Expert Teams
Dialysis Care In Nursing Homes
Case-Based Learning & Mentorship

Thursday, November 2, 2023

Moderator: Stephanie Hull
ESRD National Coordinating Center

Meeting Logistics

- Call is being recorded
- Participants can unmute themselves
  - Please stay on mute unless you are speaking
  - Do not place the call on “hold”
- Everyone is encouraged to use the video and chat features
- Meeting materials will be posted to the ESRD NCC website.

Who Is On The Call?

Clinician and Practitioner Subject Matter Experts

Dialysis Facility and Transplant Professionals

ESRD Network Staff

Kidney Care Trade Association Members

Centers for Medicare & Medicaid Services (CMS) Leadership

Expert Team Call Objectives

Prepare for improvement using shared clinical cases

Test processes through the application of knowledge from the cases

Use inquiry-based learning to problem solve

Examine clinical reasoning, problem solving, and decision making through lived experience

Act as a consultancy for behavior change and improvement

Questions to Run On

How Might We . . .

- Improve the care and lives of dialysis patients that reside in nursing homes?
- Overcome barriers to dialysis care in the nursing home?
- Address other special needs for this vulnerable population?

Guest Expert

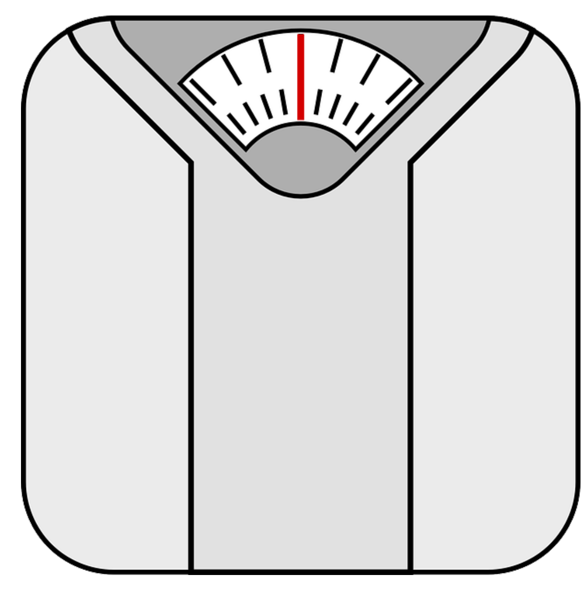
David L. Mahoney, MD, FASN, FASDIN
Chief Medical Officer
DaVita Hospital Services Group and Skilled Nursing Facility Dialysis

Treatment Refusal

ESRD NCC Quarterly Dialysis Care in the Nursing Home Expert Team Call Series

November 2, 2023

David L. Mahoney MD FASN FASDIN
Chief Medical Officer DaVita SNF Dialysis



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History

A 78 year old woman is admitted to the SNF following a hospitalization for acute kidney injury requiring dialysis. Review of the hospital record indicates that the patient was very agitated during dialysis, was confused and often crying. Dialysis is ordered at the SNF, but the patient repeatedly refuses to go.

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History - continued

The dialysis nurse goes to the patient's bedside and asks her why she does not want to come to dialysis. "I am so afraid of that machine. My sister was on dialysis and died, and I think it was because of the machine. Going on dialysis means I am going to die."

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Intervention 1 – Day 1

The nurse thanked the patient for sharing that insight. “I have had patients in the past who expressed the same fear. Once they learned about dialysis, the fear was gone.” The nurse sat at the patient’s bedside and talked with her about how dialysis works and why it is so important to stay on the ordered schedule of treatments

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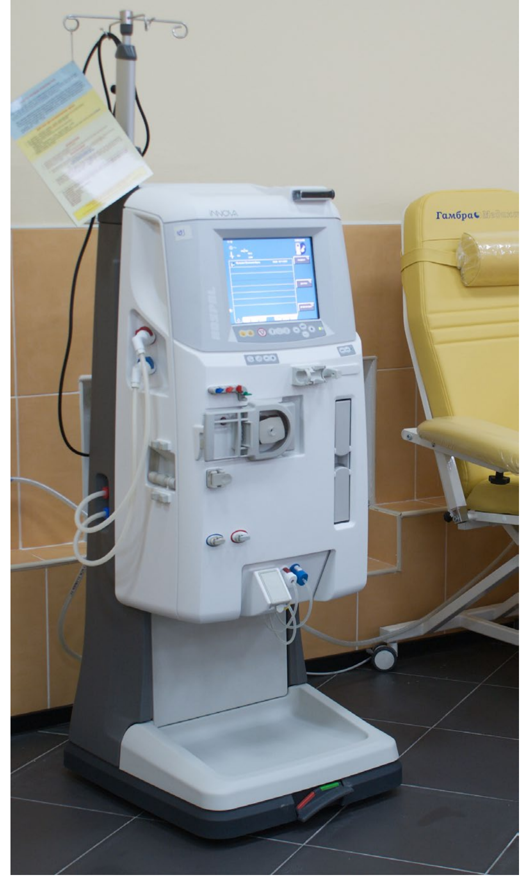
Intervention 2 – Day 1

After the other patients' treatments were finished for the day, the nurse returned and asked the patient to come to the dialysis room so that she could teach her about the machine. The patient was hesitant but agreed. While they sat together, the nurse talked about the machine and how it worked, what to expect, etc.



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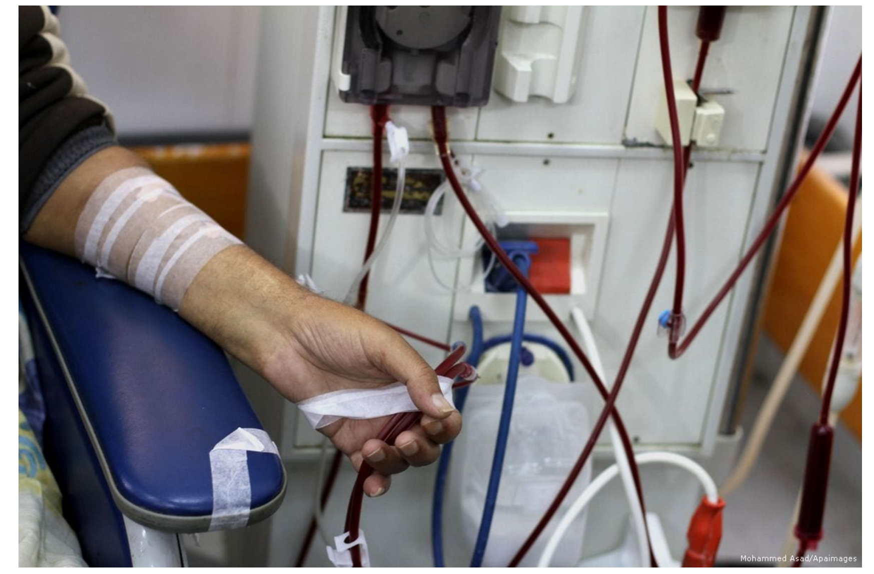
Intervention 3 – Day 2

The following day, the patient agreed to come to the dialysis room and talk with patients while they received dialysis. One woman in particular spoke of how dialysis relieved her shortness of breath and how her nausea was now gone. She invited the patient to sit with her and chat during her treatment.



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Intervention 4 – Day 2

Following her conversation with the other patient, the woman agreed to have dialysis. She was placed next to the woman with whom she had spoken, and they chatted away during dialysis. She appeared to have resolved her fear of dialysis and attended every future treatment.

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Why Is Missing Treatments So Important?

- Missing one treatment increases the risk of hospitalization within the next 30 days by 40%
- Missing one treatment doubles the risk of dying in the next 30 days
- Missing treatment is one of the most common reasons for fluid overload and respiratory distress
- Missing treatments may be a sign that the patient has psychological or social issues that have not been addressed

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Lessons Learned

- Patients may have strong reasons to refuse treatment
- Many patients are unaware of the potential consequences of missed treatments
- Taking the time to understand a patient's reason for missing or refusing treatment can make all the difference
- Care is just that

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Questions

Case Study Presentations

Katie Chorba MSN, RN (IPRO ESRD) Quality Improvement Director

Amy Stackman, RN (IPRO QIN/QIO)

Barbie Thompson, RN, BSN, Clinical Director – Hemodialysis

Angie Kroth, RN, Clinical Director – Home Therapies

Fort Smith Regional Center, Arkansas

Dialysis Care in the Nursing Home Expert Team Call- Network 9

Katie Chorba MSN, RN (IPRO ESRD)
Amy Stackman, RN (IPRO QIN/QIO)
November 2023

This material was prepared by the IPRO ESRD Network Program, comprising the ESRD Networks of New York, New England, the South Atlantic and the Ohio River Valley, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication #

Network 9 Demographics

- Ohio River Valley- OH, IN, and KY
- 624 Dialysis Facilities
- 32,191 Dialysis Patients
- 2,015 Nursing Home Resident Patients

Challenges with Nursing Home Patients Receiving Dialysis

- Communication between Nursing Home Providers and Dialysis Providers
- Staff Turnover
- Staff Education
- Acuity/Co-morbidities of the Patient Population
- EQRS Data Entry

These challenges attribute to increased infections, transfusions, and hospitalizations to this vulnerable population of patients.

Collaboration with QIN/QIO

Who, What, Where, and Why

- QIN/QIO
  - Quality Innovation Network-Quality Improvement Organization (QIN-QIO)
  - Work with nursing home providers offering education programs, technical assistance, data analysis, and tailored consulting to support improvement and change processes
- Ohio QIN/QIO covers over 712 SNF/LTC facilities

- The collaboration and partnership between ESRD and QIN/QIO groups play a crucial role in addressing communication barriers by leveraging data, sharing best practices, promoting education, enhancing patient engagement, and establishing a continuous improvement framework. This multi-faceted approach is essential in improving communication between these providers.

Collaboration Goals

- Enhance Information Sharing
- Data-Driven Insights
- Best Practice Sharing
- Collaborative Initiatives
- Education and Training
- Feedback Loops

Dialysis-Nursing Home Hand-Off Tool

Dialysis and Nursing Home Hand-Off COMMUNICATION TOOL

TO BE COMPLETED BY NURSING HOME AND SENT WITH RESIDENT FOR EACH TREATMENT

Resident Name: ______ Date: ______ Code Status: ☐ DNR ☐ CPR
Vital Signs: T ______ P ______ R ______ BP ______ Baseline Temp: ______ Allergies: ______
Current diet/fluid restrictions: ______
Last meal or snack and time consumed: ______
Current type of precautions? (If yes, for what?): ______

Contact person at nursing home for change of condition notification or questions: ______
Nursing Home name: ______ Contact number: ______

TYPE OF ACCESS: AV Fistula AV Graft Catheter (CVC)	
If Fistula or Graft, can you feel or hear a Bruit or Thrill?	☐ Y ☐ N
CVC dressing dry and intact?	☐ Y ☐ N
Signs or symptoms of infection	☐ Y ☐ N
DID PATIENT TAKE MEDICATIONS TODAY?	
Blood Pressure	☐ Y ☐ N ☐ N/A
Insulin	☐ Y ☐ N ☐ N/A
Blood Thinners	☐ Y ☐ N ☐ N/A
Opioids/Sedatives	☐ Y ☐ N ☐ N/A
(See attached medication list)	

CHANGES SINCE LAST DIALYSIS TREATMENT	NO (*Check N or describe change*)	DESCRIPTION OF CHANGE OR EVENT
Changes from baseline mental status	☐ N	
New medical problems or falls	☐ N	
Hospitalizations or ED visits	☐ N	
New medications or vaccinations	☐ N	
Labs drawn since last dialysis? (if yes, attach results)	☐ N	
Blood transfusions	☐ N	GI bleed, low hemoglobin, other:

TO BE COMPLETED BY DIALYSIS FACILITY AND RETURNED WITH RESIDENT AFTER EACH TREATMENT

Post treatment vital signs: T ______ P ______ R ______ BP ______
Complications/problems during dialysis: ______
Foods/fluid consumed during dialysis: ______ % Meal consumed ______ Fluids consumed
Medications given during dialysis: ______

Labs drawn	☐ Y ☐ N	Copy attached	☐ Y ☐ N
New or revised MD orders	☐ Y ☐ N	Copy attached	☐ Y ☐ N

Pre-dialysis weight		Post-dialysis weight	
Amount of fluid removed		Time dialyzed	

Changes, New Recommendations, Notes
Dietitian:
Social work:
Follow-up appointments made or needed:

NURSING HOME USE ONLY—UPON RETURN TO FACILITY FOLLOWING DIALYSIS

Patient Name: ______

Check all that apply	Yes	No	N/A	Dialysis center called for clarification	MD notified	Care plan changed	Nurse supervisor aware	Documentation/ follow-up/new orders
Bruit present	☐	☐	☐	☐	☐	☐	☐	☐
Thrill present	☐	☐	☐	☐	☐	☐	☐	☐
Hemodialysis catheter present	☐	☐	☐	☐	☐	☐	☐	☐
Catheter secured, clamped, and capped	☐	☐	☐	☐	☐	☐	☐	☐
Access bandage dry and intact	☐	☐	☐	☐	☐	☐	☐	☐

Vital signs: T ______ P ______ R ______ BP ______
Baseline temp: ______ Allergies: ______

Additional comments:

Nurse's signature: ______ Date/Time: ______

ALLIANT HEALTH SOLUTIONS | IPRO QIN-QIO HQIC ESRD | NQIIC Network of Quality Improvement and Innovation Contractors CENTERS FOR MEDICARE & MEDICAID SERVICES QUALITY IMPROVEMENT & INNOVATION GROUP

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Hand-Off Tool

Accessibility of the Hand-off Tool

- Will be available in IPRO Learn Tool Kits and IPRO ESRD Website
- In the resource library for the QIN/QIO
- Can be printed off and hand written
- PDF so it can be saved on desktop and filled out prior to printing

Looking Ahead

Upcoming Interventions and Future Directions for Collaboration

- Microlearnings
  - Patient education
  - Care partner education
  - Nurse/ Nurse Aide Education
- Communication Tools
  - Hand-off
  - Care Plan

Thank you….

End-Stage Renal Disease
Network Program

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IPRO ESRD Network Program/ Better Healthcare realized
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Schedule a meeting (Please Click the Link)
https://calendly.com/kchorbaiproesrd/30min

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Peritoneal Dialysis

In a Skilled Nursing Facility

Fort Smith Regional Dialysis Center

Angie Kroth, RN Director of Home Therapies

Barbie Thompson, RN BSN Director of Hemodialysis

Successful Skilled Nursing Dialysis

- Train Nursing Home Staff
  - Registered Nurse / Licensed Practical Nurse
  - Verbal & Written Test
- Staff Support 24 hours / day
  - Dialysis Center Day and On Call Phone Number
  - Baxter 24/7 Tech Support Phone Number

Ensure Quality of Care

- Daily Patient Treatment Review
- Weekly Patient Visits to Nursing Home
- Monitor Dialysis Supply Orders
- Maintain Support of Nursing Home Staff

Q and A

Knowledge Into Action

Top Take-Aways

What is one thing you learned today that you could start doing immediately?

How will this action improve your current way of doing the practice/process?

Who is involved and how can they support the action to make it sustainable?

Recap & Next Steps

- Additional pathways for learning
  - Sharing Best Practices to a greater community through coalition meetings
  - Using Case Study examples to identify new ways of doing something and missed opportunities

- Next meeting – February 1, 2024 @ 2 PM ET

Visit the ESRD NCC website to find materials and share
https://esrdncc.org/en/professionals/expert-teams/

Social Media

ESRD NCC | End Stage Renal Disease National Coordinating Center (NCC)

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