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Improving Transitions of Care for Kidney Patients: SNF Perspective

Midwest Kidney Network

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Long-Term Care Facility Requirement

The facility must ensure that residents who require dialysis receive such services that are consistent with:

- Professional standards of practice
- Residents' person-centered care plan
- Residents' goals and preferences

Requirements for Long-Term Care Facilities, October 4, 2016: F698- 483.25(l) Dialysis

Transitions of Care

SNF ⟷ Hospital

SNF ⟷ Dialysis Facility

SNF ⟷ Setting of Choice
(Home/ALF/NH)

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What Contributes to Safe Care Transitions?

Shared Communication Regarding Medical Condition

- Medication administration
- Physician/treatment orders
- Laboratory values
- Vital signs
- Advance directives and code status
- Specific directives about treatment choices
- Change in condition
- Any changes or further discussion needed between attending physician, resident, family, designated dialysis staff (nephrologist/nurse)

Shared Communication Regarding Nutritional Status

- Weight fluctuations
- Nutritional issues
- Adherence to food/fluid restrictions
- Meals before, during, or after treatment
- Intake and output as ordered

Shared Communication Regarding Dialysis Treatment

Treatment provided and resident response:

- Declines in functional status
- Falls
- Symptom changes that interfere with dialysis treatment: depression, anxiety, confusion, and/or behavioral expressions
- Concerns related to transportation

Shared Communication Following Dialysis Treatment

- Any adverse reactions/complications
- Recommendations for follow up observations and monitoring
- Concerns related to vascular access site/peritoneal catheter

Shared Communication Unrelated to Dialysis

- Any care concerns
- Occurrence or risk for pressure injuries and interventions
- Occurrence or risk of falls and interventions

Ongoing Coordination/Collaboration

- Ongoing coordination/collaboration with the dialysis facility regarding care and services
- Collaboration with the medical director, consultant pharmacist, and dialysis facility to develop policies and procedures to address common complications and to ensure access to needed medications
- Care coordination
  - Coordinated plan developed with input from **both** the nursing home and dialysis facility (nephrologist, attending physician, dialysis facility staff, and nursing home staff)

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Best Practices

Best Practice for SNFs

Surround the resident with consistent staff:

- Identify a nurse team to be the care navigators with the resident and family
- Assign consistent care team members

Know the dialysis facilities:

- Designate a staff person to coordinate activities/communication with each dialysis facility

Best Practice for SNFs

- To prepare for possible hospital transfer:
  - Designate a hospital that can provide emergency dialysis care 24 hours/day, 7 days/week
- Identify a "go-to" person at the SNF with whom the transitioning organization can communicate
- Send information at each dialysis appointment that includes:
  - Most recent medication administration record
  - Vital signs and weights
  - Any changes in status or any acute event

Best Practice for SNFs

- Engage and educate residents and families
- Maintain a communication book that goes with the resident to and from dialysis treatments
- Have a system in place to track and trend transitions
  - Maintain a log of transitions and any problems that arise
  - Review the log regularly in QAPI meetings to evaluate improvement possibilities
  - Have a system in place to track and trend transitions

Best Practice for SNFs

When discharging from the NH:

- Send the dialysis facility the same medication list and discharge instructions that are being sent to the primary care physician
- Communicate and collaborate with the home health service to improve the patient's functional status and to avoid another hospitalization

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Lessons Learned from Minnesota Nursing Homes

Best Practices from Minnesota Nursing Homes

- Set up a “first ride” to the dialysis center before they arrive at the SNF from home or the hospital
- Best to admit on a “non-dialysis” day so there is time to set up transportation
- Send current orders, post run form, and a blank PO sheet to dialysis center
- Medication orders from hospital: should be clear which medications should be given before and which after dialysis

Best Practices from Minnesota Nursing Homes

- Make sure dialysis unit and NH unit dietitians communicate
- Should be clear what the resident's expected dry weight is
- Important to know if the dialysis center has any lab results to share

Barriers to Safe Transitions

- Transport does not show up
- The resident forgets his/her bag lunch
- Medications are not scheduled around dialysis
- Post dialysis paperwork is not completed and returned to the SNF

Suggestions to Reduce Hospitalizations

- Dialysis care plan in place that states what to do in an emergency
- Monitor clinical status
  - Check bruit/thrill
  - Weights
  - Fluid intake and restrictions
  - Follow diet recommendations
  - Signs of infection
  - Blood pressure
  - Bleeding

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