

**Care Transitions Coordinator Coalition**

**June 2017**

**Improving Care Transitions for Persons with Renal Failure**

**Guest Presenter:**

* **Lisa Nuckolls, RN, CCN, BSBM – Dialysis Care Coordination Program Manager, Dialysis Clinic, Inc**

Rhonda Dickman, of THA, and Lisa Nuckolls, the guest presenter from DCI, shared sobering data on the prevalence of renal failure in Tennessee and its rising readmission rate. Key strategies to improve care transitions for this unique patient population, particularly for those with end-stage renal disease, were discussed and are outlined below.

The End Stage Renal Disease Network Medical Advisory Council developed a Transitions of Care Toolkit that was published in January 2017. Although it was designed for dialysis clinics, the recommendations in Chapter 8, Transitions Between Care Settings, can be easily adapted to hospitals. A copy of the Toolkit can be obtained at: <http://esrdnetworks.org/resources/toolkits/mac-toolkits-1/new-toolkit-transitions-of-care-toolkit/transitions-of-care-toolkit/view>

## Recommendations

* Involve the dialysis clinic in care transition communications:
  + Have a dialysis clinical representative meet with your care transitions team to discuss existing processes, review actual cases, identify causes of process failures, and develop collaborative solutions
* Make sure the dialysis clinic is aware of the patient’s hospitalization
* Work with dialysis clinics to develop a renal failure care transition packets for use when transferring to/from the facility, and that include both a checklist of needed information and a protocol for using the packet
* Notify the patient’s nephrologist of the patient’s admission to the hospital. A nephrologist is most qualified to manage the patient’s medications, medication schedule, diet, nutritional supplements, and dialysis.
* Have a nephrologist or renal dietician provide education to hospital staff on the patient’s unique care needs. Include physicians, pharmacists, nurses, and others.
* Establish lines of communication between hospital pharmacy/dietary departments and the dialysis clinic’s medical director or inpatient dialysis medical director to serve as mutual resources.
* Empower patients and families to “speak up” if diet orders and medication schedules don’t seem right.
* Establish communications with the dialysis clinic and talk frequently.
* Ask local dialysis clinics to prepare information sheets on what patient care services they can/can’t provide.
* Utilize dialysis nurses to assist with patient/family discussions on post-acute services, such as physical rehabilitation. The dialysis nurses have an established relationship with the patient/family and can address concerns.
* Be certain the dialysis clinic and post-acute service provider have contact information for each other.
* Develop a renal failure discharge protocol that includes a process for communicating important information to the dialysis clinic. Identify the information that is needed and when it is needed; create a checklist and establish a process for getting the information sent routinely; and, if possible, provide dialysis clinic access to the patient’s hospital electronic record.
* Be sure dialysis orders are written prior to discharge. Identify key information needed by the nephrologist to write dialysis orders, and establish a process to have that information available timely.
* Partner with a dialysis clinic for post-discharge patient education and follow-up calls.
* For admission medication reconciliation, obtain a current medication and allergy list from the dialysis clinic as well as the patient/family.
* Involve a pharmacist in medication reconciliation, for both admission and discharge.
* For discharge medication reconciliation, communicate with inpatient dialysis staff about medications given at dialysis.
* If the prescribing clinician was not the patient’s nephrologist or primary care physician, communicate who will be responsible for ongoing refills and monitoring, such as mediations for pain, sleep, and depression.
* Develop a collaborative relationship with dialysis clinic staff, and establish a process for communicating patient discharge information. Include hospital staff that has post-discharge communications with the patient and family. Work to align messaging as far as possible.

## Summary of Key Recommendations:

1. Team up with dialysis clinics to coordinate patient care.
2. Establish formal channels of communication.
3. Collaboratively develop a renal failure care transition protocol.
4. Implement and monitor the protocol, making improvements as needed.