End-Stage Renal Disease
Network Program

Dialysis and Nursing Home Integrated Care Plan

Successful transitions in care between the nursing home and dialysis staff depend on clear communications. Skilled Nursing Facilities (SNF), Nursing Homes (NH), and Long Term Acute Care (LTAC) facilities take care of patients with a wide variety of problems. Only a small number of their patients have kidney failure. Personnel may not be aware of the unique health needs of the dialysis patient and do not understand how dialysis care is provided. Investing time and effort to develop good communication practices that are supported through the transition processes can lead to improved patient safety and quality outcomes as well as better relationships between patients and providers. An integrated care plan that is reviewed on a monthly basis is a fundamental process to facilitate the necessary exchange of clinical information between dialysis providers and the SNF/NH/LTAC staff. Conducting these joint planning discussions accompanied by the use of a Handoff Communication Tool with each dialysis is a best practice in provision of care for an ESRD patient who resides in a SNF/NH or LTAC.

Tips for initiating an integrated care plan with the SNF/NH/LTAC

- Identify key staff at the SNF/NH/LTAC (such as DON, Charge Nurse or designee) that are consistently at the facility and establish a relationship with this person. Identify a mutual time once a month, where dialysis patient care plan meetings can be scheduled.
- Use technology such as zoom calls so personnel from multiple locations can dial in and attend the monthly care plan meeting (this may allow Nurse Practitioners or the Nephrologist to join while not on site)
- Attempt to coordinate times with the SNF/NH/LTAC staff that may already be used for this process i.e. add into the end of a staff huddle at the SNF/NH/LTAC to discuss dialysis patients' care plans.
- Use an Integrated Care Plan template to write in information which can be shared between both teams of staff (see page 2). Identifying common issues that are significant to monitor for dialysis patients may help zero in on concerns that need planning for both parties.
- Support the ongoing transmission of data using a Handoff Communication Tool so that communication occurs with each transition.
- Share the patient care plan discussions/documents with all staff who care for the patient so that they can understand any issues/concerns that were identified and work within that plan of care.
- As you are able, involve the patient or a family member to be an active part of the meetings.

IPRO End-Stage Renal Disease Network Program
Corporate Office:
1979 Marcus Avenue, Lake Success, NY 11042-1072 • Patient Services: (516) 231-9767
Toll-Free: (800) 238-3773 • Email: esrdnetworkprogram@ipro.us • Web: esrd.ipro.org

Developed by the IPRO ESRD Network Program while under contract with the Centers for Medicare & Medicaid Services.
Contract # 75FCMC19D0029 Publication # ESRD.IPRO-G5-NW-20220922-1232 v.1 10/24/2022

IPRO, the End-Stage Renal Disease Organization for the Network of New England, Network of New York, Network of the South Atlantic, and Network of the Ohio River Valley, prepared this material under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. CMS Contract Number: 75FCMC19D0029. CMS Task Order Numbers: 75FCMC21F0001 (Network 1), 75FCMC21F0002 (Network 2), 75FCMC21F0003 (Network 6), 75FCMC21F0004 (Network 9).

Care Plan Form continues on pages 2 & 3

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Dialysis/Nursing Home Integrated Care Plan

Date:

Patient Name:	DOB:	Dialysis Schedule	Room Number
Nursing Home Charge Nurse:	**Dialysis Nurse:**	**MD:**	**Nephrologist:**

Assessment/Problem	Planning/Evaluation	Intervention	Outcome:
FLUID BALANCE ***Example:*** *Nursing home patient comes to dialysis with large weight gain and signs/symptoms of fluid overload such as edema, SOB, high BP.*	*Example: Dialysis staff consults with nursing home staff to identify issues with patient's diet (eating salty foods, excessive thirst or increased fluid intake).*	***Example:*** *Dialysis RD and nursing home RD meet to develop dietary plan.*	***Example:*** *Patient presents to dialysis with 1.5- 2.0 fluid weight gains and no signs of fluid overload.*
HEMOGLOBIN: ***Example:*** *Low Hemoglobin - NH Nurse contacts dialysis unit due to low Hgb <= 8.0.*	***Example:*** *Dialysis RN reviews patient's iron stores and Aranesp dose with nephrologist. MD orders increased iron and Aranesp.*	***Example:*** *Dialysis RN reviews plan of care with NH nurse and will follow with Hgb in one week. NH nurse discusses with M.D. and will await transfusion based on dialysis actions. NH nurse will monitor patient for symptoms of anemia.*	***Example:*** *Dialysis RN sends Hgb to NH nurse; still holding at 8.0 and patient asymptomatic. No transfusion at this time.*

Dialysis/Nursing Home Integrated Care Plan

Assessment/Problem	Planning/Evaluation	Intervention	Outcome:
COGNITIVE CHANGES ***Example:*** *Dialysis staff note patient has increased memory/ judgment issues and/or difficulty completing tasks.*	***Example:*** *Dialysis staff communicate concerns with the nursing home staff to confirm change in cognition and discuss next steps in plan of care.*	***Example:*** *NH and dialysis staff create a plan to monitor patient for any other changes in condition or symptoms and share findings. Patient placed on fall risk precautions.*	***Example:*** *Patient's cognitive condition has improved, no further monitoring necessary.*
MOBILITY ***Example:*** *Impaired Mobility - Nursing home patient exhibiting signs of an unsteady gait and risk for falls after dialysis.*	***Example:*** *Communicate concerns with the nursing home staff to confirm change in mobility and risk for falls and discuss next steps in plan of care.*	***Example:*** *Patient to be transported to and from dialysis in a wheelchair.*	***Example:*** *Ambulation with walker only allowed if accompanied by NH staff.*
SIGN OF INFECTION ***Example:*** *Access Infection - Nursing home patient is complaining of tenderness at the vascular access site and BP is lower than the patient's baseline.*	***Example:*** *Dialysis RN assesses vascular access site and vital signs. Contacts nephrologist to report symptoms. MD orders blood cultures.*	***Example:*** *Dialysis RN reviews plan of care with NH nurse and will notify NH nurse of blood culture results. NH nurse will monitor patient for symptoms of sepsis and notify MD if condition worsens and hospitalization is indicated.*	***Example:*** *Blood cultures were negative and the patient's vital signs are stable.*