



## Care Plan

### *Instructions and Key Points*

#### I. What is an ESRD Patient Care Plan (Short-Term Care Plan)?

It is an interdisciplinary current treatment plan, identifying problems and a plan of correction. The plan includes input from physician, primary nurse, social worker, dietitian and patient. The plan is based on the nature of their illness, the treatment prescribed and needs. The purpose of the Patient Care Plan is to assure that the patient is receiving the appropriate care within the modality of treatment that has been selected. This will ensure continuity of care to meet the medical, psychosocial and nutritional needs of the patient.

#### II. Frequency

At this time, Care Plans must be completed within one month of admission to the facility and then monthly until the patient achieves the facility's definition of "stable". After the patient has stabilized, Care Plans are generated each six (6) months unless the patient becomes unstable. A patient who does not meet the facility's written definition of "stable" must be reviewed monthly. (v317-v322)

#### III. Definition of Stability

In order for a facility to use the check box labeled "stable" under the interdisciplinary section, it is essential that a written definition of "stable" be created by the individual facility. The criteria identifying a "stable" patient should be specific and should cover the broad spectrum of all disciplines. It is appropriate for a facility team to map out this broad-based definition as a component of the C.Q.I. process.

#### **For Care Planning purposes, examples of criteria for unstable could include:**

- All new patients within the first 60 days of initiating treatment.
- Any patient returning from a hospitalization associated with major surgery or major medical complication.
- Any patient that the physician deems unstable.
- Non-compliant patients that have not been deemed stable at QI meetings.
- Any problems that may be life threatening; e.g. hyperkalemia.

#### **Sample criteria for stable:**

- A problem is considered stable if the same issue has been evaluated and a new plan developed to resolve the issue on a monthly basis, for three (3) consecutive months. The problem cannot be life threatening. After the three months, the patient may be placed on a six-month calendar for stable care planning purposes and the issue considered "normal" for this patient. Continue to document regarding the issue on the Progress Note.

#### IV. What Not To Include

Do not include problems or needs over which you have no control in a the Care Plan. For example, a patient hospitalized as a result of a vehicle accident, or a patient needing amputation of a limb secondary to diabetes mellitus should not have these issues covered as part of his/her dialysis care plan. Additionally, if a patient has documented long-term non-compliance with well documented efforts to educate and change behavior in a particular area, that area should be signed off and not included as a component of a meaningful Care Plan. Under the medication section, just list meds that have changed or need changing as a result of the care planning process. (Do Not include entire medication list on this form.)

#### V. Points To Consider

- Care Plans should be specific to each patient and not generic in nature.
- Problems/needs should be clearly and concisely identified.
- Goals/outcomes should be measurable and should be reasonable for the patient. For example, if patient routinely has serum phosphorus of 13.0, a reasonable goal might be to reduce phosphorus levels by 20%. After this level is achieved, the goal can be reset.
- Do not use standards of practice as goals. For example, a patient with low URR who refuses to stay for full treatment time may not be a candidate for a URR goal of 65%.
- Clearly define how a goal is to be achieved and who is responsible for working with the patient to achieve the goal.
- A clear path must be evident in the medical record to substantiate any action taken to resolve a problem/need. These issues should not be identified in the Care Plan and then left undocumented in the body of the medical record; e.g. if a patient is not eating well and does not have support at home and the team has decided to make arrangements for “Meals on Wheels”, clear documentation that the contact has been made and the patient is receiving the service must be noted.

#### VI. Short Term Hemodialysis Care Plan *(see the following page)*



**Short Term Hemodialysis Care Plan**

- New Patient
- Re-Evaluation

Patient Name: \_\_\_\_\_ Attending Physician: \_\_\_\_\_

Access Type: \_\_\_\_\_ Date of Plan: \_\_\_\_\_

**MEDICAL**

Dialysis Prescription: Dialyzer \_\_\_\_\_ BFR \_\_\_\_\_ DFR \_\_\_\_\_ Bath K \_\_\_\_\_ Bath Ca \_\_\_\_\_  
RX Time \_\_\_\_\_ Tx/Wk \_\_\_\_\_ Heparin Bolus/Hourly \_\_\_\_\_

**Problem/Need**

- |   |   |
|---|---|
| <input type="checkbox"/> Stable           | <input type="checkbox"/> Adequacy: Kt/V _____ URR _____ |
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Anemia: HGB _____ FeSat _____  |
| <input type="checkbox"/> Infections       | EPO _____ SQ/IV _____ Ferritin _____ Iron Rx _____      |

Other Problem/Need/Change in Condition \_\_\_\_\_

\_\_\_\_\_

Goal/Outcome \_\_\_\_\_

\_\_\_\_\_

Plan/Intervention \_\_\_\_\_

\_\_\_\_\_

**NURSING**

**Problem/Need**

- |   |  |
|---|--|
| <input type="checkbox"/> Stable         | <input type="checkbox"/> Access Status                   |
| <input type="checkbox"/> Fluid Gains    | <input type="checkbox"/> Compliance w/Prescribed Therapy |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Dialysis Rx Problems            |

Other Problem/Need \_\_\_\_\_

\_\_\_\_\_

Goal/Outcome \_\_\_\_\_

\_\_\_\_\_

Plan/Intervention \_\_\_\_\_

\_\_\_\_\_

Care Plan Continued....

**NUTRITION**

**Problem/Need**

- Stable
- Weight Changes  
Dry Weight \_\_\_\_\_
- Nutritional Status: Alb \_\_\_\_\_ Chol \_\_\_\_\_ Potassium \_\_\_\_\_
- Compliance With Prescribed Diet
- Bone Disease: PTH \_\_\_\_\_ PO4 \_\_\_\_\_ CA \_\_\_\_\_ AL \_\_\_\_\_  
CAXPO4 Product \_\_\_\_\_ Calcijex \_\_\_\_\_ Zemplar \_\_\_\_\_

Other Problem/Need \_\_\_\_\_

\_\_\_\_\_

Goal/Outcome \_\_\_\_\_

\_\_\_\_\_

Plan/Intervention \_\_\_\_\_

\_\_\_\_\_

**PSYCHOSOCIAL**

**Problem/Need**

- Stable
- Insurance Problems/Financial
- Transplant Status
- Transportation
- Adjustment to Dialysis/Depression/Anxiety
- Support Network
- Community Referrals/Services
- Employment Issues

Other Problem/Need \_\_\_\_\_

\_\_\_\_\_

Goal/Outcome \_\_\_\_\_

\_\_\_\_\_

Plan/Intervention \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MD Signature

Date

RN Signature

Date

RD Signature

Date

LCSW Signature

Date

Patient Signature

Date

VII. Examples

*Expected Outcome:*

- The patient will achieve optimal nutritional status and will be free of the consequences of:
  - Unplanned dry weight loss. The patient will stop losing weight and begin to gain dry weight as needed
  - Low albumin
  - Arrhythmias or any heart abnormalities, which could be fatal, due to the excessive intake of potassium or inappropriate dialysate.
  - Low potassium due to inadequate intake of entire meal plan or inappropriate dialysate
  - Hyperglycemia

*Assessment:*

Define Problem Unplanned Dry Weight loss of: $\geq 10\%$ within last six months or Dry Weight $< 100\%$ of Ideal Weight (ideal weight to be adjusted for limb amputations) due to inadequate intake of protein and calories; secondary to decreased appetite or gastrointestinal symptoms.	No Problem Dry Weight is stable within normal range of $\geq 100\%$ of Ideal Weight or Adjusted Ideal Weight.
Albumin $< 3.8$ Due to: inadequate intake of protein and calories; secondary to decreased appetite or gastrointestinal symptoms.	Albumin $\geq 3.8$
Potassium $> 6.0$ Due to: excess intake, inappropriate dialysate (too high), missed/shortened tx, GI bleed or hyperglycemia	Potassium between 3.5 — 6.0
Potassium $< 3.5$ Due to: inappropriate dialysate (too low) or inadequate intake	Potassium between 3.5 — 6.0
Glucose $> 200$	Glucose $\leq 200$

*Plan/Intervention:*

- Explain to the patient/caregiver the connection to the consumption of the prescribed meal plan, enteral supplements, protein powder or IDPN.
- Offer enteral supplements to patients with albumin's  $< 3.5$
- Explain to the patient/caregiver to let the Nurse know about decreased appetite or gastrointestinal problems when assessed.
- Confer with MD as necessary re: prescribed meal plan, enteral supplements, protein powder, or IDPN evaluation, decreased appetite, gastrointestinal symptoms/medications and appropriate potassium dialysate.

- Explain to the patient/caregiver the importance of following the potassium restriction in the meal plan and the consequences of not adhering to the plan.
- Assist the patient/caregiver to identify the problem foods or medications causing the high potassium and how to select appropriate substitutes.
- Explain to the patient/caregiver why not to use salt substitute or Lite Salt.
- Confer with the MD re: possible consults.
- Instruct the patient/caregiver on how to control blood glucose with meal planning.
- Liberalize the meal plan as much as possible to accommodate food preferences within the diet prescription.
- Provide the appropriate educational materials.
- If appropriate, confer with RN/RD at SNF regarding regular monthly lab values/weight records/nutritional plan.