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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 identified barriers or issues that prevent residents from attaining their established dialysis facility goals (identified using the most current comprehensive and most recent quarterly (if the comprehensive assessment is not most recent) Minimum Data Set (MDS) assessment and/or defined in the plan of care) should be promptly communicated between the dialysis provider and the nursing home interdisciplinary teams. Any barriers experienced by a dialysis patient will require reassessment and, if indicated, creation of an updated integrated plan of care.

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 resident's experience in both nursing home and dialysis settings.
- Follow federal and state schedules for care plan reviews and ensure that 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 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 participation in real time by nurse practitioners, nephrologists, patients, and designated care partners, or key personnel from other locations.
- Implement use of 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 handoff 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 the integrated care plan as one 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.

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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 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	Notes	Action Items	IDT Member
GOALS FOR DIALYSIS CARE: • Change in resident's expressed goals, and/or priorities for care • Changes to Advance Care planning documents and/or Orders for Life Sustaining Treatments ***Example:*** *Resident expressed during dialysis that their priorities are changing, and shortened dialysis treatment times or fewer visits is now a priority.*	***Example****: Dialysis IDT team talked with resident about risks and benefits of reducing 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 Worker and Nurse*
FLUID BALANCE: • Weight changes • Target weight assessment • Fluid intake • Fluid gains • Edema • Urine output ***Example:*** *High fluid gains noted between treatments.*	***Example:*** *Discussion identifies resident's menu choices have changed and they have been consistently selecting soup as an entrée.*	***Example:*** *Dietary Consult*	***Example:*** *Registered Dietitian*

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Dialysis Provider/Nursing Home Collaborative Discussion Guide (continued)

Assessment/Problem	Notes	Action Items	IDT Member
NUTRITIONAL NEEDS: • Diet orders : ▪ Consistency ▪ Adherence ▪ Labs to review (e.g.): ▪ Phosphorous ▪ Potassium ▪ Parathyroid hormone (PTH) ▪ Albumin ▪ Calcium ▪ Sodium ▪ 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 in replacing snacks such as potato chips with lower-potassium, healthier options.*	***Example:*** *Registered Dietitian, Social Worker and Nurse*
ANEMIA: • Lab results (e.g.) ▪ Iron ▪ Hemoglobin • Medications (e.g.) ▪ Erythropoiesis-Stimulating Agent (ESA) ▪ Iron *Example: Resident's hemoglobin is trending down*	*Example: Resident history of gastro-intestinal (GI) problems discussed.*	*Example: Request GI consult and review of ESA order*	*Example: Nurse, Pharmacist*
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 nursing home and misses chaplain visits.*	***Example:*** *Review of blood pressure and target weights.* *Request chaplains adjust visit schedule until resident returns to normal level of activity.*	***Example:*** *Nurse, Social Worker, or Activity Director*

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Dialysis Provider/Nursing Home Collaborative Discussion Guide (continued)

Assessment/Problem	Notes	Action Items	IDT Member
MOBILITY: • Recent falls • Gait changes • Balance changes • Range of motion (ROM) • Orthostatic hypotension risk • Variations in level of assistance needed during transfers and/or ADLs • ROM in affected area ***Example:*** *Resident noted to require more assistance with transfers to and from scale and dialysis chair.*	***Example:*** *Baseline is transferring with standby assist. Resident now needing contact guard or wheelchair weighing.*	***Example****: Physical Therapy referral, medication review, review of fall care plan, target weight assessment.*	***Example:*** *Physical Therapist, Nurse, or Pharmacist*
INFECTION: • Access site ▪ Tenderness ▪ Redness ▪ Discharge • Wounds • Sepsis • Vital signs ▪ Temperature ▪ BP ***Example:*** *Resident complaining of pain around 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 has missed three treatments within the last two weeks.*	***Example:*** *Resident may no longer want to complete dialysis treatment.* *Discuss goals of care with resident, identify what matters most.* *Provide psycho-social support.* *Review dialysis orders for potential adjustments that may make treatment more palatable.*	***Example:*** *Social Worker, Nurse*

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Assessment/Problem	Notes	Action Items	IDT Member
ADDITIONAL FOCUS AREAS: • Transplant list status (if appropriate) • Review of dialysis prescription ▪ Dialysis adequacy ***Example:*** *Resident on hold for transplant wait list*	***Example:*** *Resident placed on hold for surgery, and that led to hospitalization and SNF stay.*	***Example:*** *Set up appointment with transplant center after discharge and include in discharge plan.*	***Example:*** *Nurse*

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NUTRITIONAL NEEDS			
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MOBILITY			
INFECTION			
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ADDITIONAL FOCUS AREAS			