The following interventions have been successfully implemented in Midwest Kidney Network dialysis facilities to reduce the risk of inpatient admissions and emergency department visits. Have a best practice to share? Please let us know!

## **infection**

* Implement quarterly technique checks with all home patients to ensure accurate technique to reduce infection risk.
* Educate skilled nursing facility (SNF) staff on central venous catheter (CVC) precautions.
* Provide infection prevention in-service for all staff and then utilize a team approach to complete audits to ensure adherence to infection prevention policies and procedures.
* Assign infection training modules through American Society of Nephrology (ASN) as supplemental staff education. Select a different infection topic to focus on each week or month during team huddles for discussion. Elicit feedback from the team on where there are gaps in unit routines that differ from recommended infection prevention guidelines.
* Schedule an ICAR assessment to identify gaps in clinic infection prevention practices.

## **Missed treatments**

* Proactive rescheduling treatments when a patient calls off. Replace “would you like to come a different day/time?” with “we can provide your makeup treatment on X day at X time.”
* Utilize a script for staff to follow when a patient calls in to miss treatment.
* For MWF only clinics, coordinate with a sister clinic as able to schedule extra treatments or missed treatments on TTS.
* Create fun competition or raffle to encourage attendance to all treatments.

## **Fluid management**

* Provide reusable ice cubes, lip balm, and measuring cup to all patients.
* Hold a weekly team review of fluid management. Share weight trends with staff and focus on patients of concern.
* Have a “weigh day” where staff assist patients in weighing in and out to ensure accurate weight process and provide education on fluid management to both staff and patients.

## **vascular Access management**

* Host a vascular access lobby day in the clinic in collaboration with the local vascular access clinic. Educate patient on best practices in vascular access and learn more about access procedures.

## **Wellness**

* Educate patients on the importance of having a primary care provider (PCP). Assist patients without a PCP establish care.
* Utilize community health workers to support patients with appointment reminders, dietary education, medication reminders, etc.
* Assist patients with setting goals based on their values and connect those goals with steps to take to achieve them. Start with easy, short-term goals, praise successes, and build on that progress to reach bigger goals.
* With changes in medications, have home patients return to clinic for lab check to ensure electrolyte balance with new dosing.

## **Transitions in Care**

* Implement focused IDT rounding for two weeks following discharge from the hospital – ensure accurate orders, medications, psychosocial needs are met, etc.
* Establish read-only access to electronic medical record for local hospitals/healthcare organizations.
* Establish clear communication pathway with care management team of local hospital to receive handoff report on discharge.

## **Dialysis unit team culture**

* Share facility goals and progress with all staff via e-mail, team huddles, and staff education boards.
* Utilize team champions and delegate quality improvement work to various team members, regardless of title/role in the clinic. Utilize team members’ unique talents to accomplish necessary tasks.
* Involve NP/PA in providing patient education on select topic each month – for example, fluid management month one, vaccines month two, access care month three, etc.