Creating an Integrated Care Plan

FOR NURSING HOME RESIDENTS RECEIVING DIALYSIS TREATMENT

Clear communication between nursing home and dialysis provider interdisciplinary teams (IDTs) is essential for successful transitions in care when nursing home residents receive dialysis. The Centers for Medicare & Medicaid Services (CMS) Guidance and Survey Process for Reviewing Home Dialysis Services in a Nursing Home (revised 03/22/23) highlights the importance of ongoing communication, collaborative care planning and delineated division of responsibilities as critical elements for the successful implementation of a plan of care for nursing home residents who leave their facility for dialysis treatments. Any barriers or issues hindering residents from achieving their goals should be promptly communicated between the dialysis provider and the nursing home IDT.

Tips for collaborating to initiate and maintain an integrated care plan.

- Identify key dialysis and nursing home staff to develop a collaborative relationship. Consider onsite visits to enhance understanding of the nursing home residents' experience in both nursing home and dialysis settings.
- Follow federal and state schedules for care plan reviews and ensure any new barriers to the resident receiving dialysis and any changes in condition trigger a collaborative review of the care plan.
- Use the Dialysis and Nursing Home Hand-Off Communication Tool to structure the conversation and ensure key information is communicated across the continuum of care between formal care plan reviews.
- Create a schedule for regular communication to review and update the resident's status and care plan.
- Use virtual platforms to enable real-time participation by nurse practitioners, nephrologists, patients, designated care partners, or key personnel from other locations.
- Implement a standard checklist to ensure key elements of each dialysis patient's care plan are reviewed.
- Document attendance at collaborative discussions and summary of discussion in each resident's medical record.
- Establish and hardwire a consistent hand-off communication tool into your facility processes.
- Establish a process for communicating findings and care plan updates to the interdisciplinary teams, residents, and designated care partners. Consider forums such as staff huddles, morning interdisciplinary meetings, unit rounds, and shift-to-shift reports.
- Use as a component of the nursing home continual survey readiness plan. Conduct random audits of medical records to determine if the medical record documentation reflects collaboration between the dialysis provider and the nursing home.

Dialysis Provider/Nursing Home Collaborative Discussion Guide

Use these prompts as a discussion guide to evaluate a resident's response to dialysis and develop or revise the care plan as needed. Each person-centered discussion will vary but should include a discussion of the person's current status, including the key elements below. Examples are provided to generate discussion.

Name: _____ Room Number: _____ DOB:_____

MD: _____ Nephrologist: _____ Dialysis Schedule: _____ MWF ____ TTS:

Collaborative discussion attendees:

Assessment/Problem	Person-Centered Discussion/Notes	Action Items	IDT Member
GOALS FOR DIALYSIS CARE: ☐ Change in resident-expressed goals and/or priorities for current or future care ***Example:*** *During dialysis, a resident expressed that their priorities are changing, and shortened dialysis treatment times or fewer visits are now a priority.*	***Example:*** *Dialysis IDT team talked with the resident about the risks and benefits of reducing the number of treatment visits per week versus shortened treatments.*	***Example:*** *Identify action steps for diet and lifestyle modifications to trial shortened treatment times.*	***Example:*** *Registered Dietitian, Social Work and Nursing*
FLUID BALANCE: ☐ Weight changes ☐ Target weight assessment ☐ Fluid intake ☐ Fluid gains ☐ Edema ☐ Urine output ***Example:*** *High fluid gains noted between treatments.*	**Example**: *Discussion identifies that the resident's menu choices have changed and they have been consistently selecting soup as an entrée.*	**Example**: *Dietary Consult*	**Example**: *Registered Dietitian*

NUTRITIONAL NEEDS: ☐ Diet orders: o Consistency o Adherence ☐ Labs to review (e.g.): o Phosphorous o Potassium o Parathyroid hormone (PTH) o Albumin o Calcium o Sodium o Glucose ☐ Increased or decreased appetite ***Example:*** *Resident's potassium level has increased.*	**Example**: *Resident's family is observed bringing resident potato chips for a snack.*	**Example**: *Engage family and care partners in planning snacks and adjustments to allow for the inclusion of other more healthy and lower potassium snacks in the resident's diet.*	**Example**: *RD, Nurse, Social Worker*
Assessment/Problem	**Person-Centered Discussion/Notes**	**Action Items**	**IDT Member**
ANEMIA: ☐ Labs results (e.g.) o Iron o Hemoglobin ☐ Medications (e.g.) o Erythropoiesis-Stimulating Agent (ESA) o Iron ***Example:*** *Resident's hemoglobin is trending down.*	***Example:*** *Resident history of gastro-intestinal (GI) problems was discussed.*	***Example:*** *Request GI consult and review of ESA order.*	***Example:*** *Nurse, Pharmcist*
COGNITIVE CHANGES: ☐ Changes in memory ☐ Difficulty with decision-making or completing task(s) ☐ Increased confusion ☐ Increased agitation ☐ Slurred or slower than normal speech ☐ Unusual mental fatigue ***Example:*** *New onset of unusual mental fatigue after the last two treatments.*	***Example:*** *Resident sleeps for four hours after returning to the nursing home and misses chaplain visits.*	***Example:*** *Review of blood pressure and target weights. Request chaplains adjust the visit schedule until the resident returns to a normal level of activity.*	***Example:*** *Nurse, Social Work or Activity Director*
MOBILITY: ☐ Recent falls ☐ Gait changes ☐ Balance changes ☐ Range of motion (ROM) ☐ Orthostatic hypotension risk ☐ Variations in the level of assistance needed during transfers and/or ADLs ☐ ROM in affected area ***Example:*** *Resident was noted to require more assistance with transfers to and from the scale and dialysis chair.*	***Example:*** *Baseline is transferring with standby assist. The resident now needs a contact guard or wheelchair weighing.*	***Example:*** *Physical Therapy referral, medication review, review of the fall care plan, and target weight assessment.*	***Example:*** *Physical Therapy, Nurse, or Pharmacist*

Assessment/Problem	Person-Centered Discussion/Notes	Action Items	IDT Member
INFECTION: ☐ Access site ○ Tenderness ○ Redness ○ Discharge ☐ Wounds ☐ Sepsis ☐ Vital signs ○ Temperature ○ BP ***Example:*** *Resident complaining of pain around the CVC exit site.*	***Example:*** *Resident states pain is 4 out of 10.*	***Example:*** *Assess for infection, confirm suture placement, address and monitor pain.*	***Example:*** *Nurse*
PSYCHOSOCIAL NEEDS: ☐ Change in mood or behavior ☐ Refusal to participate in usual activities ☐ Expressing feelings of hopelessness or anger ☐ Pain or anxiety ***Example:*** *Resident refusing to go to dialysis.*	***Example:*** *Resident missed three treatments within the last two weeks.*	***Example:*** *Resident no longer wants to complete dialysis treatment. Discuss the goals of care with the resident and identify what matters most. Provide psychosocial support. Review dialysis orders for potential adjustments that may make treatment more palatable.*	***Example:*** *Social Worker, Nurse*
ADDITIONAL FOCUS AREAS: ☐ Transplant list status (if appropriate) ☐ Review of dialysis prescription ○ Dialysis adequacy ***Example:*** *Resident on hold for the transplant waitlist.*	***Example:*** *Resident was placed on hold for surgery, which led to hospitalization and SNF stay.*	***Example:*** *Set up an appointment with the transplant center after discharge and include it in the discharge plan.*	***Example:*** *Nurse*

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ANEMIA ☐ Labs results (e.g.) ○ Iron ○ Hemoglobin ☐ Medications (e.g.) ○ Erythropoiesis-Stimulating Agent (ESA) ○ Iron			

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