PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

Patient : **Assessment Date:** ☐ **Initial** ☐ **Annual** ☐ **Monthly** ☐ **Other**

Nephrologist: Gender: DOB: Date of 1st Dialysis in facility:

Current Modality: Primary Dialysis Setting ☐ In-Center ☐ Home ☐ SNF/Long Term Care Facility

Primary CKD Diagnosis: Allergies ☐ Yes ☐ No

Secondary Diagnosis:

I. CURRENT STATUS ☐ STABLE ☐ NOT STABLE (continue below)

☐ **Marked deterioration in health status**

☐ **Concurrent poor nutritional status, unmanaged anemia AND inadequate dialysis**

☐ **Significant change in psychosocial needs**

☐ **Hospitalization (frequent or extended, indicate below):**

1) Admission Date: Discharge Date: Estimated LOS:

Discharge diagnosis(es):

2) Admission Date: Discharge Date: Estimated LOS:

Discharge diagnosis(es):

☐ **Other:**

II. PATIENT COMPLAINTS ☐ No Complaints ☐ Complaints (indicate below)

☐ **Complains Of:**

III. PHYSICAL ASSESSMENT & VITAL SIGNS

Vitals:	B/P:			Pulse:	Resp:	Temp:
Weight:	Current Weight:		BMI:	EDW:	Height:	
Pain:	☐ No Pain	☐ Mild	☐ Moderate	☐ Severe		
Skin:	☐ Warm & Dry		☐ Pale/Redness/Rash/Bruising		Wound :	
Edema:	☐ N/A	☐ +1/+2/+3			Location :	
Adequacy:	☐ Goal Met		☐ Not Met			
Dialysis Access:	☐ Functional	☐ Infection	☐ Low BFR	☐ Stenosis/Thrombosis	☐ Difficult cannulation	☐ Slow Drain Time
Heart:	☐ Normal Heart Sounds		☐ Murmur	☐ Gallop	☐ Rub	
Lungs:	☐ Clear	☐ Rales	☐ Rhonchi	☐ Wheezes	☐ Cough	
Abdomen:	☐ Normal Bowel Sounds		☐ Decreased Bowel Sounds		☐ Absent Bowel Sounds	☐ Tender to Touch
Medications:	☐ Review Complete		☐ Date:			

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

CARDIOVASCULAR ASSESSMENT & PLAN OF CARE

I. CARDIO/PULMONARY HEALTH

Patient Goal:

Date: **Goal Met:** ☐ Yes ☐ No ☐ Monitor & Maintain

Assessment:

- ☐ Atherosclerotic heart disease (ASHD)
- ☐ Cardiomyopathy ☐ Ischemic ☐ Hypertrophic ☐ Unknown
- ☐ Congestive Heart Failure (CHF) ☐ Left ☐ Right ☐ Unknown
- ☐ Dysrhythmia ☐ Atrial fibrillation ☐ Ventricular dysrhythmia
- ☐ Heart Transplant ☐ Pacemaker ☐ Internal defibrillator
- ☐ Hypertension
- ☐ Asthma
- ☐ COPD (Chronic obstructive pulmonary disease)
- ☐ Obstructive Sleep Apnea
- ☐ Supplemental Oxygen dependence
- ☐ Other:
- ☐ Ischemic Heart Disease: Angina ☐ At Rest ☐ On Exertion ☐ On Dialysis
- ☐ Myocardial Infarction
- ☐ Peripheral vascular disease/neuropathy
- ☐ Renal Artery Stenosis
- ☐ Valvular Heart Disease
- ☐ Smoking [ ] Yes [ ] No [ ] Past Smoker
- ☐ TB (Tuberculosis)

Action Plan:

- ☐ Medication review/Adjustment
- ☐ Weight reduction
- ☐ Cardiac Rehabilitation
- ☐ Vascular Studies
- ☐ Comment:
- ☐ Pulmonary Studies
- ☐ Referral ☐ Cardiac
- ☐ Reinforce adherence medications
- ☐ Other:
- ☐ Smoking Cessation Education
- ☐ Pulmonary

II. BLOOD PRESSURE/FLUID MANAGEMENT

KDOQI: ■ **Blood Pressure ≤ 130/80 mm/Hg (post treatment)** ■ **Optimal fluid volume status**

Patient Goal:

Date: **Goal Met:** ☐ Yes ☐ No ☐ Monitor & Maintain

Blood Pressure:

- ■ Pre Tx: ■ Post Tx: ■ EDW:
- ■ Avg Interdialytic Wt Gain: ■ Avg Fluid Removal:

Assessment:

- ☐ Dietary Intake
- ☐ Inability to adhere to treatment regimen
- ☐ Interdialytic muscle cramping
- ☐ Medication: Dose adjustment
- ☐ Increased thirst
- ☐ Other:
- ☐ Medication: Inadequate response
- ☐ SOB

Action Plan:

- ☐ Adjust dry weight
- ☐ Weight reduction
- ☐ Dietary prescription
- ☐ Other:
- ☐ Comment:
- ☐ Reinforce sodium and fluid control
- ☐ Sodium modeling
- ☐ Reinforce adherence medications, glucose control, self-monitoring
- ☐ Patient / family education

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

III. LIPIDS

KDOQI: ■ **LDL < 100 mg/dL** ■ **HDL > 40 mg/dL** ■ **Trig < 150 mg/dL**

Patient Goal:

Tests:	**LDL:**	**HDL:**	**TRIG:**	**CHOL:**
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain

Assessment:

- ☐ Newly diagnosed
- ☐ Dietary Intake
- ☐ Medication: Dose adjustment
- ☐ Inability to adhere to treatment regimen
- ☐ Medication: Inadequate response
- ☐ Other:

Action Plan:

- ☐ Weight reduction
- ☐ Medication
- ☐ Fibrate
- ☐ Niacin
- ☐ Statins / Medication Review
- ☐ Dietary prescription
- ☐ Physical activity
- ☐ Patient/family education
- ☐ Other:
- ☐ Comment:

IV. ANEMIA

KDOQI: ■ **Hgb 10 - 12 g/dL(general range)** ■ **TSat ≥ 20%** ■ **Ferritin 200 - 500 ng/mL HD 100 - 500 ng/mL PD**

Patient Goal:

Tests:	**Hgb:**	**TSat:**	**Ferritin:**
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain

Assessment:

- ☐ Newly diagnosed
- ☐ Recent hospitalization
- ☐ Bleeding
- ☐ Blood loss during treatment
- ☐ Clotting disorders
- ☐ Sickle cell disease
- ☐ Hypoalbuminemia
- ☐ Iron: ☐ Low stores ☐ Not ordered ☐ On hold ☐ Missed dose
- ☐ ESA: ☐ Low response ☐ Not ordered ☐ On hold ☐ Missed dose
- ☐ Thrombocytopenia
- ☐ Heparin allergy ☐ Infection / Inflammation
- ☐ Other:

Action Plan:

- ☐ Evaluate underlying cause
- ☐ Evaluate/adjust EPO administration
- ☐ Evaluate/adjust IV Iron administration
- ☐ Minimize treatment-related blood loss
- ☐ Evaluate for hyporesponse
- ☐ Blood transfusion
- ☐ Evaluate heparin dose
- ☐ Evaluate nutritional status
- ☐ Patient/family education
- ☐ Other:
- ☐ Comment:

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

BONE HEALTH & NUTRITION ASSESSMENT & PLAN OF CARE

I. BONE HEALTH

KDOQI: ■ **CA 8.4 - 10.2 mg/dL** ■ **Phos 3.5 - 5.5 mg/dL** ■ **I-PTH 150 - 300 ng/dL**

Patient Goal:

Tests:	**CA:** * CORR	**PHOS:**	**I-PTH:**
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain
Assessment:	☐ Secondary hyperparathyroidism ☐ Dietary intake ☐ Osteoarthritis	☐ Inadequate response to treatment ☐ Joint replacement ☐ Gout	☐ Financial difficulties ☐ Inability to adhere to treatment regimen ☐ Other:
Action Plan:	☐ Evaluate Serum 25-Hydroxyvitamin D ☐ Evaluate / adjust Phosphate binder ☐ Evaluate / adjust Vitamin D analog ☐ Evaluate / adjust Calcimemetic ☐ Other: ☐ Comment:	☐ Social services referral ☐ Dietary counseling ☐ Exercise for strength and mobility ☐ Other medication adjustments	☐ Patient/family education: ☐ Self-management strategies ☐ Adherence to diet / meds / tx ☐ Referral

II. NUTRITION

KDOQI: ■ **Albumin ≥ 4.0 g/dL**

Patient Goal:

Weight:	■ Pre Tx:	■ Post Tx:	■ EDW:	
Tests:	**ALB:**	**K:**		
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain			
Assessment:	☐ Dietary intake ☐ Solid weight gain ☐ Malignancy ☐ Inadequate protein intake ☐ Peptic Ulcer Disease	☐ Fluid retention ☐ Anorexia/Nausea ☐ Constipation ☐ Diverticulitis ☐ GI Bleed	☐ Gastroparesis ☐ Malabsorption ☐ Diarrhea ☐ Infection/inflammation ☐ Other:	☐ Dental ☐ Dentures ☐ Gum Disease ☐ Difficulty Chewing ☐ GERD
Action Plan:	☐ Monitor weight gain / loss ☐ Dietary counseling ☐ Dietary supplement ☐ Weight reduction ☐ Financial assistance or food assistance ☐ Comment:	☐ Physical activity / exercise regimen ☐ Medication ☐ Start ☐ Adjust ☐ Protein supplementation ☐ Evaluate for underlying cause ☐ Other:		☐ Patient / family education ☐ Self-management strategies ☐ Adherence to diet/meds/tx ☐ Referral

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

DIABETES ASSESSMENT & PLAN OF CARE

I. DIABETIC MANAGEMENT

KDOQI: ■ **HgbA1c ≤ 6.5 %**

Patient Goal:

Tests:	**GLUC:**	**HgbA1c:**	**Insulin:** ☐ Yes ☐ No Type:
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain	Dose:
Assessment:	☐ Newly diagnosed ☐ Dietary Intake ☐ Other:	☐ Inability to adhere to treatment regimen ☐ Inability to self-monitor	☐ Infection ☐ Inadequate response to treatment
Action Plan:	☐ Evaluate / adjust oral diabetic med ☐ Evaluate / adjust Insulin ☐ Patient / family education: Teach patient self-management strategies, including record keeping and interpretation of results ☐ Financial assistance ☐ Comment:	☐ Dietary counseling ☐ Order medical ID (bracelet/necklace) ☐ Other:	☐ Eye exam (annual) ☐ Referral

II. COMPREHENSIVE FOOT EXAM

Patient Goal:

Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain		
Assessment:	☐ Newly diagnosed ☐ Other:	☐ Financial difficulties	☐ Amputation:
Action Plan:	☐ Proper footwear reinforced ☐ Other: ☐ Comment:	☐ Instruct/review foot care at home	☐ Vascular surgeon referral

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

DIALYSIS ADEQUACY ASSESSMENT & PLAN OF CARE

I. DIALYSIS ADEQUACY

KDOQI: ■ [illegible] ■ Kt/V ≥ 1.2 HD

Patient Goal:

Tests:	**[illegible]:**	**Dr[illegible]V:** **Volume:**	**[illegible]:** **Resi:**
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain	☐ Yes ☐ No ☐ Monitor & Maintain	

Assessment:

- ☐ Ineffective treatment due to: [ ] Inadequate blood or dialysate flow [ ] Vascular access [ ] Inadequate heparin [ ] Reuse [ ] Improper technique/dialysate
- ☐ Skips treatments due to: [ ] Difficulty w/transportation [ ] Schedule conflicts [ ] Treatment side effects [ ] Denies importance of adequate dialysis
- ☐ Shortens dialysis time due to: [ ] Difficulty w/transportation [ ] Schedule conflicts [ ] Treatment side effects [ ] Denies needing prescribed time
- ☐ Other:

Action Plan:

- ☐ Evaluate/adjust treatment prescription
- ☐ Counseling
- ☐ Address patient's reasons for non-adherence
- ☐ Other:
- ☐ Comment:
- ☐ Social services consult
- ☐ Involve family member
- ☐ Patient / family education:
- ☐ Consequences of inadequate dialysis
- ☐ Value of permanent access
- ☐ Re-education

II. DIALYSIS ACCESS

Patient Goal:

Goal Met: ☐ Yes ☐ No ☐ Monitor & Maintain

Assessment:

- ☐ Absent or diminished bruit/thrill
- ☐ Non-functioning central venous catheter
- ☐ Non-functioning permanent vascular access
- ☐ Non-functioning PD catheter
- ☐ Difficult cannulation
- ☐ Steal syndrome
- ☐ Pain
- ☐ Infection
- ☐ Swelling
- ☐ Low access flow
- ☐ Recirculation
- ☐ High venous pressure
- ☐ Increased negative arterial pressure
- ☐ Other:
- ☐ Type:
- ☐ Location

Action Plan:

- ☐ Surgical consult
- ☐ Vascular access study referral
- ☐ Culture & sensitivity
- ☐ Other:
- ☐ Comment:
- ☐ Patient / family education:
- ☐ Value of permanent access
- ☐ Measures to prevent thrombosis and infection
- ☐ PD catheter care

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

INFECTION/HEALTH MAINTENANCE ASSESSMENT & PLAN OF CARE

I. INFECTIONS

Patient Goal:

Goal Met: ☐ Yes ☐ No ☐ Monitor & Maintain

Assessment:

- ☐ Drainage
- ☐ Redness
- ☐ Warm to touch
- ☐ Fever
- ☐ Pain
- ☐ Bacteremia or Septicemia
- ☐ (History of) VRE or other drug-resistant bacteria ☐ Active/Current
- ☐ Hepatitis B ☐ Acute ☐ Chronic
- ☐ RA (rheumatoid arthritis) ☐ Other:
- ☐ Hepatitis C ☐ Acute ☐ Chronic
- ☐ HIV
- ☐ MRSA (within last 5 years)
- ☐ SLE (systemic lupus erythematosus)
- ☐ Cytomegalovirus
- ☐ Scleroderma

Action Plan:

- ☐ Culture & sensitivity
- ☐ Antibiotic therapy
- ☐ Patient/family education
- ☐ Reinforce good hygiene practices
- ☐ Evaluate and address risk factors associated with environment, hygiene or lifestyle
- ☐ Other
- ☐ PET
- ☐ Comment:

II. HEALTH MAINTENANCE (VACCINATIONS)

CDC: ■ **Vaccinations current** ■ **HBsAb titer > 10 mIU/mL**

Patient Goal:

Tests:	**HBsAb:**	**HBsAg:**	**HBcAb:**
Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain		

Assessment:

- ☐ Hep B vaccination ☐ Received ☐ Receving 3 dose series ☐ Needs booster ☐ Refuses ☐ Contraindicated
- ☐ Hepatitis C positive ☐ Colonoscopy ☐ TB Screening
- ☐ Influenza vaccination ☐ Received ☐ Refuses ☐ Contraindicated ☐ Needs ☐ Mammogram
- ☐ Pneumoccal vaccination ☐ Received ☐ Refuses ☐ Contraindicated ☐ Needs ☐ PSA
- ☐ Other: ☐ Thyroid Testing

Action Plan:

- ☐ Administer vaccinations ☐ Patient/family education ☐ Referral
- ☐ TB skin test ☐ Other:
- ☐ Comment:

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

PSYCHOSOCIAL ASSESSMENT & PLAN OF CARE

I. ADJUSTMENT TO DIALYSIS

Patient Goal: _

Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain		
Assessment:	☐ Stable	☐ Needs intervention	☐ Cognitive barriers
	☐ Improving	☐ Difficult to identify	
Action Plan:	☐ Evaluate treatment prescription	☐ Patient / family education	☐ Social services consult
	☐ Address patient's specific concerns	☐ Involve family member(s)	
	☐ Other:		
	☐ Comment:		

II. PSYCHOSOCIAL

Patient Goal:

Goal Met:	☐ Yes ☐ No ☐ Monitor & Maintain				
Assessment:	☐ Stable	☐ Improving	☐ Needs intervention	☐ Difficult to identify	☐ Cognitive barriers
Rehabilitation Status:	☐ Employed, full time	☐ Homemaker	☐ Disabled	☐ Vocational Rehab	
	☐ Employed, part time	☐ Retired	☐ School/Training		
Family/Support System:	☐ Stable	☐ Improving	☐ Needs intervention	☐ Difficult to identify	☐ Lives alone
	☐ Other				
ADL Support:	☐ Independent	☐ Some assistance	☐ Total assistance	☐ Home Health	
	☐ Walker/Cane	☐ Wheelchair	☐ OT/PT	☐ Home O2	
	☐ Amputation:		☐ Hearing Aid/Deaf	☐ Glasses/Blind	
Social Needs:	☐ Stable	☐ Transportation	☐ Medications	☐ Insurance	
	☐ Other				
Transportation:	☐ Self	☐ Family/Caregiver	☐ Transport Service	☐ Ambulance	☐ Other:
Mental Health:	☐ Stable	☐ Depression	☐ Anxiety	☐ Anger	☐ Other:
	☐ Alcohol/substance abuse	☐ Dementia (Alzheimers)	☐ Bipolar/Schizophrenia	☐ Tobacco History.	

Cognitive:	☐ Alert and oriented	☐ Inability to make decisions	☐ Language barrier
	☐ Makes decisions independently	☐ Learning barrier	☐ Primary language:
	☐ Need assistance w/decision making	☐ Emotional barrier	
Action Plan:	☐ Social services consult	☐ Family counseling	☐ Evaluate treatment prescription
	☐ Rehabilitation services consult	☐ Spiritual counseling	☐ Exercise program
	☐ Psychosocial referral	☐ Patient education specific to learning ability	☐ Address patient's specific concerns
	☐ Physical therapy referral	☐ Involve family member	☐ Patient education
	☐ Other:		
	☐ Comment:		

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

EDUCATION ASSESSMENT & PLAN OF CARE

I. MODALITY

CMS: ■ **Modality selected**

Patient Goal:

Goal Met: ☐ Yes ☐ No

Hemo: ☐ In-center ☐ Staff-assisted ☐ Self ☐ Home ☐ Nocturnal

Peritoneal: ☐ CAPD ☐ CCPD / APD / IPD ☐ TPD

Assessment:

☐ Comprehension of materials ☐ Financial barriers ☐ Family support inadequate

☐ Learning barrier ☐ Difficulty in transportation ☐ Other:

Action Plan:

☐ Present modality options ☐ Evaluate home situation ☐ Evaluate social support

☐ Other:

☐ Comment:

II. TRANSPLANT STATUS

☐ **Yes** ☐ **No** ☐ **Undecided** ☐ **Not a suitable candidate**

Transplant facility: Referral Date:

If no, reason: ☐ Age ☐ Medical ☐ Financial ☐ Satisfied with dialysis ☐ Other:

III. DISASTER REVIEW

CMS: ■ **Verbalizes understanding of unit policy for fire, tornado, hurricane, earthquake, other _** ■ **Able to point out exits**

Patient Goal:

Goal Met: ☐ Yes ☐ No

If no, reason: ☐ Learning barrier ☐ Physical limitation ☐ Uncooperative ☐ Other:

IV. MEDICATION REVIEW

Patient Goal:

Goal Met: ☐ Yes ☐ No ☐ Monitor & Maintain

Assessment:

☐ Cannot remember medications / timing / purpose / changes ☐ Lacks resources to obtain prescriptions

☐ Perceives side effects are intolerable ☐ Does not carry medication card

☐ Does not believe or agree with prescription ☐ Other:

Action Plan:

☐ Review meds, purpose, and dose ☐ Assess for real or perceived side effects

☐ Provide written instructions with meds, purpose, schedules and doses ☐ Teach potential adverse effects of other OTC medications

☐ Provide illustrated / pictorial instructions of meds, doses, etc. ☐ Identify support and training system for proper med administration

☐ Other:

☐ Comment:

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

V. ADVANCED DIRECTIVES	**Patient Goal:**		
Assessment:	☐ Advanced directives	☐ DNR order at facility	☐ Patient refuses
	☐ Legal guardian	☐ Durable power of attorney	
Action Plan:	☐ Complete advanced directives	☐ SW referral	☐ Teach importance of advanced directives

Patient Goals:	
Goals & Comments:	

PLAN OF CARE AND INTEGRATED ASSESSMENT

Patient Name: **Patient ID:** **Plan of Care Date:**

Notes:	
Physician:	
Nurse:	
Dietitian:	
Social Worker:	
Signatures:	
Physician:	Date:
Nurse:	Date:
Dietitian:	Date:
Social Worker:	Date:
Patient:	Date: