Expert Teams – Dialysis Care in Nursing Homes

Case-Based Learning & Mentorship

Friday, May 6, 2022

Facilitator: Julie A. Moss, ESRD National Coordinating Cener



Meeting Logistics

- Call is being recorded
- Lines will be open for all high performing organizations
 - 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 Guidelines



INTRODUCE YOURSELF BEFORE SPEAKING



KEEP PATIENT-SPECIFIC INFORMATION CONFIDENTIAL



BE WILLING TO SHARE SUCCESSES AND DIFFICULTIES



BE OPEN TO FEEDBACK



ASK THE DIFFICULT QUESTIONS



RESPECT OTHERS



USE "...AND" STATEMENTS



KEEP TO TIME LIMITS



Introductions

- Meeting Focus Dialysis Care in Nursing Homes
- Guest Experts
 - Janet Anderson, MSN, RN, CNN, Sanford Health
- High Performing Organizations
- ESRD Networks
- Centers for Medicare & Medicaid Services (CMS)



What are Expert Teams?

- A group made up of individuals from different high performing organizations, each with their own deep experience and knowledge
- Help others learn faster by sharing what worked (and what didn't work) in their organization
- Bring the best possible solutions to the table
- Continually learn and improve



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?



Presentation by Guest Expert

Janet Anderson, MSN, RN, CNN Home Dialysis Manager Satellite Health



WELCOME HOME

KIDNEY CARE

NCC
May 6, 2022

By Janet Anderson, MSN, RN, CNN Twyla Nordquist, BSN, RN, CNN Maria Regnier, MSN, RN, CNN

Sanford Health Dialysis Leadership



Nursing Home Partnership



- Partnered with GSS to provide Dialysis in the Nursing Home
- April 14, 2021 Dialysis "Den" opened



Case Study Paulette



Day 1:

- Walked to dialysis. Nausea 30" into treatment
- Received NS & UF dropped to zero; BS = 174
- Tx stopped 1' 13" into treatment & feeling better 20" after ending treatment
- Returned to room per wheelchair

Day 2

- Blood pressure meds held prior to dialysis
- Initial B/P 123/78
- 15" into treatment, Paulette felt nauseous & dizzy B/P = 87/59
- NS given; UF decreased; B/P=119/75
- Treatment ended 52" into treatment. Sitting B/P=169/89; Standing 129/82

Day 3

- Blood pressure meds held, received Zofran
- NS prime "dumped" prior to starting treatment
- Nausea & dizziness 1 hour into treatment B/P=72/45; NS 200 mL
- B/P=94/66; NS 200 mL
- Treatment ended after 1' 25" dialysis
- Sitting B/P=169/89; Standing B/P=129/82
- Sent to In-center for treatment



Case Study Paulette Continued



- In-center treatments continued for 2 weeks without complications.
- 124 Cartridge ordered & educator training set up

Returned to Den to resume HHD treatments

Day 1:

- Blood pressure med held & Zofran given
- Full 2 ½ hour treatment completed without complications
- B/P=115/71 prior to dialysis
- B/P 120-140's throughout treatment
- UF 700mL

Day 2:

- Full 2 ½ hour treatment completed
- B/P 130-140's throughout treatment with 1.4 L UF

Day 3:

- Full 2 ½ hour treatment completed
- B/P 140-150's throughout treatment with 1.5 L UF



Case Study Paulette Continued



Paulette has continued to receive treatments in the Den without complications.
Survey of Quality of Life shows increased QOL.

- On scale of 1-3, QOL increased to 2.8 from 2.3
- Decreased incidence of Hospitalizations

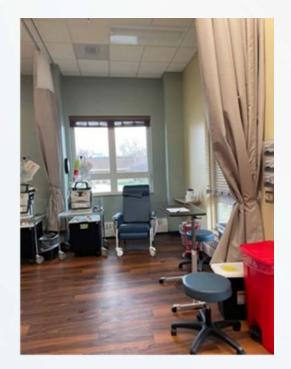
Paulette's comments regarding the Den:

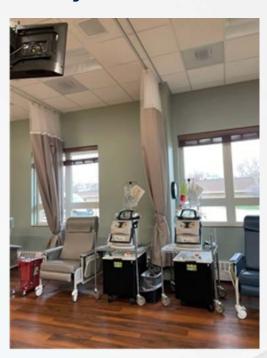
- I can just come around the corner & walk straight down. It's a lot easier.
- It gives me hope for the future.
- A lot of hope!



HHD Den at GSS-Sioux Falls, SD









Nursing Home Responsibilities: Transport resident to/from **Education Sessions** Determine Collaborative HHD w/dialysis & SBAR handoff before each tx workflows: labs, NH Staff meetings with Communication of upcoming supplies, nursing home to PD: Cycler, CAPD plan for the Den Dialysis nurse Administer any SQ or PO responsibilities of support medications each facility Resource book Schedule rides to monthly appt at clinic Monthly audits of PD set-up, connection & disconnection **Dialysis Staff Responsibilities:** Monitor patient during HHD SBAR handoff after each tx Communication/orders related to **Mock Code** meds to be held prior to dialysis Appts & schedule change Complete initially & • Communication of upcoming Weekly updated dialysis annually with both dialysis related appts schedule to NH unit Dialysis & NH staff Administer only Heparin in Den IV Iron is administered at monthly clinic appt New Patient Admissions · Collaboration of info by Dialysis & NH staff Include NH Manager in • Must be accepted at both monthly Home Dialysis Den & LTC facility **QAPI Meeting** No isolation w/dialysis and NH room in Den benchmarks No Hep B+ patient No C diff, etc.

Implementation





A

QUESTIONS:





Q&As



Questions to Run On -- Revisited



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Recap & Next Steps

- Top take-aways
- I like, I wish, I will
- Additional pathways for learning
- Event evaluation



Social Media









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Thank You

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