialysis CVAD with dwell time of 30 minutes (Maximum 2 doses in 24 hours period) **Anemia Management** ☐ ferric gluconate 62.5 mg IV every_____ given while receiving hemodialysis treatment **or** ☐ ferric gluconate 125 mg IV every_____given while receiving hemodialysis treatment ☐ Darbepoetin Alfa_____mcg IV every_____week(s) given while receiving hemodialysis treatment **or**		

Prescriber's name (print):_____Signature: _____

Date: _____ Time: _____
(dd/mm/yy) (2400hr)

RVH Royal Victoria Regional Health Centre	Addressograph/Label

Hemodialysis Treatment Orders for Admitted Patients

	☐ Epoetin Alfa_____mcg IV_____time(s) per week given while receiving hemodialysis treatment		
Additional Orders:			

**Complete all areas in signature box. Orders will not be processed without Prescriber's signature.

Prescriber's name (print): _____ Signature: _____

Date:_____ Time: _____ Prescriber's contact number:_____
(dd/mm/yy) (2400hr)

Transcriber's name (print): _____ Signature: _____ Int: _____

Date: _____ Time: _____
(dd/mm/yy) (2400hr)

Transcriber's name (print):_____ Signature: _____ Int: _____

Date:_____ Time: _____
(dd/mm/yy) (2400hr)

RVH-PPO-0306

R.PPOHTA

Copy sent to Pharmacy ➤