Quality Insights
Renal Network 3

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Regulations for End-Stage Renal Disease Facilities That Pertain to Transplant

New Jersey State: N.J.A.C. Title 8, Chapter 43A, Standards for Licensure of Ambulatory Care Facilities

8:43A-24.3 Minimum and maximum program size and transfer agreements, (b) A facility providing ambulatory dialysis services shall have a written transfer agreement with at least one hospital with a New Jersey license to provide inpatient dialysis and with at least one hospital having a Medicare-certified and Department-licensed renal transplantation program.

8:43A-24.13 Patient care plan, (b) Within one calendar month of initiation of dialysis treatment at the facility, a written plan of care shall be developed for each ambulatory dialysis patient by a multidisciplinary team consisting of at least, a nephrologist, a transplant surgeon or designee, a registered professional nurse, a registered dietitian, and a licensed social worker. The plan of care shall specify observable and measurable goals and expected patient outcomes. The multidisciplinary team shall analyze patient outcomes on a regular basis to assess the patient's progress and evaluate current and future treatment modalities and modify the plan as necessary.

8:43A-24.13 Patient care plan, (c) Every six months at minimum, the multidisciplinary team shall discuss and review the written patient care plan with each ambulatory dialysis patient and/or family and shall revise as needed.

8:43A-24.13 Patient care plan, (d) Each member of the multidisciplinary team shall enter progress notes into the chronic dialysis patient's medical record. Progress notes by the physician, registered professional nurse and dietician shall be entered in the patient's medical record at least monthly and by the social worker at least quarterly.

8:43A-24.17 (d) The pediatric care plan shall be established as follows: (1)(ii) All pediatric renal patients shall be seen and evaluated by a transplantation team within 90 days of admission.

8:43A-24.21 Chronic kidney disease counseling services (a)(1) Development of a patient educational program which shall include, but is not limited to, the following: …**(iii)** Renal replacement therapy options (that is, hemodialysis, peritoneal dialysis, transplantation);…

This is not an all-inclusive document and the ESRD facility is expected to be in compliance with all State and Federal regulations at all times. February 7, 2018

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Federal: Part 494 Conditions for Coverage for End-Stage Renal Disease Facilities

494.70, Patients' rights, (a) Standard: Patients' rights. The patient has the right to-(7) Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients; …

494.80, Patient assessment, (a) Standard: Assessment criteria. (10)/V514. Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for the nonreferral must be documented in the patient's medical record.

494.90, Patient plan of care, (a) Standard: Development of patient plan of care for each patient. 7(ii)(A,B,C)/V554. Transplantation status. When a patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The patient's plan of care must include documentation of the (A) Plan for transplantation; if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or (C) Reason(s) for the patient's nonreferral as a transplantation candidate as documented in accordance with 494.80(a)(10)

494.90, Patient plan of care, (c) Standard: Transplantation referral tracking/V561. The interdisciplinary team must (1) Track the results of each kidney transplant center referral; (2) Monitor the status of any facility patients who are on the transplant wait list; and (3) Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status.

494.90, Patient plan of care, (d) Standard: Patient education and training/V562. Standard: Patient education and training. The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.