Improving Transitions of Care for Kidney Patients

Infection Control

Post-workgroup evaluation

October 6, 2017

Presentations this morning focused on optimizing transitions of care for ESRD patients. Communication to patients and between Provider settings is essential for a successful process. The setting may include admissions and discharge from a hospital to a dialysis facility or a skilled nursing facility.

Based on the presentations this am and your own experiences, please discuss issues such as

- **Assessment tools and process to review infection risk**
- **Communication from setting to patient and facility**
- **Communication from facility and patient to setting**
- **Medication reconciliation**
- **Provider medical record retrieval**
- **Admission and discharge instructions**
- **Patient and family education.**

What is currently successful, what process does not exist or could be improved upon and are there any tools that could be developed for patient use to assist with communication to hospital or other settings.

What is working?

- CDC audits for access
- Increasing time between patients to allow for the new regulation that previous dialysis patient needs to be out of the chair before setting up for next patient
- Vascular access manager to follow-up on access appointments
- PD nurse training nurses in nursing homes, each person trained by PD nurse not train the trainer
- Peer pressure- PPE, hand hygiene- “see it, say it”
- Scrub the hub- proper CVC care, use timer cubes (give cube to patient), has become a sort of game with patients
- Wrap tails with gauze and tape
- Infection prevention committee & standards
- EPIC in some units connects to their hospital so records can be printed out by the unit without calling someone for the records.

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What needs improvement?

- Antibiotic stewardship program for the units, need pharmacy involved
- Each unit should have a pharmacist for reconciliation of meds, med education and antibiotic appropriateness.
- Discharge summary often not available to reconcile medications or find reason for antibiotics and if they are appropriate according to sensitivity.
- Patient compliance
- Catheter rates (many patients have exhausted sites)
- Education/ health care literacy
- Communication between hospital and dialysis unit regarding reason for antibiotics being given and when they are drawn (depends on who puts it in NHSN)

What process or tools need to be developed? Please be as specific as you can.

- Nursing home to dialysis unit communication form needs to be developed.
- Process for medication reconciliation 1st 24 hours to continue the correct antibiotic according to sensitivities
- ED: IV antibiotics given, don't always do pre- antibiotic blood cultures ($100 per set)
- If pt. comes to ED with fever and hypotension, Vancomycin is given if pt. has a CVC automatically
- Needs health record exchange so hospitals and dialysis can talk to each other and see each other's records
- NHSN reporting requirements dialysis unit vs. hospital need to be followed and staff educated
- Permanent access in CKD 3-4 would help with the 90 day window
- More frequent teaching about access selection before dialysis is needed
- Guidelines for audits- frequency, watching
- Staff education: Education more frequent, "2 person dressing"
- Permanent access with they come to the unit, 90 days not happening
- Infection treatment transition to outpatient HD unit
- Infection rates often r/t other infections: foot checks monthly, referral to podiatrist
- Discharge follow-up to ensure antibiotics, timing and infusion center.
- Med recs within 1swt or 23nd visit from discharge.
- Looking for antibiotic or infection issues and identified as quickly as possible
- Care Coordinator/ case management: follow up on blood cultures, antibiotics (peaks and troughs), Communication with specialists and other facilities (SNF, ALF)
- Medical homes- bring care to the patient. Example- APP liaison to primary care rounding at dialysis unit.
- Telehealth with other specialties (ID, endocrine)
- Care integration
- Assessment- artificial intelligence tool to predict infection/ sepsis and validate (FMC and Clarity

doing a project together)

- Reimbursement for renal dialysis patient home visits
- Reducing catheters
- Isolation of infections patients in the dialysis unit: (MRSA, C diff, VRE, etc.)