PHILIPPINE SOCIETY OF NEPHROLOGY

Guidelines for Nephrologist in the Operation of Hemodialysis Clinics in the Philippines

3rd Edition

2024

MESSAGE FROM THE PRESIDENT

To our Dear Members,

We are delighted to announce the launch of the highly anticipated 3rd edition of the Hemodialysis Guidelines, meticulously crafted by the Hemodialysis Committee of the Philippine Society of Nephrology (PSN). This momentous occasion marks another significant step forward in our continuous pursuit of service excellence in the field of hemodialysis.

The Hemodialysis Guidelines, now in its third iteration, reflect the extensive collaborative efforts and expertise of our esteemed committee members, who have dedicated countless hours to ensure that this edition remains practical, current, comprehensive, and aligned with the latest advancements in nephrology. It also includes the input of our members all over the country who are at the forefront in caring for and managing our hemodialysis patients.

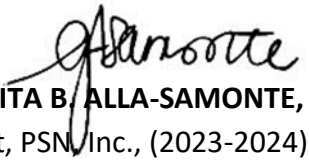
This updated edition encompasses a wealth of information and evidence-based recommendations, covering a wide range of topics crucial to the service of hemodialysis. Distinctly, one of the key strengths of these Guidelines lies in its focus on the unique challenges and considerations specific to the Philippine setting. In combining international best practices with local expertise and experiences, we have created a resource that is tailor-made to address the needs of the Filipino patient and present healthcare system. This edition of the Guidelines details the steps on how the different stakeholders, especially us Nephrologist, approach the service of hemodialysis to our patients.

We would like to express our deepest gratitude to the members of the Hemodialysis Committee of the Philippine Society of Nephrology for their unwavering commitment and dedication in developing these Guidelines. Their tireless efforts in gathering data, experiences, clinical situations and synthesizing them to recommendations resulted in a comprehensive document that will undoubtedly enhance the quality of care provided to hemodialysis patients across the Philippines.

We encourage all healthcare professionals involved in the service of hemodialysis to familiarize themselves with the Guidelines and incorporate its recommendations into their

daily practice. By doing so, we can collectively improve patient outcomes, enhance safety, and elevate the standards of hemodialysis care in the Philippines.

In conclusion, we celebrate the release of the 3rd edition of the Hemodialysis Guidelines with great pride and anticipation. May these Guidelines serve as a beacon of knowledge and guidance, empowering healthcare professionals to deliver the highest standard of care to our patients. Together, let us continue to strive for excellence and make a lasting impact in the field of nephrology.



GINGERLITA B. ALLA-SAMONTE, MD, FPCP, FPSN,
President, PSN, Inc., (2023-2024)

FOREWORD

The Committee on Hemodialysis was tasked by the Board of Trustees of the Philippine Society of Nephrology (PSN) in 2022 to review and make recommendations on the revision of the PSN Guidelines for Nephrologists in the Operation of Hemodialysis Centers in the Philippines (Second Edition, 2016) to address the gaps as well as improve the quality of service to our patients. The practice of nephrology has evolved very fast in the past eight (8) years, and we need to adapt to the challenges and changes in the working field, correct and improve the provisions based on the actual scenarios on the ground. We need to improve and enhance the less-than-ideal working conditions of our Nephrologists to a level at par with other healthcare professionals.

Moreover, the security of our members' professional licenses is constantly under threat because of incidents of negligence or mistakes by the dialysis unit's staff. Court and administrative cases have been filed, accreditations have been denied or withheld putting our colleagues to the disadvantage and causing emotionally, physically, economically harm to our members, their families, and their patients. Heartbreaking incidents that were very rare in the past, have been occurring with disconcerting frequency nowadays.

In these updated hemodialysis guidelines, the respective roles of medical practitioners and non-medical staff are defined with more clarity and substance. The Dialysis Clinical Head's responsibility is properly defined to be purely clinical. Moreover, with the help of the Committee of Third-Party Payors, honoraria and professional fees must comply with minimum standards. Expected expenses for distant travel, added security for high-risk conditions, and other benefits like medical malpractice insurance have also been included. Liabilities for misdeeds are properly allocated and ascribed to appropriately liable personalities or entities, and not to innocent victims. The Dialysis Unit Heads' meeting on April 27, 2023, during our annual convention, the Hemodialysis Summit on May 19, 2023, and the series of Townhall meetings in 2023 provided the hemodialysis committee valuable inputs from our members and some are now incorporated in the proposed updated guidelines.

I praise to the highest degree our PSN members who continue to deliver exceptional and outstanding services to patients despite very challenging working conditions in the mine

fields of hemodialysis practice, and notwithstanding the specter of a tsunami of administrative or criminal cases.

I salute also all our hardworking committee members for their passion and courage in coming up with the updated guidelines. Likewise, I thank the lawyers for their legal contribution including issues on competition law and the Ethicists to make the provisions proper and presented in the right perspective.

Our joy and satisfaction will be complete if the major provisions of these revised guidelines will be adopted by our partner government agencies who equally work with passion and commitment to provide the standard of care rightfully deserved by our patients, and that will work for the betterment of our beloved country.

GLENN R. BUTUYAN, MD, FPCP, FPSN
Chair, Committee on Hemodialysis
Member, PSN Board of Trustees

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I. RATIONALE/BACKGROUND

Every Hemodialysis Clinic (HDC) shall have an adequate number of qualified, trained, and competent staff to ensure efficient and effective delivery of Hemodialysis (HD) services. The staff composition will depend on the workload and the services being provided.

II. DEFINITION OF TERMS

For purposes of this Guidelines, the succeeding terms and acronyms shall have the following definitions:

1. **Advanced Cardiac Life Support (ACLS) -** a group of interventions used to treat and stabilize victims of life-threatening cardio-respiratory emergencies and to resuscitate victims of cardiac arrest. It also refers to a training course sponsored by the American Heart Association that instructs healthcare providers in basic and advanced resuscitation techniques.
2. **Adverse Event -** injury caused by medical management (and not necessarily the disease process) that either caused death, prolonged hospitalization, or produced a disability at the time of discharge.
3. **Applicant -** a natural or juridical person applying for a license to operate an HDC.
4. **Association for the Advancement of Medical Instrumentation (AAMI) -** an organization promoting knowledge and medical instrumentation use. It creates standards, educates, and certifies technicians; and publishes technical documents, books, periodicals, and software. Its Recommended Practices and Standards constitute a significant resource for healthcare guidelines. Noncompliance with these standards is cited by regulatory organizations that inspect healthcare facilities.
5. **Attending Nephrologist (AN)** – is a qualified Nephrologist in-charge of the over-all medical management of a patient on dialysis in an HDC.
6. **Blood Center (BC) –** a DOH accredited unit involved in recruitment, retention, screening, and selection of voluntary donors for collection of blood, testing for Transfusion Transmitted Infections (TTIs), processing and provision of blood components including its storage, issuance/release, transport, and distribution of whole blood and/or blood products to hospitals and/or other health facilities.
7. **Blood Collecting Unit (BCU) –** a DOH accredited unit primarily involved in recruitment, retention, selection, and screening of voluntary blood donors for the collection of blood (mobile of facility based) which is then transported to BC for testing and processing.
8. **Basic Life Support (BLS)-** is a set of essential emergency procedures designed to sustain life in individuals experiencing cardiac arrest, respiratory failure, or other life-threatening conditions.

9. **Blood Service Facility (BSF)-** It is a unit, agency, or institution providing blood products. The types of BSF are BS (Blood Station), BCU, Hospital BB (Blood Bank), and BC (Blood Center), such as Regional, Sub-national and National BC.
10. **Blood Services Network (BSN)-** an organization composed of the designated BCs, hospital BCs, BCUs, BSs, (Blood Stations) end-user hospitals, and other health facilities established to provide for the blood needs of a specific geographical area.
11. **Board-Certified Physician -** a physician who is a Diplomate and/or a Fellow of a medical specialty and/or subspecialty society recognized by the Philippine Medical Association and certified by the corresponding medical specialty and/or subspecialty board.
12. **Board Eligible Physician** - a physician who finished or completed an accredited medical specialty and/or subspecialty residency/fellowship training program approved by the corresponding medical specialty and/or subspecialty board.
13. **Center for Health Development (CHD)-** the regional office of DOH.
14. **Continuous Kidney Replacement Therapy (CKRT)-** includes a spectrum of dialysis methods specifically for the treatment of critically ill patients with acute kidney injury who could not undergo traditional intermittent hemodialysis because of hemodynamic instability or in whom intermittent hemodialysis could not control volume or metabolic derangements. CKRT modalities include continuous venovenous hemofiltration (CVVH), continuous venovenous hemodialysis (CVVHD), and continuous venovenous hemodiafiltration (CVVHDF). This is a treatment option for a selected group of patients or medical conditions as recommended by the Attending Nephrologist with the patient's consent.
15. **Department of Health (DOH)-** the lead government agency mandated to be the over-all technical authority on health. It is tasked to provide national policy direction and develop national plans, technical standards, and guidelines on health.
16. **Department of Health- Permit to Construct (DOH-PTC)-** issued by DOH through HFSRB to an applicant who will establish and operate an HDC upon compliance with required documents outlined in this Order before the actual construction of the subject facility. A DOH-PTC is also required for HDC with substantial alteration, expansion, renovation, or increase in HD stations. It is a prerequisite to LTO.
17. **Dialysis-** a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane. It is a cleansing process using dialyzing equipment (artificial kidney) and appropriately recognized procedures.
18. **Dialysis Clinical Head (DCH)-** a qualified nephrologist or non-nephrologist in-charge of the clinical aspect of the HDC. It used to be termed as Medical Director in non-hospital based HDC and Dialysis Unit Head in hospital based HDC.
19. **Dialysis Station -** a designated portion of HDC that accommodates the materials of at least 6 square meters capable of accommodating a dialysis chair or patient bed, a dialysis machine, and emergency equipment should the need arise.
20. **Emergency Hemodialysis -** a non-scheduled dialysis procedure that requires immediate treatment for a life-threatening condition that needs to be addressed such

as but not limited to volume overload, symptomatic and intractable hyperkalemia, drug toxicity and uremia. This could be due to a severe acute kidney injury (AKI) or chronic kidney disease (CKD).

21. **End Stage Kidney Disease (ESKD) -** previously called End Stage Renal Disease (ESRD), a term synonymous with "Stage V Chronic Kidney Disease", a severe illness with poor life expectancy if untreated. It is the complete or almost complete failure of the kidneys to function.
22. **End-User Hospital-** a hospital with a licensed clinical laboratory capable of red cell typing and cross-matching and which does not have any BSF but only receives blood and blood components for blood transfusion as needed.
23. **End-User Non-Hospital Health Facility-** a licensed/accredited non-hospital health facility without a licensed clinical laboratory but administers blood transfusion such as a dialysis clinic and birthing home under the supervision of a licensed physician/s.
24. **Extended Treatment-** hemodialysis treatment that goes beyond the routine/conventional 4 hours of treatment not necessarily decreasing the blood flow rate and dialysate flow rate but aims to remove more fluid and toxins.
25. **Hemodialysis (HD)-** a medical procedure whereby a machine delivers the patient's blood to a dialyzer (blood filter) to remove metabolic wastes and restore fluid and electrolyte balance.
26. **Hemodialysis Clinic (HDC) –** a DOH accredited facility that conducts hemodialysis procedures. It was previously called Hemodialysis Center (for non-hospital based) and Hemodialysis Unit (for hospital based). The list of DOH licensed HDC is posted at DOH website www.doh.gov.ph.
27. **Health Facilities and Services Regulatory Bureau (HFSRB) -** the regulatory body of DOH charged with the licensing function under these rules and regulations.
28. **Hemodiafiltration (HDF)-** is a form of kidney replacement therapy (KRT) that utilizes convection combined with diffusive clearance. Compared with conventional hemodialysis, HDF removes more middle-molecular-weight solutes. It also requires a double pass RO system. This is a treatment option for a selected group of patients or medical conditions as recommended by the Attending Nephrologist with the patient's consent.
29. **Hemoperfusion (HP)/ Hemadsorption -** is an extracorporeal technique utilized for blood purification. It complements convection and diffusion (the main modalities of solute removal). It involves blood (or plasma) passing through an adsorption cartridge, where solutes are removed by direct binding to the sorbent material. This is a treatment option for a selected group of patients on the recommendation of the Attending Nephrologist with the consent of the patient.
30. **License to Operate (LTO) -** a formal authority issued by DOH to an individual, agency, partnership, or corporation to operate a non-hospital-based HDC.
31. **One-Stop Shop (OSS) -** a strategy of DOH to harmonize the licensure of hospitals, their ancillary and other facilities including, but not limited to, HDC. Under the One-Stop Shop, a hospital-based HDC is not required to secure a separate LTO. The provision of

HD in a hospital shall be reflected in the hospital LTO upon full compliance to this Order.

32. **Physician On Duty (POD)** – a qualified Physician who is on Duty during the daily operations of an HDC.
33. **Patient-** refers to a person admitted to and receiving care in an HDC.
34. **Patient Medical Record-** a compilation of pertinent facts about a patient's life and health history including past and present illnesses and treatment written by health care professionals caring for the patient.
35. **Philippine Renal Disease Registry (PRDR) -** a compilation of data of all dialysis patients in the country. It was institutionalized under the National Epidemiology Center of DOH by virtue of A.O. No. 2009-0012.
36. **Philippine Society of Nephrology (PSN)** – an organization of Nephrologists (Kidney Disease Specialists) in the Philippines.
37. **Philippine College of Physicians (PCP)** – an organization of Internists (Internal Medicine Specialists) in the Philippines.
38. **Portable RO** – an RO system that produces the same quality of water needed for Hemodialysis treatment that can be transported in different areas of the healthcare facility like ICU, Isolation, or Emergency Room where it is needed.
39. **Renal Disease Control Program (REDCOP) –** used to be with the National Kidney Transplant Institute (NKTI) but is now transferred to the DOH as the main implementing agency of REDCOP. The Renal Disease Control Program addresses all levels of renal disease prevention (health promotion, primary, secondary, tertiary prevention including prevention of death of ESRD patients through transplantation and organ donation) by conceptualizing planning, implementing projects and activities on research, training, advocacy, service, and quality assurance.
40. **Refurbished HD Machine-** a pre-owned HD machine sent back to the supplier with the capability to recondition and calibrate the unit to specifications.
41. **Reverse Osmosis (RO) -** a filtration method that removes many large molecules and ions from solutions by applying pressure when it is on one side of a selective membrane. The result is that the solute is retained on the pressurized side of the membrane, and the pure solvent is allowed to pass to the other side. It represents the ultimate in ultra-filtration.
42. **Routine or Conventional Hemodialysis-** a regular intermittent hemodialysis treatment of 12h or less per week.
43. **Sustained or Slow Low-Efficiency Dialysis (SLED)** - also known as **Extended Daily Dialysis** is a form of treatment wherein a conventional hemodialysis equipment is modified to provide extended-duration dialysis using lower blood flow and dialysis flow rates for a select group of patients on the recommendation of the Attending Nephrologist and with the patient's consent.
44. **Unit Manager of Hospital (UMH)**- the manager in-charge of the administrative aspect and daily operations of a hospital based HDC.

45. **Unit Operations Manager (UOM)** – the manager in-charge of the administrative aspect and daily operations of the non-hospital based HDC.
46. **Water Treatment**- treating water used for HD to maintain a continuous water supply that meets the provisions of AAMI "Standards for Water for Hemodialysis."

III. SPECIFIC STANDARD

Every HDC shall be organized to provide safe, quality, effective and efficient HD services.

A. PERSONNEL

1. Medical Personnel

1.1 Dialysis Clinical Head (DCH) of HDC

The Dialysis Clinical Head oversees the medical operations of the unit and ensures that all dialysis procedures established and implemented in the unit are within acceptable norms of practice and regulatory standards. The position is different from that of a medical director in a hospital facility.

a. Qualification

a1. Every HDC shall have a Dialysis Clinical Head who is duly licensed by the Professional Regulations Commission (PRC) and should be a nephrologist certified by the Philippine Specialty Boards of the Philippine Society of Nephrology (PSN). The Philippine Society of Nephrology shall regularly provide DOH with an updated list of its board-certified members.

a2. He /she shall be in practice in the local area that is easily accessible to the HDC.

a3. He/she shall have a Certificate of Attestation (for Nephrologist) or Certificate of Attestation for No Available Nephrologist (for non-Nephrologist) from PSN.

a4. He/she shall have a PSN or Local Chapter Endorsement for Dialysis Clinical Head to ensure that he/she is in good standing (for Nephrologist).

a5. Whenever a board-certified nephrologist is not readily available for the position within the city, municipality, province, or nearby areas where the HDC is located, the HFSRB /CHD shall allow the following physicians to handle the HDC in order of priority:

i. Board Eligible in Nephrology

ii. Board certified in Internal Medicine (IM) / Pediatrics with work experience in any DOH licensed HDC for at least six (6) months.

iii. Board eligible in Internal Medicine (IM) / Pediatrics with work experience in any DOH licensed HDC for at least six (6) months.

iv. General Practitioner with work experience in any DOH licensed HDC for at least six (6) months in areas identified by the DOH to be in need.

a6. The training of a non-nephrologist for the position of Dialysis Clinical Head shall be in accordance with the training and accreditation guidelines set and developed by PSN.

a7. The non-board-certified nephrologist shall be allowed to handle an HDC for a maximum of 3 years with an undertaking signed by the owner to provide a replacement as soon as a board-certified nephrologist is available. The Local Chapter of PSN shall monitor and recommend to the HDC a replacement once available.

a8. The non-nephrologist physician shall be allowed to handle only one (1) HDC for a period of one year with undertaking signed by the owner to provide a replacement as soon as a nephrologist is available. The Local Chapter of PSN shall monitor and recommend to the HDC a replacement once available.

a9. In cases when a non-board-certified nephrologist or a non-nephrologist is functioning as Dialysis Clinical Head, a board-certified nephrologist shall be designated by PSN through the local Chapter to assist and guide the non-board certified and non-nephrologist in managing the HDC and their patients.

a10. The justification for the need to open an HDC in an area where there is no readily available board-certified nephrologist to head the HDC shall be endorsed by the PSN local chapter to the Hemodialysis Committee for evaluation and once approved it will be submitted to DOH prior to its licensing.

a11. The Dialysis Clinical Head shall receive compensation as determined within the current guidelines set by the PSN.

a12. There should be a service contract agreement between the Dialysis Clinical Head and the HDC owner or representative which shall include among others the appropriate compensation for the Dialysis Clinical Head of the HDC.

b. The Duties and Responsibilities – of the HDC Dialysis Clinical Head shall be, but not limited to the following:

b1. He/she shall be involved in the design and planning of the HDC prior to application of Permit to Construct (PTC).

b2. He/she shall oversee the implementation of the following:

i. Overall Patient care in the unit – considering the disease and his/her co-morbidities.

ii. Hemodialysis access – needle, cannulation protocol, catheter care and treatment of access complications.

iii. Dialysis Solutions which include ensuring safe water, storage, mixing and delivery of dialysate fluid.

iv. Safe and functional equipment which includes the dialysis machine, machine-pump, dialyzer, ultrafiltration system, alarms, and fail-safe mechanism.

v. Operator skills and competence in the delivery of prescribed dose and treatment protocol in the management of hemodialysis and its complications.

b3. He/she shall provide the HDC owners or representatives with the medical operations requirements of the DOH and discuss the same with the Unit Operations Manager (UOM) of the nonhospital based HDC, or the Unit Manager of a hospital based HDC as well as answer questions of the latter.

b4. He/she shall develop or provide guidelines, internal medical protocol, policies and procedures on dialysis and related treatment in accordance with the standards formulated by DOH and PSN and imposed upon the owners or management of the HDC to implement.

b5. He/she shall set the requirements on education and performance criteria, assess the credentials of its medical employees to ensure they are qualified for their respective positions before they are hired by the owners of the HDC.

b6. He/she shall identify the training needs and gaps in knowledge and skills of the Hemodialysis staff, require and initiate training programs for the HDC staff for certification of continuous improvement of knowledge and skills.

b7. He/she shall initiate, support, and implement Quality Assessment and Performance Improvement (QAPI) activities, which shall be documented.

b8. He/she shall recommend and require the HDC owners and the Unit Operations Manager or Unit Manager of Hospital to strictly implement compliance with infection control and surveillance practices in the HDC.

b9. He/she shall coordinate with the HDC owners and Unit Operations Manager or Unit Manager of Hospital to ensure that qualified medical professionals, including physicians-on-duty who will be involved in the day-to-day operations of the HDC, are present.

b10. He/she shall conduct Continuous Quality Improvement (CQI) meetings in the HDC at least once a month. The CQI meetings shall be documented.

b11. He/she shall recommend strict water quality standards based on applicable AAMI guidelines including but not limited to the following:

i. Programs and policies to ascertain safe mixing of water and dialysate.

ii. Monitoring of safe water regulations and specifications.

iii. Installation of a complete water treatment and distribution system that meets applicable requirements and standards.

b12. He/she shall visit the HDC at least four (4) times a month or once (1) a week. In Geographically Isolated and Disadvantaged Areas (GIDA) two (2) consecutive days two (2) times a month is allowed if the Unit Operations Manager or Unit Manager of Hospital is continuously coordinating with him/her. The HDC visit shall be documented. During calamities, man-made or natural disaster, pandemic or other exigencies that prevent physical visit to the HDC, he/she must do a virtual visit through teleconference which should be properly documented.

b13. The Board Certified and Board Eligible Nephrologist shall handle a maximum of three (3) HDCs. However, in areas where there is a limited number of nephrologists, or no nephrologist in GIDA, or there is no trained non-nephrologist physician available to take the position, then he/ she shall be allowed to handle a maximum of five (5) HDCs.

b14. He/she shall require the HDC to allow patients to choose their own Attending Nephrologist (AN) who are qualified to practice in the area and has satisfied the requirements set by the HDC.

b15. If the Dialysis Clinical Head is a co-owner of the HDC he/she should not be the exclusive AN to all patients.

c. The Dialysis Clinical Head shall not be responsible for the following.

c1. It is not the responsibility of the Dialysis Clinical Head to monitor and supervise the day-to-day operations of the Dialysis Clinic. It being understood that the HDC Company shall appoint and maintain a Unit Operations Manager or Unit Manager of Hospital who will closely monitor the day-to-day operations, including the proper and truthful filling of claims, of the HDC. However, the Dialysis Clinical Head should be updated often on the operations of the HDC and should be properly documented.

c2. It is not the responsibility of the Dialysis Clinical Head to personally check daily the equipment, medicines, and medical tools and supplies of the HDC. The HDC Company shall ensure that these responsibilities are performed by its competent staff.

c3. It is not the responsibility of the Dialysis Clinical Head to be responsible for the professional negligence of the other medical and non-medical personnel employed by the HDC. The HD Center Company shall ensure that the Dialysis Clinical Head shall be freed

from such liability, and appropriately reimburse the latter for any such liabilities incurred by the Dialysis Clinical Head.

c4. It is not the responsibility of the Dialysis Clinical Head to act as employer of the HDC. All responsibilities and liabilities of an employer shall be the exclusive obligations of the HDC Company.

d. Recommended Monthly Compensation of Dialysis Clinical Head

d1. Recommended Minimum Monthly Salary based on the number of Stations approved by DOH and net of VAT.

i. Five (5) Station or less: Php. 15,000

ii. Six (6) to Ten (10) stations: Php. 20,000

iii. Eleven (11) to Fifteen (15) stations: Php. 30,000

iv. Sixteen (16) to Twenty-five (25) stations: Php. 40,000

v. Twenty - six (26) to thirty (30) stations: Php. 50,000

vi. Thirty-one (31) or more stations: Php. 50,000 + Php 1000/station in excess.

vii. Mega Dialysis (more than fifty (50) stations): Php. 75,000

viii. LGU Model; Non-Plantilla or Private-Public Partnership: Php. 25,000 or more

ix. Government Hospitals or LGU; Plantilla - Minimum of MS (Medical Specialist) 1 category

d2. Additional Benefits and Compensation

i. More than 50 kms distance from place of practice/residence – Php 5,000/month.

ii. GIDA – roundtrip fare plus board and local transportation

iii. High-risk areas – travel insurance

iv. One (1) HDC sponsored PSN accredited conference or postgrad in the country yearly with free registration, accommodation, and transportation.

v. Priority decking privileges

vi. Sponsored training on ACLS/BLS

vii. Free flu, pneumococcal and hepatitis vaccination

viii. Free Hepatitis profile yearly

ix. Free clinic space

x. Incentives or bonus/es

xi. In the event the Dialysis Clinical Head loses his/her PhilHealth accreditation because of the wrong doings or negligence of the HDC company or any of its staff, the

Dialysis Clinical Head shall receive a compensation of One hundred fifty thousand to two hundred thousand pesos (Php 150,000-200,000) per month for loss of income from patients on PHIC until such time that he/she recovers PhilHealth accreditation.

e. Legal actions against the Dialysis Clinical Head

Any wrongdoing committed by any employee, officer, or by the HDC Company, or actions done which do not conform to the standards and procedures provided by the Dialysis Clinical Head, including but not limited to medical malpractices and negligence, tampering of files, deceased or fraudulent claims, and stealing, shall not make the Dialysis Clinical Head liable in any and all criminal, civil, and administrative cases. It shall be the sole and exclusive responsibility of the HDC Company to ensure that such incidents will not happen. In case the Dialysis Clinical Head is included in any such court, quasi-court, or administrative actions, he shall engage the services of a lawyer of his own choice to independently represent his defense, and the HDC Company shall fully and promptly pay and/or reimburse all expenses incurred for said purpose.

1.2. Attending Nephrologist (AN)

a. Qualification

a1. Every dialysis patient shall have an Attending Nephrologist (AN) who is duly licensed by the Professional Regulations Commission (PRC) and who should have completed training in nephrology in a PSN accredited and/or recognized training institution. The Philippine Society of Nephrology shall regularly provide DOH with an updated list of its Nephrologists.

a2. He/she shall be in practice in the local area that is easily accessible to the HDC.

a3. He/she shall apply at the HDC unit for affiliation and must submit all necessary credentials required by the HDC. The following are the required credentials:

i. Curriculum Vitae.

ii. Updated PHIC accreditation.

iii. Updated PRC license.

iv. PSN/Local Chapter Endorsement for Attending Nephrologist.

b. Duties and Responsibilities

b1. He/she shall provide information regarding all options for patients with end stage kidney disease (ESKD). This should be

properly documented, and the informed consent form is preferably witnessed by two people who shall also sign the form. The HDC should have a copy of this consent form attached to the medical chart.

b2. He/she shall perform a complete clinical assessment prior to initiation of hemodialysis.

b3. He/she shall coordinate with a vascular surgeon or trained general surgeon regarding provision and care of the patient's vascular access.

b4. He/she shall provide the initial and maintenance dialysis prescription.

b5. He/she shall provide a complete medical abstract with dialysis prescription and list of current medications when needed.

b6. He/she shall provide at least once a month consultation with a patient, preferably face to face or if necessary, through telemedicine using the following acceptable virtual platforms:

    i. Audiovisual device (smartphones, tablets, Computer, etc.)

    ii. Video conferencing communication platform (Zoom, MS Teams, Messenger, Viber, etc.)

b7. He/she shall be in active management with the physician on duty (POD) and nurse on duty (NOD).

b8. He/she shall coordinate with the dialysis nurses and/or physician on duty in cases of emergencies.

b9. He/she shall discuss thoroughly and perform long-term medical planning with the patient.

b10. He/she shall coordinate with other HDC and provide documentary requirements including Hemodialysis Patient's Endorsement Form (HPEF) in case the patient plans to travel, transfer residence, or transfer to the care of another nephrologist.

b11. He/she shall comply with the documentary requirements for the availment of Patient's hemodialysis benefits from PhilHealth, PCSO, DSWD and/or other payors.

b12. He/she shall provide a proper endorsement (letter and/or call) in case his/ her patient is admitted under the care of another nephrologist.

b13. He/she shall receive compensation/ professional fee as an attending nephrologist as set within the current PSN guidelines.

b14. No physician shall accept any gift or monetary consideration from the HDC in the form of rebate fees and the likes.

c. Recommended Minimum Professional Fee (PF) for regular hemodialysis treatments in the Outpatient (OPD).

c1. For PhilHealth 'Indigent Sponsored Program' in government HDCs and HMOs- No balance billing.

c2. With PhilHealth, nonhospital based HDC (regular PhilHealth members) – Php 800/session.

c3. With PhilHealth, private hospital based (regular PHIC members) – Php 800/session; Without PhilHealth, Pay Patient – Php 800/session.

c4. Without PhilHealth, on PCSO – Php 800/session

c5. Non-HMO Third Party Payor – Balance Billing of PF (difference of Third-Party PF and AN's minimum PF (Php 800/session)

c6. True Indigents – may waive co-pay, under discretion and written instruction from AN

c7. For packaged HD treatments (with cash payments on top of PhilHealth, PCSO and other third-party non-HMO payors)

c8. After the PHIC case rate treatment benefit has been consumed, the non-PhilHealth case rate (Php 800/session) will be applied.

c9. Any other Package treatment: Php 800/session minus PF incorporated in the package.

c10. HD+HP (Hemoperfusion) - Php 1,500/session

c11. LGU or Government Units- Non-Plantilla: 60-100 % of PhilHealth share.

d. Recommended Minimum Professional Fee (PF) FOR IN-PATIENTS

d1. Routine HD treatment – Php 1, 000 /session

d2. Critical (ICU Setting) Conventional HD – Php 1,500/session

d3. Emergency (non-ICU setting) Conventional – Php 1,200 /session

d4. SLED (Slow Low Efficiency Dialysis) – Php 1, 500/session.

d5. CKRT (Continuous Kidney Replacement Therapy)- minimum of Php 3,000/day

e. Recommended Minimum PF FOR EMERGENCY DIALYSIS TREATMENTS (OPD)

e1. Emergency, non-scheduled HD Treatment, during office hours – Php 800.

e2. Emergency HD treatment, beyond office hours – Php 1,200 /treatment

e3. Extended Treatment – Php 1,500

f. These recommended fees shall be reviewed periodically by the PSN Board as deemed necessary in consultation with the members of the Society.

g. Compensation for Loss of PhilHealth Accreditation or PRC License incurred by negligence of the HDC Company

In the event the Attending Nephrologist loses his/her PhilHealth accreditation because of the wrong doings or negligence of the HDC or any of its staff, the Attending Nephrologist shall receive a compensation of One hundred fifty thousand to two hundred thousand pesos (Php 150,000-200,000/ month) for loss of income from Patients on PHIC until such time that he/she recovers PhilHealth accreditation.

h. Legal actions against the Attending Nephrologist

Any wrongdoing committed by any employee, officer, or by the HDC Company, or actions done which do not conform to the standards and procedures including but not limited to medical malpractices and negligence, tampering of files, deceased or fraudulent claims, shall not make the Attending Nephrologist liable in any and all criminal, civil, and administrative cases. It shall be the sole and exclusive responsibility of the HDC Company to ensure that such incidents will not happen. In case the Attending Nephrologist is included in any such court, quasi-court, or administrative actions, he shall engage the services of a lawyer of his own choice to independently represent his defense, and the HDC Company shall fully and promptly pay and/or reimburse all expenses incurred for said purpose.

i. Non-compliance of Nephrologist to the HD Guidelines

i1. Non-compliance of PSN members with these guidelines shall be reported to and initially handled by the HD Committee of the Chapter. In case the Chapter is not able to resolve the issues then it will be elevated to the PSN HD Committee or to the Ethics Committee for appropriate action.

i2. The Local Chapter handling the case should ensure that all sides are heard and considered before making decisions or endorsing it to the PSN HD Committee or Ethics Committee.

1.3. Physician on Duty (POD)

a. Qualification

a1. Every HDC shall have a physician on duty (POD) who is duly licensed by the Professional Regulations Commission (PRC) and attends to the acute care of hemodialysis patients during their treatment session under the supervision of the Attending Nephrologist and Dialysis Clinical Head and in order of priority:

i. Board certified in Nephrology.

ii. Board Eligible in Nephrology

iii. Board certified in IM/Pedia with work experience in any DOH licensed HDC for at least three months.

iv. Board eligible in IM/Pedia with work experience in any DOH licensed HDC for at least three months.

v. Nephrology fellows-in training in hospital based HDC with nephrology fellowship training program.

vi. In Hospitals with a PCP accredited training program, Internal medicine residents rotating in nephrology and/or senior medical residents may assist in the HDC as stipulated in their training program manual with at least three (3) months of work experience in any DOH licensed HDC or its equivalent (to be determined by the CME Committee).

vii. In Private Hospitals, Residents on Duty with work experience in any DOH licensed HDC for at least six months.

viii. Family Medicine/General Practitioner with work experience in any DOH licensed HDC for at least six (6) months.

a2. He/she shall have an updated certificate of training in advance cardiac life support (ACLS) conducted by a DOH accredited provider.

a3. He/she shall have an updated certificate of training in a PSN conducted/accredited post-grad course for POD.

a4. The ratio of POD to the number of HD patient stations is ideally 1:15 but if there is limited number of PODs in the area a maximum of 1:20 is allowed as long as he/she is able to adequately attend to the needs of the patients.

b. Duties and Responsibilities

b1. He/she shall provide acute care to patients undergoing HD during his/her tour of duty based on the rules and regulations established by DOH and approved company policies and procedures.

b2. He/she shall communicate with and update the AN regarding the acute problems and medical emergencies pre-, intra- and post-dialysis treatment. No referral to other specialty/ies will be made without the knowledge of the AN or the Dialysis Clinical Head.

b3. He/she shall carry out the AN's order and prescription and accomplish the doctor's progress notes.

b4. He/she shall refer and endorse patients requiring admission to a hospital when necessary.

b5. He/she must be physically present during hours of operations of HDC.

b6. He/she shall document clinical findings and coordinate with the AN regarding the patients' conditions and long-term management.

b7. He/she shall evaluate all patients during his/ her tour of duty and document all findings and orders.

b8. He/she shall review previous treatment records, previous orders if done/not done, relay and interpret new laboratory tests in coordination with the AN.

b9. He/she shall attend to the patient's acute needs and apply the immediate measures as necessary in coordination with the AN and HDC nurse.

1.4. Dialysis Head Nurse

a. Qualification

a1. Every HDC shall have a head nurse who is duly licensed by the Professional Regulations Commission (PRC) in accordance with R.A No. 9173 known as the "Philippine Nursing Act of 2002."

a2. He/she shall have a certificate of training in the nursing care of renal dialysis patients from a structured training program for three (3) months or more if necessary. The following topics should be included in the program:

i. Principles of Renal functions, laboratory interpretations, Nutrition, and psychological changes including management of disruptive behaviors.

ii. Indications and principles of hemodialysis, hemodialysis prescription, proper assessment pre and post dialysis, complications of dialysis and its management, vascular access care and evaluation and aim for promoting longevity of dialysis patients.

iii. Disaster preparedness, and role in emergency situations

iv. Understanding roles of each member of the hemodialysis team and cultivating professionalism.

a3. He/she shall have an updated certificate of training in Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS) conducted by a DOH accredited provider.

a4. He/she shall have at least two (2) years' experience as a dialysis nurse.

b. Duties and Responsibilities

b1. He/she shall assess, plan, organize and analyze systems in providing proper nursing service.

b2. He/she shall review any information on the delivery of care and evaluate its outcome.

b3. He/she shall plan, organize, and assess all nursing activities.

b4. He/she shall conduct regular bedside teaching or conference to the HDC medical staff.

b5. He/she shall assess staffing patterns and determine the assignment given to each medical staff and analyze its effectiveness.

b6. He/she shall ensure for a reliever to staff nurses on emergency/unplanned absences.

b7. He/she shall ensure strict implementation of infection control in the unit.

b8. He/ she shall initiate, schedule, and attend CQI meeting with the Dialysis Clinical Head and the rest of the staff.

b9. He/ she shall create plans or solutions together with the Dialysis Clinical Head on current identified problems of the unit.

1.5. Dialysis Nurse

a. Qualification

a1. Every HDC shall have a dialysis nurse who is duly licensed by the Professional Regulations Commission (PRC) in accordance with R.A. No. 9173 known as the "Philippine Nursing Act of 2002.

a2. He/she shall have a certificate of training in the nursing care of renal dialysis patients from a structured training program for three (3) months or more if necessary. The following topics should be included in the program:

i. Principles of Renal functions, laboratory interpretations, Nutrition, and psychological changes including management of disruptive behaviors.

ii. Indications and principles of hemodialysis, hemodialysis prescription, proper assessment pre- and post-dialysis, complications of dialysis and its management, vascular access care and evaluation and aim for promoting longevity of dialysis patients.

iii. Disaster preparedness, and role in emergency situations

iv. Understanding roles of each member of the hemodialysis team and cultivating professionalism.

a3. He/she shall have an updated certificate of training in Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS) conducted by a DOH accredited provider.

a4. The ratio of dialysis nurses to the number of HD patients shall not be more than 1:4 per shift. However, in the presence of a Nursing assistant it could be increased to 1:6.

b. The duties and responsibilities of an HDC nurse are, but not limited to the following:

b1. He/she shall properly orient each patient on the policies of the HDC as well as their rights and privileges and the role of his/her AN. An instructional video will be beneficial for this purpose.

b2. He/she shall provide direct care to patients undergoing Hemodialysis based on the rules and regulations established by DOH and approved HDC policies and procedures.

b3. He/she shall check and prepare all materials needed and ensure it is available before the start of dialysis session.

b4. He/she shall carry out doctors' orders and ensure that dialysis procedures are performed accordingly.

b5. He/she shall assess each patient using the nursing care protocols before, during and after dialysis treatment.

b6. He/she shall communicate with and update the AN and POD regarding identified medical problems pre-, intra- and post- dialysis treatment and initiate appropriate nursing intervention based on internal medical protocols of the HDC.

b7. He/she shall maintain an open and clear line of communication relaying and documenting information and data as required by the HDC.

b8. He/she shall assess, inspect, regulate, and monitor all machine settings and parameters and address properly any alarm/alert during the course of HD treatment.

b9. He/she shall prepare the patient's dialysis access using the required standards of care.

b10. He/she shall update the patient's medical record including progress notes, medication given, interventions done, and new prescriptions from the AN or POD during and after every dialysis session.

b11. He/she shall administer medications as prescribed by the AN or the POD with proper monitoring and documentation.

b12. He/she shall initiate/perform Cardio-Pulmonary Resuscitation (CPR) in coordination with the POD or AN in the event a patient goes into cardiac and/or pulmonary arrest in an organized manner with proper documentation.

b13. He/she shall make an inventory of the e-cart medicines and ensure availability of medicines as well as dialysis supplies at the end of every shift.

b14. He/she shall provide information and health education to dialysis patients and significant others regarding the nursing plan of care and its implementation at home.

b15. He/she shall ensure that each patient has signed informed consent and witnessed by two people who will also sign the form.

1.6. Dialysis Nurse Assistant

a. Qualification

a1. B.S. Nursing graduate (underboard).

a2. B.S. Nursing undergraduate (completed at least 2nd year level).

a3. B.S. Midwifery graduate.

b. The duties and responsibilities of a dialysis assistant are, but not limited to, the following:

b1. He/she shall assist the dialysis nurses in providing hemodialysis treatment and care to dialysis patients.

b2. He/she shall assist the dialysis patients during admission and discharge at the HDC (taking of vital signs, pre- and post- weight) and report to the dialysis nurse of any irregularities.

b3. He/she shall assist in cleaning and disinfecting the machines and dialysis chairs.

b4. He/she shall assist in the preparation of the dialysis machines prior to treatment.

b5. He/she shall monitor and record patient's vital signs properly during and after the HD procedure.

b6. He/she shall perform errands such as securing medicines, dialyzers and other supplies, blood and blood products for transfusion that are needed for the patients under his/her care.

b7. He/she shall facilitate in securing documents needed by the patients such as referral letters, medical abstracts, and medical certificates.

1.7. Dialysis Technician

a. Qualification

a1. He/she shall be at least a high school graduate.

a2. He/she shall have a certificate of training as a dialysis technician by a structured training program for three (3) months or more if necessary. The following topics should be included in the program:

i. Principles of Renal functions and hemodialysis.

ii. Hemodialysis machine basic structure and function, Dialysis reprocessing, and Eco priming.

iii. Basics of Dialysis water treatment, dialysis concentrates and solutions.

iv. Infection control in the HDC, waste management and role on disaster preparedness and emergency situations.

b. The duties and responsibilities of a dialysis technician are, but not limited to the following:

b1. He/she shall perform adequate rinsing and priming of dialyzers prior to their use.

b2. He/she shall ensure that the dialyzer belongs to the patient by properly identifying the patient and the dialyzer under his/her name during each session.

b3. He/she shall ensure that reused dialyzers which pass the performance test will only be used. Any failed dialyzer should be disposed of properly.

b4. He/she shall prepare dialysis baths according to the right formula and proper calibration and settings on the dialysis machine.

b5. He/she shall prepare, rinse, and disinfect dialysis machines prior and after every dialysis procedure.

b6. He/she shall prepare and calibrate the reprocessing machines at the start of the day prior to its use.

b7. He/she shall properly label and collect all used dialyzers in the dialysis area and store them properly in accordance with the internal protocol of the HDC to prevent the spillage of blood products as well as avoid their contamination if still for reuse.

b8. He/she shall dispose of hazardous and non-hazardous wastes in a proper manner and in designated containers.

b9. He/she shall perform and assess reprocessing of used dialyzers based on AAMI standards.

b10. He/she shall record dialyzer reuse number in HD flow sheet.

b11. He/she shall store reprocessed dialyzers in an organized and systematic manner.

b12. He/she shall assist and perform regular preventive maintenance of all HD machines including monitoring and proper recording of machine hours, machine repairs, and machine-related problems.

b13. He/she shall conduct proper regular disinfection of the dialysis unit, HD machines, medical equipment, reprocessing machines, RO

(Reverse Osmosis) and water distribution systems and ensure their proper performance daily.

b14. He/she shall ensure that regular backwashing and all proper maintenance of the RO water system be performed daily to provide safe and adequate water supply and avoid interference in the HDC operations.

b15. He/she shall conduct monthly bacteriology testing of all required water products as well as bi-annual chemical analysis of the treated water in DOH accredited laboratories.

b16. He/she shall assist the HD team during emergencies and perform BLS during cardiac and/or pulmonary arrest.

b17. He/she shall enforce as well as observe company set policies and perform tasks delegated to him/her from time to time.

2. NON-MEDICAL PERSONNEL

2.1. Unit Operations Manager (UOM)/ Unit Manager in Hospital (UMH)

A. For non-hospital based HDC, with more than fifteen (15) stations, the UOM is a separate position.

B. For non-hospital based HDC with less than fifteen (15) stations the UOM could be a concurrent position within the Unit.

C. For hospital based HDC, the Unit Manager in Hospital or its equivalent.

a. Qualification

a1. Two or more years of proven success in operations management or as head of a unit or department that handles five (5) or more employees.

a2. He/she has leadership qualities, and communication and literary skills.

a3. He/she must fully understand all necessary ordinances and obey as well as implement policies related to the operations of an HDC.

a4. Strong skills in budget development and oversight.

a5. Excellent ability to delegate responsibilities while maintaining organizational control of the unit and customer service.

a6. Proficiency in conflict management and business negotiation processes.

a7. Master's degree in hospital administration and its equivalent or master's degree in business administration, are preferred, Or;

a8. Bachelor's degree in operations management, business administration or a medically related four-year course.

b. Administrative Responsibilities

b1. He/she shall ensure that laws, circulars, guidelines, and memos from DOH, PHIC, PSN, LGUs, and other third-party payors are properly implemented as well as closely monitor the day-to-day operations of the HDC.

b2. He/she shall ensure that all required forms for third party payors are properly and truthfully filled out.

b3. He/she shall ensure the availability, cost effectiveness, and timeliness of supplies and equipment.

b4. He/she shall ensure that all medical supplies are FDA approved/certified, and all equipment is properly reviewed and approved by the Dialysis Clinical Head.

b5. He/she shall ensure that all administrative policies, procedures and systems are properly implemented.

b6. He/she ensures that no physician, employee, patient, or medical facilities shall be given any gift or monetary consideration from the dialysis unit in the form of rebate fees and the likes.

b7. He/she ensures that the HDC unit should allow patients from other Nephrologist in the local area to undergo treatment in their unit, unless there is a valid legal reason, and it is discouraged that patients be automatically transferred to the in-house Nephrologist.

c. Clinic Management Responsibilities

c1. He/she shall supervise the regular QAPI review in collaboration with the Dialysis Clinical Head.

c2. He/she shall develop systems and procedures to improve the quality-of-service delivery in coordination with the Dialysis Clinical Head.

c3. He/she shall supervise the preventive maintenance of the HD machines, RO system, water distribution systems and other medical equipment.

c4. He/she shall supervise all HD machine repairs and do a monitoring of machine-related problems.

c5. He/she shall supervise the regular disinfection of the dialysis unit, HD machines, medical equipment, reprocessing machines, RO and water distribution systems.

d. Financial Management Responsibilities

d1. He/she shall ensure the financial viability of the HDC.

d2. He/she shall oversee the financial operations of the HDC including the accounts payable and ensure complete and accurate financial records.

d3. He/she shall ensure timely and appropriate payment of professional fees/salaries/benefits to the Dialysis Clinical Head, attending nephrologists, and staff as mandated by PHIC, DOLE, and other agencies.

d4. He/she shall provide a monthly summary of all PhilHealth/HMO/other Payors/Co-Pay collections to the Dialysis Clinical Head/AN and ensure that the professional fees are paid within Thirty (30) days from the time of receipt as mandated by PhilHealth.

2.2. Medical Records Officer and Custodian

A dialysis staff should be designated as Medical Record Officer/Custodian

a. Qualifications

a1. He/she has undergone training in ICD10, basic records management, and hospital health information management as required by DOH.

b. The duties and responsibilities of a Medical Record Officer/Custodian are, but not limited to the following:

b1. He/she shall ensure proper ICD10 input to each patient's chart and file.

b2. He/shall be the custodian/safekeeper of records.

b3. He/she shall function as Registry coordinator.

b4. He/she shall ensure completeness of records and forms for submission to DOH.

b5. He/she shall implement the Hospital/HDC medical records manual and other acceptable standards in medical records keeping.

2.3. Administrative Staff

a. The administrative staff shall be under the supervision of the UOM/UMH.

b. There shall be administrative staff to ensure efficient non-medical work activities and may include the following:

i. Accounting Clerk

ii. PHIC Officer / Clerk

iii. Cashier

iv. Security Personnel

v. Housekeeping Staff

vi. Maintenance Staff

vii. Secretary/Clerk/Liaison Officer

viii. Supply/Procurement Clerk

ix. Pollution Control Officer

x. Safety Officer 2

B. Physical Facilities

Every HDC shall have physical facilities with adequate areas to ensure the safety of staff, patients, and their relatives.

A. Every HDC shall conform to applicable local and national regulations for the construction, renovation, maintenance, and repair of the same.

B. Every HDC shall conform to the required space for the conduct of its activities depending on its workload and the services being provided.

C. Every HDC shall have an approved DOH-PTC in accordance with the planning and design guidelines prepared by DOH through BHFS posted at DOH website www.doh.gov.ph. The floor plan of the entire dialysis facility shall be signed and sealed by a licensed architect and/or engineer and shall contain the following areas listed below.

B1. Dialysis Service Complex

a. Screening and Triage Area

i. Every HDC shall provide a screening and triage room or area for infectious diseases.

ii. The area must allow waiting patients to be adequately separated according to the guidelines set by the authorized government agency.

b. HD Station

i. Each HD station shall not be less than two (2) meters by three (3) meters to accommodate a dialysis chair or bed, a dialysis machine and emergency apparatus when needed.

ii. Passageway or corridors shall be wide enough for access of stretcher and emergency equipment.

iii. Each HD station shall have adequate electrical convenience outlet(s).

iv. Each HD station shall have a water line for delivery of treated water to the individual dialysis machine.

v. Each HD station shall have physical barriers, or Isolation station/rooms, or cohorting plan for patients with COVID-19 and other emerging highly Infectious diseases.

vi. Every HDC shall have a designated area for donning and doffing.

vii. Each HD station shall have adequate ventilation.

c. Nurse's Station with Work Area

i. The nurse's station shall be strategically located in an area which allows adequate surveillance of patients on HD.

ii. The work area contains a work counter, hand washing sink and storage cabinets including a counter area for medicine preparation.

d. Water Treatment Room

The water treatment design shall follow the provisions stipulated in Section III. B3. 4 of this Guideline under policies on equipment and supplies re: typical arrangement of a water treatment system.

e. Dialyzer Reprocessing Area/Room (only for HDC that re- process dialyzer)

i. Every HDC shall have a separate reprocessing area and machine for Hepatitis B dialyzer, otherwise, single use.

ii. Every HDC shall have a separate reprocessing area and machine for Hepatitis C dialyzer, otherwise, single use.

iii. There shall be no re-use of dialyzer for patients with HIV. (ref: CDC guideline/Occupational Health and Safety)

iv. For SARS Cov2 and other highly infectious patients, follow the latest PSN and/or DOH guidelines.

f. Supply and Storage Room

Every HDC shall provide a room/area with storage cabinets for sterile instruments/supplies and other materials.

g. Service Support Area

Every HDC shall provide for the following support areas:

i. Waste holding cubicle/area.
ii. Soiled linen cubicle/area.
iii. Janitor's closet.
iv. Emergency generator room/area

B2. Non - Treatment Areas or Reception Area Section

a. Business Office

a1. Every HDC shall provide a reception/information counter, admitting area, cashier's area (for non-hospital based HDC), records section and a doctor's consultation cubicle for the Dialysis Clinical Head.

a2. Every HDC shall provide a room for storage and protection of medical records.

b. Waiting Area

Every HDC shall provide enough seats for patients and visitors.

c. Toilet Facility

c1. Every nonhospital based HDC shall provide a PWD/Senior Citizen friendly toilet facility with urinal, water closet and lavatory for patients and their visitors.

c2. Every hospital based HDC shall ensure access to a toilet facility.

d. Staff Pantry or Break Room

Every HDC shall provide an eating area, a counter with sink, locker, and dressing room with toilet for staff use.

B3. Equipment and Instruments / Supplies

Every HDC shall have available and operational equipment, instruments, materials, and supplies for HD procedure to be provided.

Every HDC shall be adequately equipped with the following to provide quality service to HD patients.

1. **HD Machine** (machine hours, date of acquisition of machine)
    a. All HD machines shall use bicarbonate as buffer.
    b. There shall be assignment or numbering of HD machines.
    c. There shall be a dedicated HD machine for patients with Hepatitis B. Otherwise, patients confirmed to have hepatitis B shall be referred to a HDC with dedicated machines for them.
    d. The use of Hepatitis C Virus (HCV) dedicated HD machine is not recommended based on current scientific evidence if there is strict adherence to standard of care in preventing blood borne viruses. However, this does not prevent the HDC from exercising the option to use a dedicated HCV machine.
    e. The use of SARS Cov2 dedicated HD machine is not recommended based on current scientific evidence. Treatment and isolation of SARS Cov2 infected hemodialysis patients should adhere to the latest PSN recommended guidelines.
    f. The use of HIV dedicated HD machines is not recommended based on current scientific evidence if there is strict adherence to standard of care in preventing blood borne viruses.
    g. Lifespan and machine worthiness of HD machines.

i. New machines with known manufacturing dates shall be covered by existing guidelines which are not more than 50,000 machine hours. Machines should undergo semi-annual/annual machine treatment worthiness after 5 years of use.
ii. Machines acquired in January 2009 or refurbished machines will no longer be allowed.

h. Back-up HD machines may be allowed to minimize disruption of HD services when an HD machine is non-functional. This back up machine should be registered and undergo the same preventive maintenance and life span.

2. Dialysis Chair/ Patient Bed

Every HDC shall provide dialysis chair(s) capable of full recline and Trendelenburg position or patient bed(s) with guard rails (90 cm x 70 cm) or its equivalent.

3. E-Cart

Every HDC shall provide an E-cart with the following medicines, equipment, and supplies.

a. Basic Medicines

Intravenous

i. Amiodarone 150 mg/ampoule (2 pcs)
ii. Atropine sulfate/ ampoule (1 pc)
iii. 10% Calcium gluconate 10mL/ampoule (2 pcs)
iv. 50% Dextrose 50mL/vial (10 pcs)
v. D5W 250 ml/bottle (2 pcs)
vi. Digoxin 500mcg/ampoule (2 pcs)
vii. Diphenhydramine 50mg/ampoule (2 pcs)
viii. Dobutamine 250mg/ampoule (2 pcs)
ix. Dopamine 250mg/ampoule (2 pcs)
x. Epinephrine 1mg/ampoule (10 pcs)
xi. Hydrocortisone 100mg/vial (4 pcs)
xii. 2% Lidocaine 5mL/ampoule (2 pcs)
xiii. Metoclopramide 10mg/ampoule (2 pcs)
xiv. Norepinephrine 2mg/mL (5 pcs)
xv. Paracetamol 300mg/ampoule (2 pcs)
xvi. Salbutamol 2.5mg/nebule (5 pcs)

xvii. Tranexamic acid 500mg/ampoule (2 pcs)

xviii. Verapamil 5mg/ampoule (1 pcs)

xix. Diazepam 10mg/ampoule (4 pcs)

Oral medication and other supply

i. Aspirin 80mg/tablet (4pcs)

ii. Clonidine 75mcg/tablet (10 pcs)

iii. Isosorbide dinitrate 5mg/tablet (5 pcs) IV Fluid

iv. 5% Dextrose in water, 250mL (2 pcs) Medical Supplies

v. Blood Glucose Strips (10 pcs)

vi. IV Catheter G20 (2 pcs)

vii. IV Catheter G18 (2 pcs)

viii. IV Catheter G22 (2 pcs)

ix. IV infusion set (Macro set) (1 pcs)

x. IV infusion set (Micro set) (3 pcs)

xi. Blood transfusion set (2 pcs)

xii. Salbutamol 2.5mg/nebule (5 pcs)

b. Basic Equipment

b1. Airway adjuncts (oropharyngeal and nasopharyngeal airways)

b2. Airway/Intubation set

i. Laryngoscope handle (1pc)

ii. Laryngoscope Mac blade (4 pcs)

iii. Guide wire (3 pcs)

iv. Ambubag (1pc)

v. Endotracheal tube Size 7 (1 pc)

vi. Endotracheal tube Size 7.5 (1 pc)

vii. Endotracheal tube Size 8 (1 pc)

viii. ECG Pads (5 pcs)

ix. Suction catheter French 16 (2 pcs)

x. Suction catheter French 14 (2pcs)

xi. ET tie (2 pcs)

b3. Biomedical refrigerator or its equivalent for storage of biological and other heat-sensitive drugs. Designate a specific refrigerator with a thermometer for medications only if biomedical refrigerator is not available.

b4. Calculator

b5. Cardiac Board

b6. ECG/cardiac leads

b7. Defibrillator with cardiac monitor and/or pacemaker function.

b8. Different set of bins including puncture proof sharps container.

b9. Fire extinguishers.

b10. Floor lamps (drop light and/or goose neck lamp)

b11. Foot stools

b12. IV stands (poles)

b13. Mayo tables and tray (minimum)

i. Curved /straight Mayo scissors.

ii. Metal tray with cover

iii. Mosquito forceps, curve

iv. Tissue forceps

v. Needle holder.

b14. Nebulizer

b15. Oxygen tank (with gauge and humidifier)

b16. Penlight or flashlight

b17. Portable suction device (with suction catheters)

b18. Pulse oximeter.

b19. Random blood sugar meter (Glucometer with strips)

b20. Digital BP/Sphygmomanometer (non-mercurial)

b21. Dedicated stethoscope for infectious and non-infectious cases

b22. Stretcher/Dialysis Chair or its equivalent

b23. Digital Thermometer scan 2

b24. Pro-gown/surgical gown

b25. Weighing Scale (Platform or wheelchair weighing scale)

C. Basic Supplies

c1. Alcohol disinfectants

c2. Asepto bulb syringe

c3. Gloves (clean and sterile gloves)

c4. Nasal cannula

c5. Oxygen mask and tubing

c6. Nasogastric tube

c7. Protective face shield or eye protector

c8. KN95 / N95

c9. Standard surgical face mask

c10. Sterile gauze

4. Water Treatment Area

The typical arrangement of a water treatment system is as follows:

a. Raw water

b. Conventional bulk filters (back washable filter or multi-media filter)

c. Softener - Due to the scarcity of raw water supply, the size of the water softener must be computed to be capable of softening raw water supply for at least 4- days of operation on its full capacity based on the existing feed water hardness quality of the center so that raw water used to regenerate will be greatly reduced. The less frequent the softener regeneration means less raw water is used.

d. Carbon filter - It shall be properly sized to have the assurance to effectively remove chlorine and chloramine from the raw water supply base on the expected maximum dialysis water demand. It must have a means of water sampling port to collect water to regularly test the effectivity of the carbon filter. The Activated Carbon used must have a document showing its safety & effectiveness (material safety data sheet or MSDS or other related documents to be filed)

e. Reverse Osmosis (R.O.) Pre-filter must be able to provide a filtration size of </= 5 microns. Reverse Osmosis (R.O.) For Single Pass and Double Pass.

e1. The system shall be able to produce R.O. water continuously achieving the minimum water quality requirement listed in the **ANSI/AAMI/ISO 13959 "International Standard specifies minimum requirements for water to be used in hemodialysis and related therapies."**

e2. The system shall be able to continuously monitor the raw and product water quality (In-Line TDS or Conductivity Meter).

e3. The water quality meter that monitors the product water must have a calibration certificate from the manufacturer. A yearly calibration verification must be documented to assure the accuracy of its function.

e4. The system should be able to generate an audible alarm to alert the operator that the product's water quality exceeds the maximum allowable limit and take appropriate safety action.

e5. The system shall have a means of a contingency design to operate safely with a minimum treatment interruption.

e6. The design must have a means to recover RO concentration and use for nonportable purposes (i.e. backwashing of filters, cleaning, etc.)

f. Product Water Distribution System/ Plumbing System

f1. **Direct Feed System –** A system that will deliver fresh product water produced by the R.O. membranes directly to the dialysis machines and other ancillary equipment such as reprocessing and bicarbonate mixing machines.

i. Design shall be able to supply the demand necessary to operate all the equipment needed for dialysis treatment.
ii. Design shall be able to meet the flow velocity of at least 1.5 to 3 ft per second to minimize biofilm growth inside the plumbing.
iii. Design shall have the means to disinfect or sterilize (by heat or chemical) the product's water distribution system from the R.O. up to the last plumbing connection of the loop.
iv. Design shall have the means to test the presence and the absence of the chemical use for disinfection of the distribution system.
v. Areas of stagnant flow shall be avoided (dead zone) in the distribution plumbing design. Plumbing must maintain the shortest dead leg pipe or segment.
vi. Distribution of piping materials shall not contribute chemicals (such as aluminum, copper, lead, and mercury) or bacterial contamination to the product water. The common plumbing materials recommended for R.O. water distribution is PEX, PVC, & STAINLESS PIPES. R.O. water distribution should be designed to minimize bacterial proliferation and

biofilm formation by using a continuous recirculation loop with a flow in the return line.

f2. **In-Direct Feed System** - A system that will deliver R.O. product water store from a storage tank to the dialysis machines and other ancillary equipment such as reprocessing and bicarbonate mixing machine.

i. Storage shall have a conical bottom to be able to drain all the water from the tank. Recommended tank materials are PE or Stainless steel.
ii. Tank design shall be sealed and have a means to prevent microbial growth.
iii. Design shall be able to supply the demand necessary to operate all the equipment needed for dialysis treatment.
iv. Design shall have the means to disinfect or sterilize (heat or chemical means) the product water tank to distribution system up to the last plumbing connection of the loop.
v. Design shall have the means to test the presence and the absence of the chemical use for disinfection of the distribution system.
vi. Areas of stagnant flow shall be avoided (dead zone) in the distribution plumbing design. Plumbing must maintain the shortest dead leg pipe or segment.
vii. Distribution of piping materials shall not contribute chemicals (such as aluminum, copper, lead, and mercury) or bacterial contamination to the product water. The common plumbing materials recommended for RO water distribution are PEX, PVC, & STAINLESS PIPES. RO water distribution should be designed to minimize bacterial proliferation and biofilm formation bay using a continuous recirculation loop with a flow in the return line.

f3. Every HDC shall have written policies and procedures for storage of water and the appropriate sterilization method(s) used.

5. Dialyzer Reprocessing Area (Automated or Semi-automated)

6. Every HDC shall provide a **standby generator** (not less than 20 KV A) appropriate to the size of the facility.

7. Business Office

Every HDC shall also provide the following:

a. A computer with internet connection (to include hardware and software for PRDR).

b. An ambulance or transport vehicle or show proof of contract (MOA) with providers of ambulance services. The management of HDC shall ensure availability of ambulance transport to a hospital that caters to unstable dialysis patient.

c. There shall be a regular calibration, preventive maintenance, and repair program for equipment.

d. There shall be a contingency plan in case of equipment breakdown. The availability of back-up hemodialysis machines that are in good working condition is highly encouraged.

C. Modalities of Treatment and Other Medical Services

1. Modalities

a. Non-Hospital based HDC.

a1. Routine Hemodialysis

a2. Hemoperfusion (HP)

a3. Online Hemodiafiltration (HDF)

a4. SLED/Extended Treatment

b. Hospital based HDC.

b1. OPD Settings

i. Routine or Emergency Hemodialysis

ii. Hemoperfusion (HP)

iii. Online Hemodiafiltration (HDF)

iv. SLED/Extended Treatment

b2. ICU Settings - Water supply should come from the RO system of the Hospital HDC or from a portable RO. A dedicated HD machine is not necessary.

i. Routine or Emergency Hemodialysis

ii. Hemoperfusion (HP)

iii. SLED/Extended Treatment

iv. CKRT

b3. Emergency Room Settings - Water supply should come from the R.O. of the Hospital HDC or from a portable RO. A dedicated HD machine is not necessary.

i. Emergency Hemodialysis
ii. Hemoperfusion (HP)
iii. SLED/Extended Treatment

b4. Isolation Settings - for highly infectious diseases. The water supply should come from the R.O. of the Hospital HDC or a portable RO. A dedicated HD machine is not necessary.

i. Routine or Emergency Hemodialysis
ii. Hemoperfusion (HP)
iii. SLED/Extended Treatment

2. Other Medical Services

a. Blood Transfusion

a1. Blood shall be obtained only from DOH accredited Blood Service Facility (BSF) or the Philippine National Red Cross.

a2. A non-hospital based HDC can be an END-USER NON-HOSPITAL HEALTH FACILITY, a licensed/accredited non-hospital facility without licensed clinical laboratory but which can administer blood transfusion, when necessary, as long as it has an updated MOA with a DOH accredited Hospital based Blood Collecting Unit (BCU) or Blood Service Facility (BSF).

a3. The HDC staff shall ensure the proper documentation, handling, and administration of blood products to HD patients. These policies shall be encoded in a blood transfusion protocol as part of the HDC's Manual of Operations.

a4. The HDC shall have at all times medications and equipment used in the management of blood transfusion related reactions. All such cases shall be properly documented and reported to the BSN as per DOH protocols.

a5. The HDC shall have the capacity and equipment to transport a patient to a referral hospital in the event that a blood transfusion related reaction requires an in-hospital admission.

a6. If an HDC is unable to provide blood transfusion services, the said HDC is directed to ensure that a proper and

continuous referral process to a BSF or an in- hospital transfusion unit is in place. This is to ensure that patients are properly cared for and to avoid the fragmentation of dialysis services.

b. Administration of Parenteral Medications

b1. IV antibiotics

b2. IV Iron (avoid dextran based)

b3. Erythropoietin (SC or IV)

b4. Other parenteral medications prescribed by the Physicians.

D. Policies and Documentation

a. Service Delivery

a. Every HDC shall ensure that the services delivered to patients conform to accepted medical guidelines, quality standards and national government policies.

b. Every HDC shall have a Manual of Operations or Standard Operating Procedures (SOP) for the provision of HD services and for the operation and maintenance of the facility.

c. Every HDC shall have documented technical policies and procedures for the services being provided in the facility to ensure quality of services rendered to HD patients. There shall be policies and procedures on, but not limited to the following:

c1. Water treatment system (quality testing, maintenance, safety, etc.)

c2. Infection control (bloodborne, airborne, precautions, handling, aseptic techniques, disinfection procedures, etc.)

c3. Waste management (infectious, non -infectious, minimization measures and recycling)

c4. Manpower management (provision of adequate personnel, employee handbook, periodic performance assessments, etc.)

c5. Dialyzer labelling, use and reprocessing.

c6. Regular laboratory testing of patients (monthly, quarterly, semi-annual, annual, etc.)

c7. Periodic review of medications and hemodialysis prescriptions

c8. Equipment testing, maintenance, and calibration

c9. Medical charting and documentation of all procedures, events, and complications

c10. Disaster risk management (fire, earthquake, flood, etc.)

c11. Emergency response and management

c12. Hospital or other facility transfer (referral procedure, documentation, conduction, etc.)

2. **Disabled and Senior Citizen Policies-** The HDC should abide by current the national policies on senior citizens.

3. **Quality Improvement (QI) Activities**

    a. Every HDC shall establish and maintain a system for continuous quality improvement activities.

    b. Each HDC shall have policies and procedures on Quality Assessment and Performance Improvement (QAPI) and continuous quality improvement (CQI).

    c. The Quality Assessment and Performance Improvement shall have a written plan and its implementation shall be continuous with periodic reviews.

    d. Metrics for QAPI it may include the following:

        i. Patient demographics and census of Hemodialysis procedure and adequacy.

        ii. Anemia management includes transfusion Infection control and management.

        iii. Weight management & nutrition

        iv. Preventive medicine (vaccination programs, etc.)

        v. Vascular access management

        vi. Risk management (falls, needle injuries, medication errors, blood spills, etc.)

        vii. Patient grievance and satisfaction

        viii. Occupational health and safety (hazard identification, risk assessment and control)

        ix. Credentialling and continuing professional education of staff.

4. **Environmental Management Policies**

    a. Every HDC shall ensure that the environment is safe for its patients and staff and that the following measures and/or safeguards shall be observed.

    b. There shall be well ventilated, lighted, clean, safe, and functional areas based on the services provided.

c. There shall be a program of proper maintenance and monitoring of physical facilities.

d. Water supply for all purposes shall be adequate in volume and pressure. Likewise, potability and safety of water shall be ensured.

e. The water for HD purposes shall be treated accordingly to maintain continuous water supply that is biologically and chemically compatible with acceptable HD techniques. Periodic water analysis (for microbiological and chemical tests) at three (3) sampling points shall be done.

    i. Raw water analysis

    ii. Product water analysis

    iii. Point of use water analysis

f. The components of water analysis are listed below. (List of laboratories capable of conducting microbiological and chemical analyses of water in HDC is posted at DOH website.)

    i. Microbiological analysis shall be done at least every month and as often as necessary depending on the results. The bacterial count shall be < 100 colonies per milliliter.
    ii. Chemical analysis shall be done at least every six (6) months and as deemed necessary following DOH Adopted guidelines of AAMI Standards for Water for Hemodialysis.
    iii. Chemical analysis of water at two (2) sampling points, namely product water and point of use, may be allowed in HDC applying for renewal of LTO, provided there is no change in location. The frequency of analysis shall be every six (6) months and as often as needed.

g. Each HDC shall keep a record of plumbing system disinfection. Disinfection following any of the methods stated below shall be done quarterly and whenever microbiologic counts reach or exceed the acceptable limits.

    i. Chemical disinfection

    ii. Heat disinfection.

    iii. Ozone disinfection

h. There shall be procedures for the proper disposal of infectious wastes and toxic and hazardous substances and that shall be made in accordance with R.A. 6969 and other related policy guidelines and/or issuances.

    i. Every HDC shall establish and implement a system for proper solid waste management which shall be in accordance with the revised DOH Manual of Health Care Waste Management and Environmental Management Bureau – Department of Environment and Natural

Resources *(EMB-DENR)* environmental laws, particularly R.A. **9003 (Ecological Solid Waste Management Act)** and the **Environmental Sanitation Code** and other pertinent policy guidelines and/or issuances.

ii. Every HDC shall establish and implement a system for proper liquid waste management which shall be in accordance with the revised DOH Manual on Health Care Waste Management and other EMB-DENR policy guidelines and/or issuances.

i. There shall be a "no smoking" (including VAPE) policy and that the same shall be strictly enforced.

j. There shall be a contingency and disaster preparedness plan in case of accidents and emergencies.

5. Audit Policies

a. Medical Audit: ACLS activations/ambulance transfers/successful resuscitations/expiries)

b. Technical Audit: Preventive maintenance, water analysis-culture/chemical, reuse program, etc.

6. Information Management - Every HDC shall maintain a record system to provide readily available information on each patient.

a. Contents of Medical Records - Each HDC shall maintain complete medical records of all patients within the facility, including those patients' administering self-care. All current files (soft or hard copy) shall be kept at the nurses' station and shall be placed in the patient's file folder once completed. Each patient's record shall be kept confidential and shall contain sufficient information to identify the patient and to justify the diagnosis and treatment. The right of the patient to obtain records of treatment and other relevant medical information shall be observed. Current medical records shall contain, but is not limited to, the following:

a1. Summary or face sheet with patient identification data, diagnosis, physician's name and phone number, family member to be contacted in case of emergency with phone number, patient's address and phone number, date of admission.

a2. Doctor's orders. Standing orders shall be updated at least quarterly or as deemed necessary.

a3. Dialysis treatment sheet (soft or hard copy) properly filled in.

a4. Laboratory, x-rays, and other diagnostic reports.

a5. Personal history and physical examination records.

a6. Clinical and graphic record of patient's vital signs.

a7. Medication record.

a8. Dietary assessments, updates, and progress notes.

a9. Consultations, hospitalizations.

a10. Nurse's progress notes for each dialysis session.

a11. Problem list.

a12. Duplicate copy of Clinical Abstract and Medical Certificate.

a13. Informed consent updated at least annually and as deemed necessary.

a14. Records of transfer/referral of patient to another health facility or AN.

a15. Advance Directive, if any.

a16. Documentation on patient education.

a17. Updated hepatitis profile.

a18. Updated Patient's vaccination status.

i. Hepatitis B (double dose) at 0, 1 ,6 months. Routine post-vaccination testing thirty (30) days after the last dose.

ii. Influenza vaccination

iii. Pneumococcal vaccination

iv. COVID-19 vaccination

b. **Complications/adverse events** logbook shall include, but is not limited to, the following: **(DOH HDC logbook following the format posted at DOH website)**

b1. Medial conditions that resulted in delay of discharge from HDC.

b2. Medical conditions that resulted in admission to the hospital of the patient following HD treatment.

b3. Medical conditions that resulted to death of the patient during or immediately after HD.

b4. Complications related to HD procedure.

b5. Complications related to vascular access.

b6. Complications related to disease.

b7. Outcome

i. Death

ii. Changed to another treatment modality.

iii. Kidney Transplant

iv. Lost to follow up.

v. Refused further treatment.

7. **REDCOP Patient Registry -** Every HDC shall register their patients to PRDR in support to REDCOP (or its equivalent) of DOH and in coordination with PSN. Encoding shall be done in each HDC using the required forms from REDCOP. An annual statistical report shall be submitted to REDCOP relative thereto.

8. **Technical Records/logbook**

    a. Every HDC shall maintain the following technical records.

        a1. Blueprint of the dialysis unit

        a2. Records of R.O. system, loop disinfection and water analysis.

        a3. Logbook/records on efficiency/machine hours of HD machines.

        a4. Inventory card of each HD machine to determine the dates of manufacture, acquisition, and installation.

        a5. Schedule of calibration of HD machine/equipment.

        a6. Logbook/records of preventive and corrective maintenance of HD machine/equipment.

    b. All HDC shall submit data/information as may be required by DOH through BHFS for purposes of research, standards setting, improving access to HD services, and the like.

    c. Retention and disposal of records and other relevant information whether paper-based or electronic media shall be in accordance with related and future issuances by DOH.

9. **Administrative Records**

    a. Every HDC shall maintain the following administrative records.

        a1. Minutes of Meeting

        a2. Attendance logbook.

        a3. 201 staff files (include vaccination status)

    b. Immunization of HDC staff such as, but not limited to, the following:

        b1. Hepatitis B at 0, 1, 6 months. Routine post- vaccination testing thirty (30) days after the last dose.

        b2. Influenza vaccination annually

        b3. Pneumococcal vaccination

        b4. COVID-19 vaccination

    c. Report of DOH inspection and monitoring activities

IV. PROCEDURAL GUIDELINES

A. Application For DOH-PTC

1. The following are the required documents to be accomplished and submitted to HFSRB before a DOH- PTC can be issued to an applicant of an HDC.
    a. Duly accomplished application form signed and reviewed by the Dialysis Clinical Head.
    b. PSN Certificate of Attestation for Dialysis Clinical Head
    c. Proof of ownership
    d. Department of Trade and Industry registration
    e. Securities and Exchange Commission (SEC) Registration with Articles of Incorporation and By-laws.
    f. Enabling Act or Board Resolution for government institutions
    g. Cooperative Development Authority Registration with Articles of Cooperation and By-laws for Cooperatives.
    h. Three sets of architectural floor plans signed and sealed by an architect and/or engineer. The floor plan shall be in accordance with Section III. B. Physical Facilities of this Order.
    i. Feasibility study rationalizing the need to establish an HDC at the proposed site. Existing or established HDCs for relocation or expansion within the same town or city, as well as hospital based HDCs, shall not be required to submit a feasibility study.
2. The applicant shall complete the application form and required documents and shall submit them to Health Facilities and Services Regulatory Bureau (HFSRB) personally, registered mail or a courier. Upon filing of application, the applicant shall pay the corresponding fee to DOH cashier in person or through postal money order.
3. The HFSRB through the Health Facility Establishment Review Committee shall review and evaluate the submitted plans and documents of the proposed HDC with respect to basic requirements and with the prescribed prototype plan(s) and technical guidelines in the planning and design of an HDC within a period of 15 working days.
4. The HFSRB shall approve or disapprove the issuance of a DOH- PTC. If disapproved, HFSRB shall return the documents together with their findings and recommendations to the applicant. The applicant shall make the necessary revisions on the documents and shall submit the

revised documents to HFSRB for another review. The applicant shall be entitled to only three (3) revisions.

5. The Health Facilities and Services Regulatory Bureau shall issue a DOH-PTC to the applicant upon approval of the same within a period of 15 working days from the time the first application was submitted or from the time the last revision was submitted.

B. Application For Initial LTO

1. Applicants can acquire the prescribed application form for LTO at HFSRB or CHD or at DOH website www.doh.gov.ph.
2. The duly accomplished form together with the necessary attachments such as, but not limited to; list of personnel, list of equipment and other relevant records shall be submitted to HFSRB.
3. Pre-evaluation by the local PSN chapter of the duly accomplished application for the PSN Certificate of Attestation or the Certificate of Attestation of No Available Nephrologist and endorsed by the Chapter President to the PSN HD Committee Chairman for final review and approval.
4. All hospital based HDC shall follow OSS Licensure System for Hospitals under A.O. No. 2007 - 0021 re: "Harmonization and Streamlining of the Regulatory Processes", A.O. No. 2010-0035 re: "Re-centralization of the Issuances of Permit to Construct (PTC) for All Levels of Hospitals, License to Operate (L TO) for All New Hospitals and Renewal of LTO for Levels 3 and 4 Hospitals", its related issuances and this Order.
5. All non-hospital based HDC shall follow OSS Licensure System for non-hospital based HDC in accordance with A.O. No. 2008- 0027 re: "One-Stop Shop System for the Regulation of...Non-Hospital Based Dialysis Clinics ... ", its related issuances and this Order.

C. Application For Renewal of LTO

1. The Center for Health Development shall retain the renewal of LTO for Level 1 and Level 2 hospital based HDC following OSS Licensure System for Hospitals.
2. The Health Facility Services and Regulatory Bureau shall retain the renewal of LTO of non-hospital based HDC and LTO for Level 3 and Level 4 hospital based HDC following OSS Licensure System for Hospitals.
3. Every HDC shall submit proof of participation in renal registry (PRDR-Philippine Renal Disease Registry) set by DOH.
4. Every HDC shall submit a PSN Certificate of Attestation.
5. The License to Operate of an HDC shall be cancelled automatically without notice upon failure to submit a duly accomplished application form and failure to pay the proper fee within thirty (30) calendar days after the expiration date stated on its license. The HDC shall cease its

operation and apply for a new/initial LTO following Section VI. B. Application for Initial LTO of this Order.

ANNEX I

Certificate of Attestation

I. **Purpose**: The 'Certificate of Attestation' will be issued by PSN to all Hemodialysis Clinics (HDC) who are applying for the license to operate (LTO) or re-accreditation from DOH-BFHS as well as when securing accreditation from PhilHealth.

II. **Procedure:**

A. Submit the information sheet to PSN office located at 24/F, Unit 2406 One San Miguel Avenue Condominium, San Miguel Avenue corner Shaw Boulevard, Ortigas Center, Pasig City, together with the following:

1. Dialysis Clinical Head of the HDC:

a. Registered area of residence and practice

b. PSN local chapter endorsement for an available competent physician to be the Dialysis Clinical Head (by hierarchy, descending order)
   - 1 PSN board certified nephrologist
   - 2 PSN board eligible nephrologist

c. Photocopy of Attendance/ Participation of a Post Graduate Course for Dialysis Clinical Head certificate issued by PSN (to be implemented on August 1, 2025) **Exemption:** Minimum of 10 years of experience as Dialysis Clinical Head with the following requirements:
   Proof of Experience
   - Certificate of Employment or Contract as dialysis Clinical Head or
   - Attestation by the PSN Chapter President in his/her area of practice

   Note: Seasoned Dialysis Clinical Head are highly encouraged to attend a post graduate course

d. Current contract / appointment paper of the Dialysis Clinical Head of the HDC specifying the responsibilities / benefits / incentives / compensation. The appointment paper shall have the conform signature of the appointee.

e. Pay the processing fee of Php. 1,500.00 at the PSN Office.

f. Submit the certificate to DOH-BHFS or PhilHealth.

Annex II

PSN INFORMATION SHEET
CERTIFICATE OF ATTESTATION FOR HEMODIALYSIS CLINIC (HDC)

I. Name, address, email address and contact numbers of the HDC.

_____

_____

II. Purpose of PSN Certificate of Attestation and period being covered:

☐DOH Initial License/Renewal Inclusive Date: ___
☐PhilHealth accreditation/re-accreditation Inclusive Date: ___

III. Classification of HDC: Check appropriate box:

A. According to ownership

☐Government
☐Private

B. According to Institutional Character

☐Hospital based.
☐Non – Hospital based

IV. Name of Owner/President/CEO:

_____
(Signature over Printed Name and Designation)

V. Name of Dialysis Clinical Head

_____
(Signature over Printed Name and Designation)

VI. Address of Residence of Dialysis Clinical Head

_____
(Complete Address)

VII. Attach PSN Certificate of Participation in the Post Graduate Course for Dialysis Clinical Heads or Certificate of Exemption if qualified.

VIII. List of other HDCs (Name and Address) handled by the Dialysis Clinical Head.

1.
2.

I hereby certify that the above information is true.

_____
Dialysis Clinical Head
(Signature over Printed Name and Date)

Annex III

PSN CHECKLIST/REQUIREMENTS FOR CERTIFICATE OF ATTESTATION

(For PSN Committee on HD / Secretariat)

I. Is there a completely filled in form ☐YES ☐NO

- ☐Name/Address
- ☐Type of Facility
- ☐Covered Period of Accreditation
- ☐Classification of Facility
- ☐Owner's Name and Signature
- ☐Dialysis Clinical Head Name and Signature
- ☐Address of the Dialysis Clinical Head
- ☐List of other HDCs (Name and Address) handled by the Nephrologist.

II. Is the area of residence of the Nephrologist within distance of accessibility to physically visit the HDC?

☐YES ☐NO

III. Is there an endorsement from the PSN Local Chapter?

☐YES ☐NO

IV. Is there a complete Current Appointment/Contract of Dialysis Clinical Head with the following components?

- ☐Duties and Responsibilities
- ☐Benefits
- ☐Incentives
- ☐Medico-Legal Insurance
- ☐Compensation
- ☐Effectivity
- ☐Conforme Signature

V. Is the Dialysis Clinical Head a Diplomate or Fellow of PSN?

☐YES ☐NO

VI. Is there a Certificate of Training of the Dialysis Clinical Head?

☐YES ☐NO

VII. Other HDCs being handled by the Dialysis Clinical Head:

	Name	Address
1.	_____	_____
2.	_____	_____
3.	_____	_____

Remarks:
Approved
Pending

Name and Signature
Committee Chair, HD
Date: _____

ANNEX IV

ENDORSEMENT FOR A NEPHROLOGIST

Date

Name

Chairman, Committee on Hemodialysis

PSN, Inc

RE: PSN/Chapter Endorsement Letter

Dear Dr. _____,

The (NAME OF LOCAL CHAPTER) has known (NAME OF NEPHROLOGIST) to be a member of good standing since (year) with the qualifications that meet the minimum standards to accept the position as Dialysis Clinical Head of

(Name of Hospital based HDC/ Non=Hospital based HDC)
(Address)

Attached with this letter are the documents required for the issuance of the certificate attestation.

Sincerely,

Name of President of Local Chapter

ANNEX V

ENDORSEMENT FOR A NON-NEPHROLOGIST AS TEMPORARY DIALYSIS CLINICAL HEAD OF THE HDC

Date

Name

Chairman, Committee on Hemodialysis

PSN, Inc

RE: PSN/Chapter Endorsement Letter

Dear Dr. _____,

The (NAME OF LOCAL CHAPTER) **has no known available local member t**o accept the position as Dialysis Clinical Head of

(Name of Hospital based unit/ Free Standing HD center)
(Address)

We therefore endorse, (NAME OF PHYSICIAN), a non - nephrologist to temporarily accepting the position as Dialysis Clinical Head for this year (12 months, state starting date to ending date) while waiting for a locally based nephrologist.

Attached with this letter are the documents required for the issuance of the certificate attestation.

Sincerely,

Name of PSN Secretary/President of Local Chapter

ANNEX VI

PSN/CHAPTER ENDORSEMENT FOR DIALYSIS CLINICAL HEAD OF THE HDC

Date

Name

Chairman, Committee on Hemodialysis

PSN, Inc

RE: PSN/Chapter Endorsement Letter

Dear Dr. _____,

The PSN/NAME OF LOCAL CHAPTER recognizes that the Nephrologist below is an active member and is of good standing of our Society/Chapter intends to accept the position as Dialysis Clinical Head of

(Name of Hospital based HDC/ Non-Hospital based HDC)
(Address)

We therefore endorse, (NAME OF PHYSICIAN), as qualified to take the position of Dialysis Clinical Head.

Sincerely,

Name of PSN Secretary/President of Local Chapter

ANNEX VII

PSN/CHAPTER ENDORSEMENT FOR ATTENDING NEPHROLOGIST OF THE HDC

Date

Name

HDC

RE: PSN/Chapter Endorsement Letter

Dear Dr. _____,

The PSN/NAME OF LOCAL CHAPTER recognizes that the Nephrologist below is an active member and is of good standing of our Society/Chapter and intends to apply as Attending Nephrologist of his patients in your Hemodialysis Clinic (HDC).

_____

We therefore endorse, (NAME OF PHYSICIAN), as qualified to take the position of Attending Nephrologist in your HDC.

Sincerely,

Name of PSN Secretary/President of Local Chapter

ANNEX VIII

Hemodialysis Endorsement Form

PHILIPPINE SOCIETY OF NEPHROLOGY
HEMODIALYSIS PATIENT'S ENDORSEMENT FORM

REFERRING HEMODIALYSIS CENTER (HDC):	RECEIVING HDC	DATE

Patient's Name	Last Name First Name Middle Name	**Date of Birth**	**Age/Sex**	**Contact Number**
Address				
Person to notify in case of emergency			**Relation to Patient**	**Contact Number**
Diagnosis				
Co-Morbid Condition/s 1._____ 2._____ 3._____			**Other Attending Physicians/Subspecialty** 1._____ 2._____ 3._____	

Hepatitis Profile	Qualitative	Quantitative	Date	Latest Immunization/s	Dose	Date
HBs Antigen				Hepatitis B vaccine ___1st ___2nd ___3rd Dose		
Anti-HBs Antibody				Hepatitis B vaccine booster		
Anti-HBc Antibody				Influenza vaccine		
Anti-HCV IgM				Pneumococcal vaccine		

Vascular Access	Access Location	Surgeon	Date created	Hospital
Internal Jugular Vein/ Permanent Catheter				
AV Fistula				
AV Graft				

Hemodialysis Prescription		Current Medication/s
Frequency		
Duration		
Dialyzer		
Dialysate Flow Rate		
Blood Flow Rate		
Dialysate Bath		
Anticoagulant/Dose		
Dry Weight		**BLOOD TYPE**

Complications/Problems Encountered During Hemodialysis:
1._____ 4._____
2._____ 5._____
3._____ 6._____

□ I will still be the attending nephrologist	**Contact #**	**PHIC Accreditation No. /Validity**
□ Transfer service to _____, MD	**Contact #**	**PHIC Accreditation No. /Validity**
Attachments: □ Last 3 Hemodialysis Treatment Sheet □ Laboratory Flow Sheet / Results		
Name and Signature of Referring Nephrologist		

** Please inform referring nephrologist once patient is accepted in the receiving HDC.*
** Accomplish in duplicate and retain one copy in the patient's chart.*

Downloadable from www.psn.ph

ANNEX IX

TO :
SUBJECT : APPOINTMENT - DIALYSIS CLINICAL HEAD

CONTRACT OF SERVICE AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

This contract made and executed by and between a duly organized corporation with office and place of business at_____, represented herein by its General Manager of legal age, Filipino citizen, hereinafter referred to as HEMODIALSYSIS CLINIC COMPANY (HDCC); -and- _____, ___ years old of legal age, Filipino citizen, with residence at _____, duly authorized to render Nephrology care hereinafter referred to as "DIALYSIS CLINICAL HEAD"(DCH).

W I T N E S S E T H:

WHEREAS (HDCC) enters a Contract of Service with the Dialysis Clinical Head, to render professional medical services as Dialysis Clinical Head of the Hemodialysis Clinic (HDC).

WHEREAS (HDCC) is operating and housing a Department of Health Licensed dialysis center known as "_____ (name of company)";

WHEREAS the "(HDCC)" needs a Licensed Physician certified by the Specialty board of the Philippine Society of Nephrology',

WHEREAS (HDCC) has offered to avail of the services of the Dialysis Clinical Head for the latter to Head the Clinical aspect the Company's Hemodialysis Clinic, which offer was accepted.

NOW THEREFORE, for and in consideration of the foregoing and upon terms and conditions agreed upon, the (HDCC) and the Dialysis Clinical Head have agreed to the following terms and conditions:

SECTION 1: ENGAGEMENT

(HDCC) hereby engages the services of the Dialysis Clinical Head and the latter agrees to the engagement. The agreement between the parties shall be guided by the current PSN Hemodialysis Guidelines 2024, and current PHIC guidelines. The Hemodialysis Clinic subject of this agreement is located at _____.

1. The duties and responsibilities of the HDC Dialysis Clinical Head are the following:

    i. He/she shall warrant and ensure that he will, during the duration of this agreement, maintain in good standing his status as a duly

licensed medical professional by the Professional Regulation Commission (PRC) and certified by the Specialty board of the Philippine Society of Nephrology (PSN).

ii. He/he shall provide to the (HDCC) the medical operations requirements of the DOH, PHIC, and PSN, discuss the same with the daily operations manager of the Company, as well as answer questions of the latter.

iii. He/she shall provide the guidelines that must be followed by the (HDCC) on the acceptable norms and standards of medical practice in all medical procedures that will be done in the Hemodialysis Clinic. If the Hemodialysis Clinic does not follow the guidelines, the Dialysis Clinical Head is not liable for any resulting negligence or malpractice by a staff or HDC Owner. The Dialysis Clinical Head shall inform the DOH of such negligence or malpractice.

iv. He/she shall develop and require the (HDCC) to implement internal medical protocols, policies and procedures on dialysis and related treatment in accordance with the standards formulated by the DOH in coordination with the PSN.

v. He/she shall identify and require a training program for Hemodialysis staff for certification, continuous improvement of skills and knowledge.

vi. He/she shall review and assess the credentials of the medical employees to be hired by (HDCC) with a view to ensuring that they are qualified for their respective positions.

vii. He/she shall identify and recommend to the (HDCC) infection control and surveillance practices that must be strictly followed by the latter.

viii. He/she shall institute policies and guidelines that must be followed by the (HDCC) with a view to requiring the presence of physicians on duty during the operating hours of the HDC.

ix. He/she shall render his/her services as indicated in the current PSN Hemodialysis Guidelines of 2024 and shall devote his/her best efforts and abilities thereto, at such times and during the term hereof, and in such manner as the (HDCC) and Dialysis Clinical Head shall mutually agree upon. He/she shall be physically present at the Hemodialysis Clinic at least four (4) times a month or once (1) a week unless there are situations where the safety of the Dialysis Clinical Head is at high risk and in emergency cases that his/her physical presence is not possible. In GIDA two (2) consecutive days two (2) times a month is allowed.

x. The DIALYSIS Clinical Head is only allowed to handle Hemodialysis Clinic within a 50-km radius of his/her place of practice or residence. However, in areas where there are no other nephrologists available

the Dialysis Clinical head may go beyond 50 Kms if He is able to comply with the requirements of this contract.

2. The Dialysis Clinical Head shall not be responsible for the following:

b1. It is not the responsibility of the Dialysis Clinical Head to monitor and supervise the day-to-day operations of the Dialysis Center. It being understood that the HDCC shall appoint and maintain an Operations Manager who will closely monitor the day-to-day operations of the Hemodialysis Clinic.

b2. It is not the responsibility of the Dialysis Clinical Head to personally check equipment, medicines, and medical tools and supplies of the Dialysis Center. The (HDCC) shall ensure that these responsibilities are performed by its competent staff.

b3. It is not the responsibility of the Dialysis Clinical Head to be responsible for the professional negligence of the other medical professionals employed by the HDC. The HDCC shall ensure that the HDC Dialysis Clinical Head shall be freed from such liability, and appropriately reimburse the latter for any such liabilities incurred by the Dialysis Clinical Head.

b4. It is not the responsibility of the Dialysis Clinical Head to act as employer of the HDC. All responsibilities and liabilities of an employer shall be the exclusive obligations of the (HDCC).

3. The duties and responsibilities of the HDCC are the following:

a. It shall ensure that it will comply with all the requirements set forth by DOH, PHIC, PSN, DENR, DOLE and other regulatory bodies and follow the protocols, policies, and procedures recommended by the Dialysis Clinical Head.

b. It shall ensure that there will be physicians on duty during all the operating hours of the HDC, and the appropriate number of nurses and other required medical staff.

c. It shall ensure that all the equipment, medicines, and medical tools and supplies used in the Dialysis Center are of good quality, FDA approved, and safe and competently operated, and proficiently prescribed.

d. It shall ensure that all the physicians, nurses, and medical staff employed by the HDCC are qualified and competent.

e. It shall ensure that the patients are professionally diagnosed and competently prescribed with the appropriate medical procedures and dosages of medicine.

f. It shall ensure that all employees are paid in accordance with the minimum and mandatory requirements of the law.

g. It shall provide the Attending Nephrologists with a copy of the list of PhilHealth payments to their respective patients monthly and pay them accordingly as prescribed by the PhilHealth reimbursement policy.

h. It shall ensure the filling of clean and honest PhilHealth claims for reimbursement,

i. It shall ensure that the rights of patients be respected and followed.

SECTION 2: COMPENSATION

As mandated by the Philippine Society of Nephrology (PSN), the Dialysis Clinical Head, as consideration for the consultancy fee to be rendered by Dialysis Clinical Head, (HDCC) shall pay the Dialysis Clinical Head the monthly compensation of

Php _____.00 net or exclusive of withholding tax as monthly honorarium for the visitations. The compensation shall be adjusted based on the number of machines operational as recommended by the current PSN Hemodialysis Guidelines for Nephrologist 2023. He will also be the priority to be decked for walk-in patients. The Dialysis Clinical Head shall likewise be compensated for emergency meetings and additional workload which the HD Center Company requires at a mutually agreed honorarium. If the Dialysis Clinical Head needs to travel for more than 50 kms from the base practice or residence an additional Php 5,000.00 is added for gas and additional expenses monthly. In Geographically Isolated and Disadvantaged Areas (GIDA) all transportation, accommodation, and travel insurance shall be shouldered by the HDCC. The above compensations shall be subject to review and adjustment upon mutual agreement of both parties within thirty (30) days prior to expiration of each term.

Additionally, the HDCC shall likewise sponsor the DIALYSIS CLINICAL HEAD for all his registration, bed and board, and transportation expenses in at least one (1) PSN sponsored or accredited conference of his choice in the country yearly. The Dialysis Clinical Head shall also be entitled to additional benefits through incentive programs that HDC may adopt from time to time. He shall also be provided with a free clinic space. His rates for his professional fees as Attending Nephrologist to his patients shall be based on the recommended fee by the current PSN Hemodialysis Guidelines 2024 including emergency fee and inpatient fees. Travel insurance should also be provided if the risk for accidents is high as well as mandatory medical malpractice insurance with a minimum of 5 million yearly.

SECTION 3: TERM/ PERIOD

The term of this Contract is deemed to have commenced on ___ day of _____, 202_ and shall continue for a period of one year, and upon agreement by the parties in writing, shall be renewable every year.

SECTION 4: TERMINATION OF CONTRACT

1. The DIALYISIS CLINICAL HEAD shall have the option to unilaterally terminate this contract upon thirty (30) days' advance written notice to the HDCC.
2. The DIALYSIS CLINICAL HEAD may also terminate this contract upon prior written notice to HDCC, if the HDCC defaults in the performance of its obligation under this Contract or fails to provide the minimum standards and number of personnel, basic medicines, and equipment necessary for the delivery of services of the dialysis center and HDCC fails to cure the default within thirty (30) days from written notice of the DIALYSIS CLINICAL HEAD.
3. The HDCC may also terminate this contract upon 30 days prior written notice to DIALYSIS CLINICAL HEAD, if the latter fails to cure within thirty (30) days from written notice of his/her default and /or non-performance of his/her obligation under this contract and other grounds enumerated hereunder.
4. The DIALYSIS CLINICAL HEAD may also terminate this contract immediately, upon prior written notice to HDCC, if there is clear evidence of loss of trust to the point that the license, integrity, and safety of the Dialysis Clinical Head is in danger or compromised.
5. Any wrongdoing committed by any employee, officer, or by the HDCC which does not conform to the standards and procedures provided by the Dialysis Clinical Head, including but not limited to medical malpractices and negligence, tampering of files, deceased or fraudulent claims, and stealing, shall not make the Dialysis Clinical Head liable in any and all criminal, civil, and administrative cases. It shall be the sole and exclusive responsibility of the HDCC to ensure that such incidents will not happen. In case the Dialysis Clinical Head is included in any such court, quasi-court, or administrative actions, he shall engage the services of a lawyer of his own choice to independently represent his defense, and the HDCC shall fully and promptly pay and/or reimburse all expenses incurred for said purpose.
6. In cases wherein the DIALYSIS CLINICAL HEAD lost his/her PhilHealth accreditation because of the wrongdoing or negligence of the HDCC or any of its staff, the Dialysis Clinical head shall receive a compensation of Php 150,000-200,000/ month for loss of income from Patients on PHIC until his/her PhilHealth accreditation is restored.

SECTION 5: ENTIRE AGREEMENT

This Contract contains the entire agreement of the parties hereto, and no modification thereof shall be binding upon the parties unless the same is in writing signed by the respective parties hereto.

SECTION 6: COUNTERPARTS

This contract may be executed simultaneously in one or more counterparts. Each one of which be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties have hereunto affixed their signatures this _____ day of _____, 202_ at _____.

_____	_____
_____	_____
General Manager	Dialysis Clinical Head

Signed in the presence of:

_____

_____

A C K N O W L E D G E M E N T

REPUBLIC OF THE PHILIPPINES (_____) S. S. BEFORE ME A Notary Public for and _____, this _____ day of _____, personally appeared:

Name Competent Evidence of Identification

1.
2.

Known to me and to me known the same people who executed the foregoing Contract for Services and who acknowledged to me that the same is their free and voluntary act and deed, and with full power and authority to sign and execute the same.

This contract, which consists of 3 pages including this page on which this acknowledgement is written, is signed by the parties and their instrumental witness on each and every page thereof.

WITNESS MY HAND AND SEAL, in the place and on the date first above written.

NOTARY PUBLIC

Doc. No. _____
Page No. _____
Book No. _____
Series 202_.

ANNEX X

This informed consent is the minimum requirement for the protection of the AN. Additional provision may be included as deemed necessary.

PATIENT INFORMED CONSENT

Name of Institution: _____

PIN: _____

Name (Surname, Name, Middle Initial): _____

Birthday: _____

Attending Nephrologist: _____

Information Checklist: (Initiation of Hemodialysis)

My Nephrologist (Kidney doctor)/his or her assistant physician has informed me of the following:

A. Cl**inical Condition**	○ About my condition, end stage kidney disease. This means my kidneys are severely and permanently damaged. ○ About the likely outcome with and without dialysis.
B. Treatment options	○ About treatment options, including: • Hemodialysis and related procedures • Peritoneal dialysis • Kidney transplantation (if I am suitable) • Conservative kidney management. (Supportive care without dialysis)
C. Vascular Access	○ That I will need a vascular access that will be inserted by Vascular surgeon or my attending nephrologist. ○ That the vascular access may either be IJ catheter, AV fistula, AV graft or perm catheter as considered by my nephrologist.
D. Risks & Complications	○ About possible risks and complications of haemodialysis treatment. These can include the following but not exclusively: • Bleeding or blood clotting • Infections • Sensitivity reaction • Heart failure & Arrhythmias • Problems with the dialysis equipment ○ Sometimes hemodialysis might not work for me. This could be because of. • failed access to my blood. • poor heart function. • failure to improve my quality of life.

E.	**Rights & Responsibilities**	○ About my rights as a patient, including the right to.. • Privacy. • be treated with respect and dignity. • be involved in decision making regarding my care. • receive high-quality care and information. ○ That I can help achieve the best possible outcome by participating fully in my treatment. I understand I will need to. • have regular blood tests. • take medications as prescribed by my nephrologist/his or her assistant. • attend scheduled medical appointments and dialysis treatment. • cooperate with my dialysis treating team. • That I need to conduct myself appropriately while in the dialysis unit and show respect for staff, other patients, and volunteers. • That I will abide by the rules and regulations of the dialysis unit including timely arrival during my treatment and to inform the unit ahead of time if I will be absent or be late for valid reasons. • That I will inform my Nephrologist of any changes in place of treatment or any complaints I might have.
F.	**Regular monitoring for infections**	○ That I will need regular blood testing to monitor my health and how I am responding to the treatment. I will also be regularly tested for infectious diseases that can affect dialysis patients, such as TB, Hepatitis B, Hepatitis C, HIV & SARS COV2. ○ That I may also be tested for other infections, if I, or someone else, has potentially been exposed.
G.	**PSN/DOH Registry**	○ That my renal unit will send my health information (***De-identified***) to the Philippine Society of Nephrology/DOH registry • This information will be used to improve the quality of care and outcomes for people with end stage kidney disease in the Philippines. • I can talk to my nephrologist if I do not want this to happen.
H.	**Communication of clinical information**	○ That my health record and information (both electronic and written) will be shared with staff from this renal unit and any other attending physicians I go to. This is to help coordinate my care, no matter who is helping me. ○ That my personal data will be handled in accordance with the Data Privacy Act.
I.	**Treatment change**	○ That I can change the type of treatment I am having, and that this is sometimes recommended by my nephrologist.

J.	**Stopping treatment**	○ That if dialysis treatment is no longer of benefit to me, there is the option of stopping dialysis and being managed with conservative kidney management (supportive care without dialysis).
K.	**Advance care planning and goals of care**	○ About the benefits of discussing and documenting treatment plans in case my condition worsens in the future (advance care planning). I have been informed of the importance of communicating with the treating team about my goals of care.

The above information was fully explained to me in simple terms and in dialect that I fully understood.

Patient Informed Consent

I have read and/or had explained to me the contents of this form and I understand the information in it.

I have been informed of all my treatment options for end stage kidney disease and I have had the opportunity to ask questions.

I give my consent to this ongoing treatment and to what is explained above.

Patient's Signature Over Printed Name Signature Over Printed Name of Responsible Party

Date Signed Relationship to Patient

Attending Nephrologist Witness' Signature Over Printed Name

ANNEX XI

Informed Consent for Hemodialysis Telehealth

By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. I understand that the telemedicine consultation sessions will involve my healthcare provider, and myself. However, any individuals whom I will allow to participate in may also be involved. Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data.
- Videos, pictures, text messages, audio, and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent.

I understand that my healthcare provider will make every effort to ensure the privacy and confidentiality of my personal and medical information. However, as with any Internet-based communication, I acknowledge the risk of a security breach and that my information could be intercepted or disclosed without my consent.

I understand that telehealth/telemedicine services have their own unique limitations, such as the inability to provide a physical examination. In addition, telehealth/telemedicine sessions may not always be possible.

Disruption of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between my healthcare provider, myself, and other involved individuals (if any).

I hereby release and hold harmless **[NAME OF NEPHROLOGIST] and any member of the healthcare team** from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/ telemedicine, it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the patient, and I am 18 years of age or older, or that I am the legal representative of the patient, or that I am otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

_____ _____

Signature over Printed Name of Patient Legal Representative

Date and Time: _____

Relationship to Patient

Name of Patient: _____

ANNEX XII

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The HD Guidelines may be found and downloaded from www.psn.ph