Improving Transitions of Care for People on Dialysis

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End Stage Renal Disease (ESRD) Network 11

April 2019

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Commitment to Transitions of Care

Midwest Kidney Network serves 50,000 patients and 545 providers of dialysis and kidney transplant services.

In 2017, we hosted an educational meeting focused on improving transitions of care for people on dialysis.

Meeting participants included hospital inpatient discharge planners, emergency department personnel, skilled nursing facility representatives, health information experts, and out-patient dialysis staff.

The following slides highlight the goals, best practices, and resources collected to improve care transitions for people on chronic dialysis.

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What are Transitions of Care?

Movement of patients between healthcare settings as their health conditions and care needs change, such as:

- Hospitals
- Skilled nursing facilities
- Outpatient services
- Modality changes (such as home dialysis)
- Facility changes

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Why Transitions of Care?

"Care transitions are complex. If we miss a step in the process, patients might not get what they need.

Consider the example of a patient with heart failure who leaves a hospital without the right prescriptions and instructions to take his medicines correctly. He may require re-hospitalization because of medication errors."

Transitions of Care Toolkit, Forum of ESRD Networks, 2017

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Transitions of Care: Key Concepts

1. Kidney patients and their families have many unique transitions.
2. Kidney failure does not go away, though treatment and settings may change.
3. Changes that seem routine for provider staff may be highly stressful for patients.
4. Communication is critical.
5. Respect is essential.
6. This is a complicated life journey.

Transitions of Care Toolkit, Forum of ESRD Networks, 2017

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Resources
Transitions of Care

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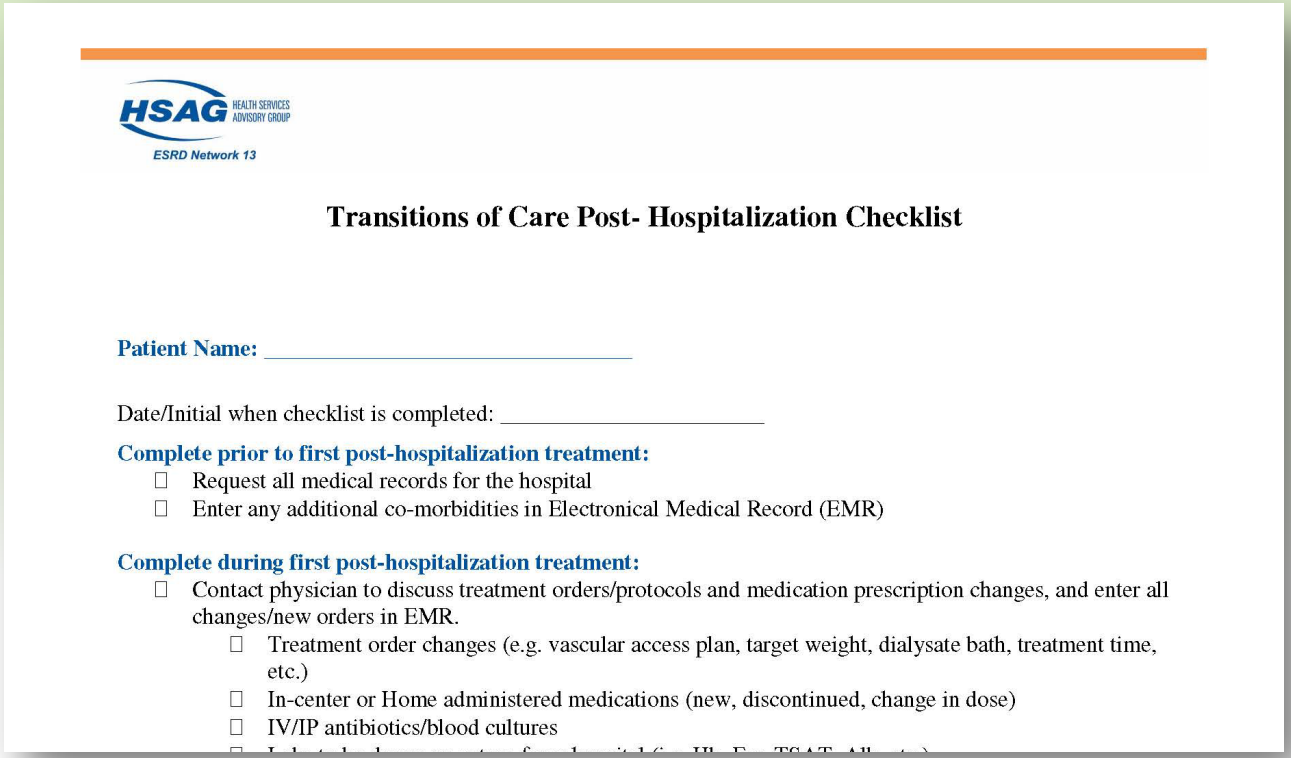
Care Transitions Checklist: Post-hospitalization



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Transitions of Care Post- Hospitalization Checklist

Patient Name: _____

Date/Initial when checklist is completed: _____

Complete prior to first post-hospitalization treatment:

- ☐ Request all medical records for the hospital
- ☐ Enter any additional co-morbidities in Electronical Medical Record (EMR)

Complete during first post-hospitalization treatment:

- ☐ Contact physician to discuss treatment orders/protocols and medication prescription changes, and enter all changes/new orders in EMR.
  - ☐ Treatment order changes (e.g. vascular access plan, target weight, dialysate bath, treatment time, etc.)
  - ☐ In-center or Home administered medications (new, discontinued, change in dose)
  - ☐ IV/IP antibiotics/blood cultures

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Emergency Department (ED) Perspectives on Transitions of Care

David Somand, MD
University of Michigan
Ann Arbor, MI

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Emergency Department Actions

- Identify care team
- Communicate with nephrology on all ED admits
- Discharge planning, social worker in ED 24/7
- Social worker afternoons and evenings
- Provider alternative resources/ arrange follow-up
- Alternatives to admission/ appropriate sites of care

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Hospital Discharge Planning Perspective

Kristin Woody, MSW
Regions Hospital
St. Paul, MN

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Hospital Discharge Planning Initiation/New Start of Dialysis

- Case Manager meets with patient/ family to determine choice of agency
- Referral sent per patient decision
- Discussion regarding location, chair/ run time and days
- Coordination of other needs
- Transportation discussion with patient and family

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Hospital Discharge Planning
Admission with ESRD Complications

- Existing dialysis patient missed dialysis
- Access complications
- Missed rides to dialysis unit
- Exacerbation of other illness
- Point of entry- ED, is patient observation patient?

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Hospital Discharge Planning
Resumption of Outpatient Dialysis

- Case Management team sends referral and orders for resuming dialysis
- Patient typically remains at own dialysis unit unless acuity changes
- Ensure patient has transportation
- Educate regarding importance of keeping appointments

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Final Discharge Planning

Determine discharge needs

- Home with no meds
- Home with meds
- Transitional care
- Long term care

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Hospital to Nursing Home/Skilled Nursing Facility Perspective

Kristi Wergin, RN, BSN, CPHQ,
Stratis Health,
Bloomington, MN

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Nursing Home Discharge

- Communication regarding medical condition
- Communication regarding nutritional needs
- Communication regarding dialysis treatment
- Medicine reconciliation

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Best Practices
Nursing Home to Dialysis

- Use consistent staff, find one person at dialysis unit to coordinate care.
- Know the dialysis unit staff to coordinate activities and communicate.
- Send information to Nursing Home: Recent meds, vital signs and weight, changes in status.
- Maintain a communication book that goes with resident each treatment.
- Send medication list and dry weight.

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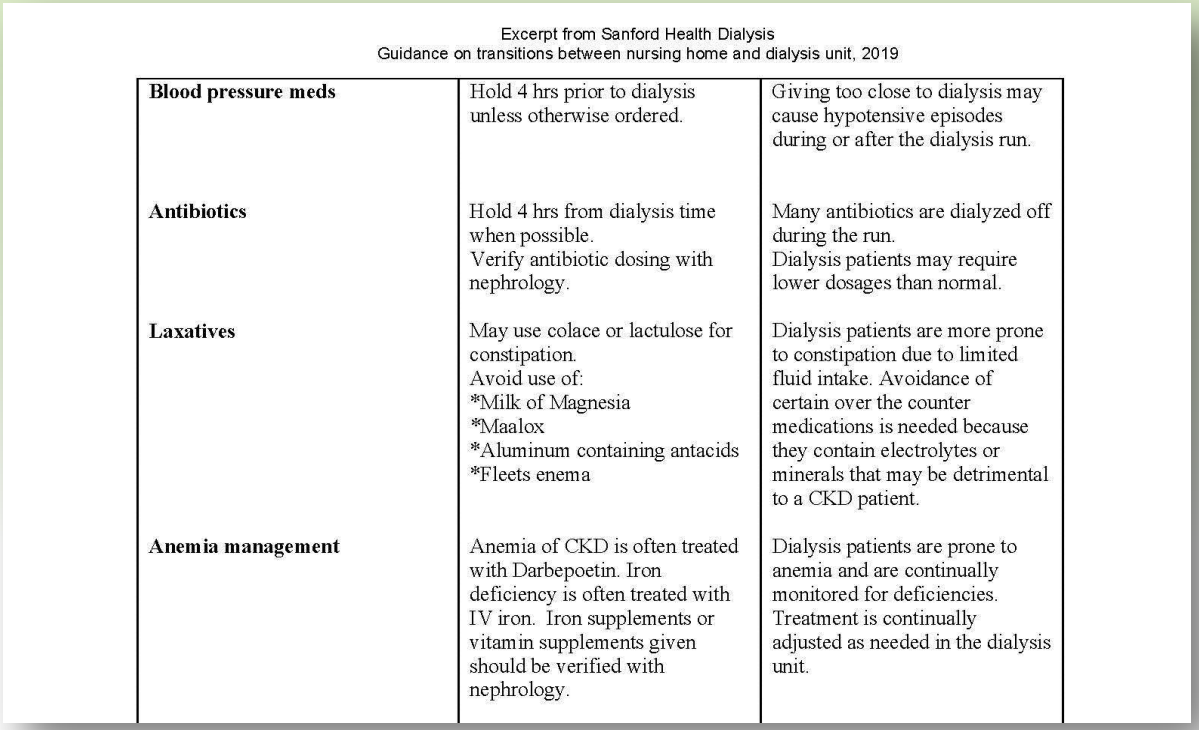
Dialysis to Nursing Home Sample Education Form



Excerpt from Sanford Health Dialysis
Guidance on transitions between nursing home and dialysis unit, 2019

Blood pressure meds	Hold 4 hrs prior to dialysis unless otherwise ordered.	Giving too close to dialysis may cause hypotensive episodes during or after the dialysis run.
Antibiotics	Hold 4 hrs from dialysis time when possible. Verify antibiotic dosing with nephrology.	Many antibiotics are dialyzed off during the run. Dialysis patients may require lower dosages than normal.
Laxatives	May use colace or lactulose for constipation. Avoid use of: *Milk of Magnesia *Maalox *Aluminum containing antacids *Fleets enema	Dialysis patients are more prone to constipation due to limited fluid intake. Avoidance of certain over the counter medications is needed because they contain electrolytes or minerals that may be detrimental to a CKD patient.
Anemia management	Anemia of CKD is often treated with Darbepoetin. Iron deficiency is often treated with IV iron. Iron supplements or vitamin supplements given should be verified with nephrology.	Dialysis patients are prone to anemia and are continually monitored for deficiencies. Treatment is continually adjusted as needed in the dialysis unit.

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Best Practices from Hospital to Nursing Home

- Set up first ride from Nursing Home to dialysis
- Send current orders, post run form, medication instructions
- Medication instructions should be specific as to what meds to give before and after dialysis
- Make sure the dietitians in both facilities communicate

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Dialysis to Hospital or Nursing Home Dialysis Facility Perspective

Cari Dock, RN, BS
Regional Operations Director
DaVita, MN

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Hospital to Dialysis Unit

- Dialysis prescription adjusted- dry weight, updated treatment orders
- Medication changes
- Care follow-up: future appointments, comorbid changes

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Communication Form: *Hospital Inpatient to Dialysis Center*

Hospital Infection Preventionist Report to Dialysis Center

Hospital Name: _____ Location: _____ Date: _____

Person completing form: _____ Title: _____ Phone #: _____
Print Clearly

Patient Name: _____/ ID: _____ DOB: / /
Print Clearly

Admission Date: _____ Discharge Date: _____

Date of Culture: _____ Within first day of admission: Yes No
CDC – "One calendar day after hospital admission includes positive blood cultures collected on the day of or the day following admission to the hospital."

Culture Site: _____

Organism(s): _____

Is organism a Multidrug Resistant Organism? (MDRO): Yes No

Fax a list of sensitivities to enter in NHSN: Yes No

Were any antibiotics administered during this hospitalization? Yes No Date: _____

Name of Antibiotic: _____ Dose: _____ Frequency: _____

Name of Antibiotic: _____ Dose: _____ Frequency: _____

Continue antibiotic as an outpatient? Yes No

Vascular Access

Were there any changes to the vascular access during this hospitalization? Yes No

Was a new vascular access placed? (Circle correct answer) Fistula Graft HeRO Catheter

Was a non-dialysis vascular access placed? (Circle correct answer) PICC Port Other _____

Any follow-up appointments or tests required? Yes No List: _____

Reported to: _____ RN Dialysis Unit: _____

Revised 4/2/2015
Sanford Health Dialysis

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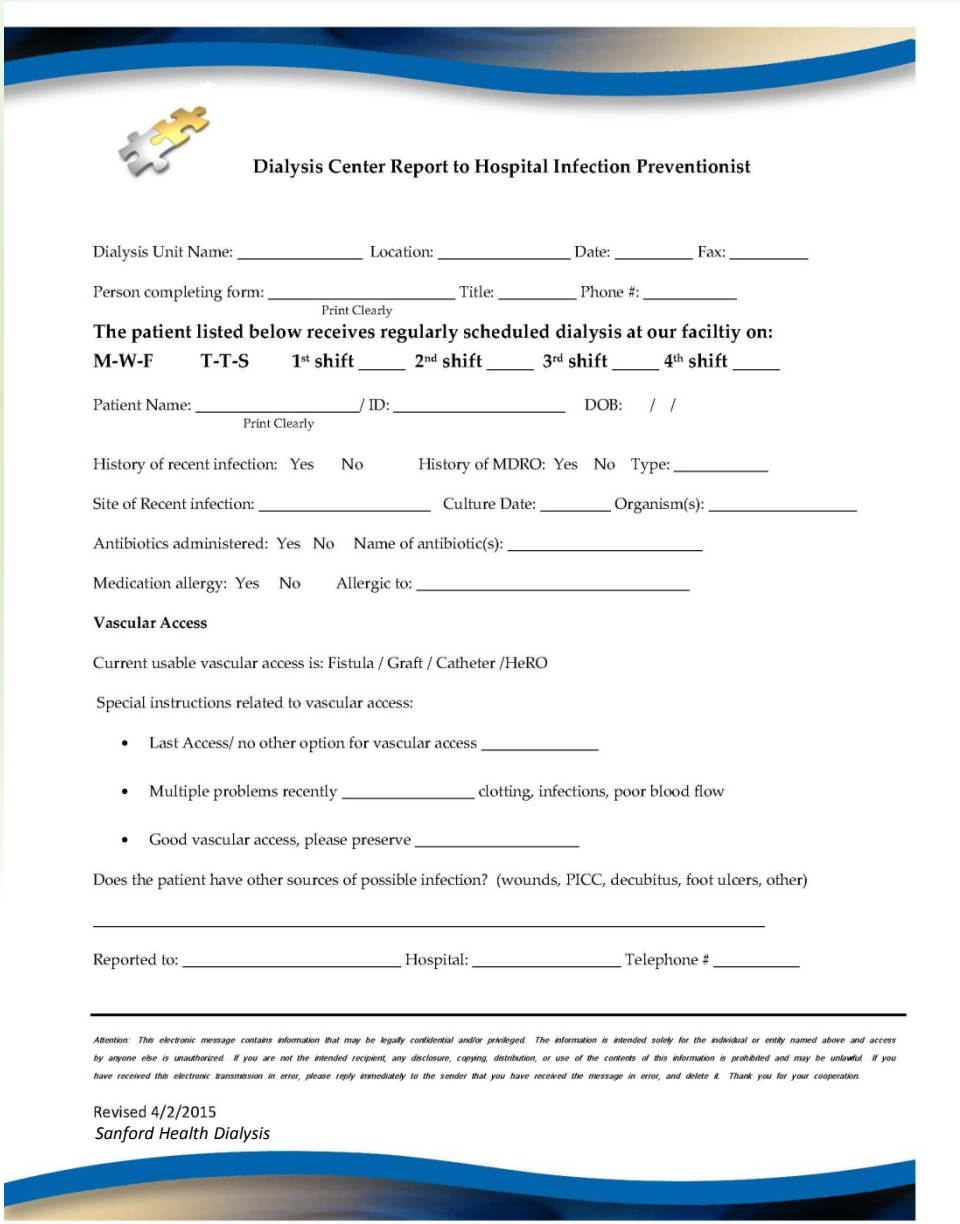
Dialysis Unit to Hospital

- Call ahead if patient is going to the ED
- Send dialysis orders, hepatitis status, diagnosis list, recent labs
- Send vascular access information
- Send dialysis schedule in the unit and transportation issues

Communication Form: *Dialysis Center to Hospital Inpatient*



Dialysis Center Report to Hospital Infection Preventionist

Dialysis Unit Name: _____ Location: _____ Date: _____ Fax: _____

Person completing form: _____ Title: _____ Phone #: _____
Print Clearly

The patient listed below receives regularly scheduled dialysis at our faciltiy on:
M-W-F T-T-S 1st shift ____ 2nd shift ____ 3rd shift ____ 4th shift ____

Patient Name: _____/ ID: _____ DOB: / /
Print Clearly

History of recent infection: Yes No History of MDRO: Yes No Type: _____

Site of Recent infection: _____ Culture Date: _____ Organism(s): _____

Antibiotics administered: Yes No Name of antibiotic(s): _____

Medication allergy: Yes No Allergic to: _____

Vascular Access

Current usable vascular access is: Fistula / Graft / Catheter /HeRO

Special instructions related to vascular access:

- Last Access/ no other option for vascular access _____
- Multiple problems recently _____ clotting, infections, poor blood flow
- Good vascular access, please preserve _____

Does the patient have other sources of possible infection? (wounds, PICC, decubitus, foot ulcers, other)

_____

Reported to: _____ Hospital: _____ Telephone # _____

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Revised 4/2/2015
Sanford Health Dialysis

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Resources

Documents highlighted in this presentation

- Forum of ESRD Networks Transitions of Care Toolkit
- Post-hospitalization Checklist
- Dialysis to Nursing Home Plan of Care
- Communication Form: Hospital to Dialysis Unit
- Communication Form: Dialysis Unit to Hospital

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Resources

Thank you for working to improve care transitions. For the resources presented here and more visit us at

midwestkidneynetwork.org/patient-safety/care-transitions

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