

Minimum Standards for Social Worker Involvement in the Care of ESRD Patients

Standards

1. Evidence of a psychosocial evaluation by a qualified social worker will be documented in the patient's medical record* not later than one month after initiation of dialysis.
2. Participation of a qualified social worker in the development of the Comprehensive Multidisciplinary Patient Assessment (CMPA) will be documented by signature on the CMPA and in the medical record, within one month of initiation of dialysis.
3. Evidence of participation by a qualified social worker in each patient's written plan of care. The written patient plan of care must be individualized for the patients, built on the comprehensive patient assessment, and include at minimum: problem(s) identified at assessment/reassessment, measurable goals/outcomes, interventions for achieving the goals, timetables and reassessment date(s). Implementation of plan of care should be demonstrated in the treatment records, progress notes, laboratory results. The Plan of Care for patients whose condition is unstable is reviewed at least monthly while annual updates are acceptable for stable patients. Refer to V520 of the ESRD Conditions for Coverage for the minimum criteria for stable versus unstable patients. The Plan of Care is revised as necessary to ensure that it provides for the patient's ongoing needs
4. Progress notes by a qualified social worker will be documented as per the ESRD Conditions for Coverage. If more frequent intervention is indicated or assistance required, the social worker will document this in the medical record on an "as needed" basis. This will also be reflected in the social work treatment plan, which may include one or more of the following:
 - a. Communication with staff concerning the patient's attitude behavior toward his/her illness and treatment modality
 - b. Communication with patient and/ group therapy
 - c. Referral to community agencies.

Psychosocial evaluation is defined as:

The social worker's written professional assessment of the patient/family, which may include the patient's strengths and weaknesses, problem definition, and attitude toward illness. The assessment is based upon a study of the patient/family current life situation and pertinent aspects of his/her past life. Psychosocial treatment plans and goals are developed based on this evaluation.

"Qualified social worker" is defined in the Federal Regulations, Section 494.140 (d) (1): as:

The facility must have a social worker who (1) holds a master's degree in social work with a specialization in clinical practice from a school of social work accredited by the Council on Social Work Education; or (2) has served at least 2 years in social work, 1 year of which was in a dialysis unit or transplantation program prior to September 1, 1976, and has established a consultative relationship with a social worker who qualifies under paragraph above.

*Confidential material will be available to the professional staff but will not be in the bedside chart.

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Minimum Standards for Dietitian Involvement in the Care of ESRD Patients

Standards

1. Evidence of nutritional assessment by a qualified dietitian will be documented in the patient's medical record not later than one month after initiation of dialysis and/or prior to transplantation.
2. Dietary recommendations based on nutritional assessment and on prescribed diet will be documented by a qualified dietitian in the medical record not later than one month after initiation of dialysis and/or prior to transplantation.
3. Participation of a qualified dietitian in the development of the Comprehensive Multidisciplinary Patient Assessment (CMPA) will be documented by signature on the CMPA and in the medical record within one month of initiation of dialysis and/or prior to transplantation.
4. Progress notes by a qualified dietitian will be in the medical record and written at least quarterly (every three months). If more frequent intervention is indicated or assistance required, the dietitian will document in the medical record on an "as needed" basis. This will also be reflected in the treatment plan of care, which may include one or more of the following:
 - a. Communication with staff and patient and/or family concerning monitoring of the patient's dietary compliance, response to diet and nutritional status
 - b. Patient and/or family education and counseling.
5. Evidence of participation by a qualified dietitian in each patient's written plan of care. The written patient plan of care must be individualized for the patients, built on the comprehensive patient assessment, and include at minimum: problem(s) identified at assessment/reassessment, measurable goals/outcomes, interventions for achieving the goals, timetables and reassessment date(s). Implementation of plan of care should be demonstrated in the treatment records, progress notes, laboratory results. The Plan of Care for patients whose condition is unstable is reviewed at least monthly while annual updates are acceptable for stable patients. Refer to V520 of the ESRD Conditions for Coverage for the minimum criteria for stable versus unstable patients. The Plan of Care is revised as necessary to ensure that it provides for the patient's ongoing needs.

"Qualified Dietitian" is defined in the federal regulations, Section 494.140 (c) (2): as:

The facility must have a dietitian who must (1) be a registered dietitian with the Commission on Dietetic Registration; and (2) have a minimum of 1 year professional work experience in clinical nutrition as a registered dietitian.

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